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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

The Causes and Conditions That Led to a $12 Billion Supplemental Funding Request

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Executive Summary

The Veterans Health Administration (VHA) oversees and provides medical care for enrolled veterans at VA facilities and from healthcare providers in the community, drawing from VA's annual budget. In July 2024, VA informed Congress that about $12 billion in additional funding was potentially needed for VHA to support its spending for the last three months of fiscal year (FY) 2024 and for all of FY 2025—an amount equaling about 8 percent of VHA's estimated obligations for FY 2025.[1] That is, as of July 2024, there were still nearly three months remaining in FY 2024 and VHA had experienced higher-than-expected obligations that it possibly could not support within its FY 2024 budget. As a result, according to VHA officials, they thought they might need to dip into carryover funds in FY 2024 meant for the next fiscal year. Without that carryover and given continuing higher obligations than anticipated, there would be a shortfall in funding for FY 2025, amounting to the projected total of $12 billion.

Also in July 2024, VA requested supplemental funding of nearly $3 billion to ensure the Veterans Benefits Administration (VBA) had sufficient funds to pay disability compensation and pensions to veterans and other eligible beneficiaries for the rest of FY 2024, which was subsequently approved in legislation passed on September 20, 2024.[2] This legislation also required the VA Office of Inspector General (OIG) to review the factors and conditions that resulted in VHA's need for additional support for the last three months of FY 2024 and for all of FY 2025, as well as the request for supplemental VBA funding for FY 2024.[3]

Before this legislation passed, the OIG had already begun a review in August 2024 to determine the causes that contributed to VHA's request for additional funds. As detailed in this report, the review revealed that additional funding was primarily requested to cover VHA staffing ($4.4 billion), community care ($1.9 billion), and pharmacy and prosthetics services ($3.9 billion). This report focuses only on the VHA reported potential shortfall. Another OIG oversight report examines VBA's supplemental request.[4]

Using data and assumptions for projections on spending that would take place two or more years in the future contributed to VHA making inaccurate estimates leading up to its FY 2025 budget

[1] VA briefing to congressional staff from the House and Senate Veterans' Affairs Committees, "Medical Care 2025 Budget Update" in *Veterans Benefits Administration and Veterans Health Administration Potential Shortfalls, July 2024*. VHA's FY 2025 President's Budget was $149.5 billion. *U.S. Department of Veterans Affairs FY 2025 Budget Submission*, vol. 2, *Medical Programs*, March 2024.

[2] The Veterans Benefits Continuity and Accountability Supplemental Appropriations Act of 2024, Pub. L. No. 118-82 § 104.

[3] Appendix A details how the OIG responded to the legislative requirements concerning VHA.

[4] VA OIG, *Review of VA's $2.9 Billion Supplemental Funds Request for FY 2024 to Support Veterans' Benefits Payments*, Report No. 24-03692-76, March 27, 2025.

request. In addition, VHA found it challenging to meet the budget goals it had set for the FY 2025 President's Budget.

VHA's funding process occurs across two fiscal years, beginning two years before the targeted fiscal year.[5] The first part, called the advance appropriations, occurs in the previous year's budget request (for example, the FY 2024 budget request that VA submitted in 2023 included the FY 2025 advance appropriations for VHA medical care) and provides the bulk of a fiscal year's funding. The second part of a fiscal year's budget process, called the revised estimate (or "second bite"), is a request to adjust the advance appropriations funding level based on more current information and data; it occurs the spring before the fiscal year starts (for example, VA would have submitted the revised FY 2025 estimate in the FY 2025 President's Budget in spring 2024). Because estimating the financial resources VHA needs to provide medical care for a fiscal year begins several years before that fiscal year starts, the budget estimates involve uncertainty about future conditions—such as surges in costs and use of services, new mandates in congressional legislation, and unforeseen economic events.

This budget process requires collaboration among multiple VHA offices, data drawn from several VA and VHA systems and applications, and the expertise of a contracted actuarial consulting firm. It also involves both modeled and nonmodeled projections, which are sent to VHA's Office of Finance (finance office).[6] The finance office reviews, calculates, and combines both modeled and nonmodeled estimates into an overall VHA estimate for review and approval by the Office of the Under Secretary for Health. After this office approves these estimates, they are sent to VA's Office of Budget, then the overall estimate goes to VA's assistant secretary for management. After that step, sometime around September of each year, the VA Secretary approves and submits the overall budget request to the Office of Management and Budget (OMB)—the agency within the executive branch that develops the various federal department budgets into the President's Budget. Oftentimes, several iterations of estimates are developed and considered by VA financial and budget personnel, based on changing information, input from program offices, briefings by the VHA governance board, and other factors such as the funding needs of VA's other administrations.

What the Review Found

VHA's FY 2025 original budget request (the advance appropriations) was included in the FY 2024 President's Budget that was published in March 2023; it relied on data and assumptions

[5] The Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, authorized VHA to request advance appropriations for medical services, medical support and compliance, and medical facilities appropriations. The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016, Pub. L. No. 114-315, authorized VHA to request advance appropriations for medical community care.

[6] VHA uses the Enrollee Health Care Projection Model to estimate most resources VA needs for healthcare services. Nonmodeled estimates include projected spending needs from VHA program offices.

from 2021. VHA did not include a revised estimate (second bite) for medical care in its final FY 2025 budget request in March 2024. Despite a legislative budget cap for FY 2025, VHA and VA officials believed the previously approved amount in the advance appropriations of $112.6 billion plus other funding and anticipated carryover would be sufficient to fund medical care in FY 2025.

Even after developing options and goals in January 2024 to stay within the budget—which included reducing both hiring and the reliance on community care—VHA failed to achieve these goals. In July 2024, VA briefed Congress on a potential shortfall of almost $12 billion to provide medical care for the remainder of FY 2024 and FY 2025.[7] The drivers of the shortfall faced by VHA included managing higher-than-anticipated personnel costs after experiencing significant growth during FY 2023 and early FY 2024, higher costs for community care that were not offset by greater investments in direct VA care, and substantial surges in costs and demands for pharmacy and prosthetics services.

When VA briefed Congress in July 2024 about VHA's potential shortfall to provide medical care for the remaining three months of FY 2024 and for all of FY 2025, the estimate was calculated by comparing anticipated available resources ($288.2 billion) to revised estimated obligations ($300.2 billion) for FYs 2024 and 2025 using FY 2024 obligations to date.[8] It included about $10.2 billion for staffing, community care, and pharmacy and prosthetics services.[9] VHA moved forward with the supplemental funding request in August 2024 and OMB submitted the request to the presidential administration at the time to be included in the FY 2025 budget or a continuing resolution.[10] No funding was approved in September 2024 for VHA. In November 2024 (about two months into FY 2025), VHA had revised this supplemental funding request down to $6.6 billion for only the remainder of FY 2025, based on updated actual obligations data from FY 2024. Just weeks before publishing this report, Congress passed a continuing resolution on March 14, 2025, to provide $6 billion in mandatory funding to VHA's Toxic Exposures Fund to address the remaining funding requirements for FY 2025.[11]

[7] VA briefing to Congress, "Medical Care 2025 Budget Update," July 2024.

[8] VA briefing to Congress, "Medical Care 2025 Budget Update," July 2024.

[9] The remaining $2 billion includes nonrecurring maintenance and "all other non-pay" costs. The non-pay category includes costs such as "Travel and Transportation of Persons" and "Transportation of Things."

[10] Congressional Research Service, *Continuing Resolutions: Overview of Components and Practices,* May 16, 2023, p. 1. The program activities of most federal agencies are generally funded on an annual basis by Congress passing regular appropriations bills. When those are not enacted by the beginning of the fiscal year (October 1), one or more continuing appropriations bills (commonly known as continuing resolutions) may be enacted to provide temporary funding to continue certain programs and activities until Congress passes the regular appropriations bills. FY 2025 Continuing Resolution (CR) Appropriations Issues, p. 24.

[11] Full-Year Continuing Appropriations and Extensions Act, 2025, H.R. 1968, 119th Cong. § 11110 (2025) (enacted).

Appropriations Request Relied on Available Data and Assumptions

The two-year process for VHA's FY 2025 budget request began about halfway through FY 2022 (spring 2022) based on the data available at the time. The finance office also sent a "budget call" to program offices requesting their funding requirements. In addition, although officials from the program office responsible for community care told the OIG review team that they have not always been consulted on the modeled parts of the budget, VHA's Office of Enrollment and Forecasting stated it had held meetings with the relevant program offices to discuss trends in the use of community care, pharmacy, and prosthetics to help inform model assumptions. From May through July 2022, VHA used data from FY 2021 as the baseline for inputs into the *modeled* parts of the FY 2024 President's Budget—the 2022 Enrollee Health Care Projection Model (EHCPM)—when preparing its portion of VA's submission for the FY 2024 President's Budget. That budget included the advance appropriations request of nearly $112.6 billion for FY 2025 medical care spending. Because the data used captured a time when VHA was responding to the COVID-19 pandemic, the data reflect the unique needs for staffing, medical services, and other factors from that atypical period.

Ultimately, the FY 2024 President's Budget that was published in March 2023 included estimated obligations of $141.9 billion for FY 2024 and $146.8 billion for FY 2025, which included the advance appropriations for FY 2025 of $112.6 billion. The FY 2024 President's Budget proposed a cancellation of about $7.1 billion for medical care in FY 2024—that is, it asked Congress to cancel VHA's authority to use that amount. It did so because, although not typical of a budget cycle, the FY 2024 President's Budget also requested about $17.1 billion in Cost of War Toxic Exposures Fund (TEF) for VA medical care. This was on top of its original advance appropriations for FY 2024 and about $3.8 billion from other adjustments such as collections.[12] Even with the requested cancellation, VHA planned on having $9.8 billion in unobligated carryover funds at the end of FY 2024.[13]

VHA's FY 2025 advance appropriations of $112.6 billion for medical care were much lower than the previous year's advance appropriations of about $128.1 billion. VHA expected this would be sufficient given the anticipated carryover from FY 2024—of which officials planned to use about $8.5 billion in FY 2025—as well as about $21.5 billion from the TEF in FY 2025 and other resources.

[12] *U.S. Department of Veterans Affairs FY 2024 Budget Submission*, vol. 2. The TEF was established to help pay for health care associated with exposure to environmental hazards. It was established by the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act (PACT Act) of 2022, which also expanded available services for millions of veterans exposed to toxic materials. White House, "President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans" (fact sheet), accessed September 8, 2024.

[13] Appropriations received from Congress are usually available for one fiscal year, but some appropriations are available for the next year or multiple years or can be used indefinitely. These are referred to as carryover funds.

Unexpected Legislative Cap [redacted] Put Limits on VHA Increasing Its FY 2025 Advance Appropriations Request [*Redacted per OMB Circular A-11*][14]

While VHA was forming its revised estimate (second bite) for FY 2025 in the spring and summer of 2023 for the FY 2025 President's Budget, Congress passed legislation that put limits on VHA's ability to request additional funds for FY 2025. In June 2023, Congress passed the Fiscal Responsibility Act, which created limits—specifically it imposed a 1 percent cap for FYs 2024 and 2025 for discretionary spending across federal agencies.[15] [redacted] Considering the discretionary spending cap and expected carryover and money from the TEF, VA leaders concluded in September 2023 [redacted] that the $112.6 billion advance appropriations for FY 2025 from the FY 2024 President's Budget would adequately fund the FY 2025 medical care accounts.

However, on November 21, 2023, [redacted] VHA's CFO informed the under secretary for health that VA would likely need more funding in FY 2025 to deliver health care than the previous estimates projected.[16] Although the CFO did not provide a specific higher estimate, she noted that the end of FY 2023 spending was higher [redacted] because of increased costs in both direct and community care. In November 2023, the CFO also acknowledged that VHA invested in its in-house capacity to deliver care and reduce community care spending, but the community care expenses also continued to increase.

On November 28, 2023, VHA's CFO provided a similar briefing to the VHA governance board.[17] The CFO noted that VHA would have to reduce funding for initiatives like mental health care or make assumptions about future costs and productivity based on growth trends.[18] At this meeting, the VHA governance board formally recommended that VHA host a "financial

[14] The redactions in this report were coordinated with OMB. The resulting revisions and redactions to the text throughout this report were made in accordance with OMB guidance and OMB Circular A-11, *Preparation, Submission, and Execution of the Budget* related to the nondisclosure of pre-decisional budget activities and communications.

[15] Fiscal Responsibility Act of 2023, Pub. L. No. 118-5, 137 Stat. 10. Section 102, states that for the revised defense and nondefense discretionary categories, the cap represents "the amount that is equal to the total budget authority for such category for base funding as published in the Congressional Budget Office cost estimate for the applicable appropriations Acts for the preceding fiscal year (table 1–S of H.R. 2617, published on December 21, 2022), reduced by one percent." Discretionary spending refers to nonmandatory funding provided in appropriations bills; *U.S. Department of Veterans Affairs FY 2025 Budget Submission*, vol. 2.

[16] Laura Duke, VHA CFO, "USH Monthly Budget Update," PowerPoint presentation, November 2023. The titles and positions referenced in this document were held as of the time of the review.

[17] Minutes of VHA Governance Board, November 28–29, 2023.

[18] Minutes of VHA Governance Board, November 28–29, 2023.

sequester"—a meeting for VHA leaders to focus on budget challenges—to discuss alternatives for staying in the FY 2024 President's Budget estimates. [redacted].

VHA Developed Options to Stay Within the FY 2024 Budget

Adding to the many challenges, VHA's finance leaders informed the Veterans Integrated Service Networks (VISNs) of a rescission totaling nearly $2 billion from VHA medical care in the upcoming FY 2024 Consolidated Appropriations Act.[19] VHA's "financial sequester" in January 2024 had produced the following recommended strategies to help VHA stay within the FY 2024 President's Budget for FYs 2024 and 2025:[20]

- Require program offices to internally review and identify resources that could be redirected to support field operations.
- Reduce nonrecurring maintenance to $2 billion to supplement field operations funds.[21]
- Hold staffing at the FY 2023 level through attrition and meet emergent needs through strategic hiring.
- Hold community care growth to 10 percent over the FY 2023 level for FYs 2024 and 2025 by improving management of care referrals and initiative implementation (specifically the Referral Coordination Initiative, which was designed to inform veterans of all VA and community care options).[22]
- Apply additional cost-management strategies at the VISN level, such as requiring VISNs to submit monthly deficit projections to the finance office.

[19] VHA divides the United States into 18 VISNs: regional systems of care working together to better meet local healthcare needs and provide greater access to care.

[20] This financial sequester was led by VHA's CFO and the VISN 1 director and included several other key participants from VHA's program offices.

[21] By comparison, VHA spent over $3.2 billion in this category in FY 2023.

[22] "VHA Referral Coordination Initiative Implementation Checklist," VHA Referral Coordination Initiative SharePoint site, accessed August 20, 2021. (This internal VA website is not publicly accessible.) The checklist says, "100% implementation required by June 30, 2021." The Office of Integrated Veteran Care (IVC) relied on its Referral Coordination Initiative to improve scheduling for specialty care.

VHA's Failure to Achieve FY 2024 Goals Set in January 2024 Exacerbated FY 2025 Budget Concerns

Also in January 2024, during a governance board meeting, VHA's CFO reported that the community care growth rate was at around 20 percent based on data from December 2023, exceeding the financial sequester goal of 10 percent [redacted]. The OIG found that VHA's initiatives to reduce community care growth by providing more direct care options had not been effective—partly because facilities had not fully implemented the Referral Coordination Initiative.

[redacted] While VHA leaders attributed the failure to meet staffing goals to low attrition rates, the OIG analyzed staffing data and determined that VHA also had increased its personnel levels at a steady rate from November 2023 through February 2024.

VA's FY 2025 President's Budget Was Published

VHA's final submission included in the FY 2025 President's Budget maintained the approved medical care advance appropriations amount of $112.6 billion from the FY 2024 President's Budget. The overall revised submission included the following VHA estimated needs for FY 2025:

- **Staffing** – 383,186 positions, down from 403,616 in the FY 2024 budget (associated with a cost of about $64 billion, down from about $68.5 billion)
- **Community care** – about $40.9 billion, up from about $35.4 billion in the FY 2024 budget
- **Pharmacy services** – about $11.8 billion, up from about $11.4 billion in the FY 2024 budget
- **Prosthetics services** – $4.5 billion, up from about $3.9 billion in FY 2024 budget

A total estimated funding of $149.5 billion would be available for medical care for the FY 2025 budget—about $2.7 billion more than the original estimate of $146.8 billion from the FY 2024 budget. This included an increase of over $800 million for discretionary funding and $1.9 billion for mandatory funding overall, across all discretionary and mandatory budget accounts.

VHA Requested Supplemental Funding for FY 2025 and Later Lowered Its Estimated Potential Shortfall

According to a VA official, in May 2024, VHA told OMB that actual execution for staffing and community care was higher than anticipated for FY 2024. [redacted]

[redacted] Despite reports from VHA program offices to the finance office beginning in January 2024, the under secretary for health said he was unaware of any anticipated shortfall from pharmacy and prosthetics services until July 2024. At that time, VA briefed Congress on VHA's potential shortfall of nearly $12 billion. In August 2024, the presidential administration at the time submitted a request for about $12 billion in supplemental funding through a continuing resolution. According to VA, failure to receive these funds could have an impact on veterans' healthcare services.

On September 23, 2024, VHA's CFO updated the July briefing presentation to Congress to explain the continuing resolution request to address the potential shortfall. In its briefing document, VHA continued to estimate "a potential shortfall of $12 billion in 2025 for VHA Medical Care."[23] According to the VA Secretary's statements to the OIG review team, VHA's CFO briefed him in October that the anticipated shortfall was less than the initial $12 billion estimate[redacted]

On September 25, 2024, Congress passed a continuing resolution through December 20, 2024, which did not include VHA's $12 billion request.[24] A subsequent, updated continuing resolution through March 2025 also did not include VHA's request.[25]

On November 26, 2024, the under secretary for health told Congress that VHA needed $6.6 billion for veterans' medical care instead of the $12 billion it had previously requested.[26] He reiterated this in testimony before the House Veterans' Affairs Committee on December 5, 2024. During this hearing, the under secretary said VHA was able to stay within its FY 2024 budget due to aggressive efforts to manage the budget—including cost savings that will not be sustainable, such as the delayed replacement of aging infrastructure and equipment—but that "if VA medical care does not receive additional funding in FY25, VA will be forced to make difficult decisions to remain within the current budget."[27]

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[23] Laura Duke, VHA CFO, "Veterans Health Administration 2025 Medical Care Anomaly Request September 2024," PowerPoint presentation, Congressional Committees on Veterans Affairs and Appropriations, September 23, 2024.

[24] Continuing Appropriations and Extensions Act, 2025, Pub. L. No. 118-83 (2024).

[25] American Relief Act, 2025, Pub. L. No. 118-158. As mentioned earlier, Congress passed a continuing resolution in mid-March 2025 to provide $6 billion in mandatory funding to VHA's Toxic Exposures Fund to address the remaining funding requirements for FY 2025. Full-Year Continuing Appropriations and Extensions Act, 2025, H.R. 1968, 119th Cong. § 11110 (2025) (enacted).

[26] VHA briefing to Congress, *VA Medical Care FY 2025 Budget Update*, November 26, 2024.

[27] *Fact and Fiction: Getting to the Bottom of the VA Budget Shortfall, Before the House Committee on Veterans' Affairs*, 118th Cong. (December 5, 2024) (statement of Shereef Elnahal, MD, MBA, Under Secretary for Health, Veterans Health Administration).

VHA's FY 2025 original budget request that was included in the FY 2024 President's Budget submission to Congress relied on data and assumptions from 2021 (the most recent data available at the time). Factors that contributed to VHA not requesting more funding [redacted], an unanticipated Fiscal Responsibility Act budget cap it did not want to exceed, [redacted]. VHA and VA leaders believed the previously approved amount of $112.6 billion plus other funding and anticipated carryover would be sufficient to fund medical care in FY 2025. While VHA developed various options with goals at its January 2024 sequester to stay within the FY 2024 President's Budget estimates—which included reducing both hiring and the use of community care while building in-house healthcare capacity VHA failed to achieve these cost-reduction goals. In July 2024, VA briefed Congress on VHA's potential shortfall of nearly $12 billion and then formally requested the supplemental funding in August. In November 2024, VHA had revised this request down to $6.6 billion, based on updated actual obligations data from FY 2024.

As the report indicates, not all stakeholders were fully engaged in the process of forming budget assumptions and assisting with estimates. The financial management systems, processes, and projections were limited by the availability of data that are sometimes years old. In addition, ongoing changes to budget estimates made it difficult to communicate the extent of the projected shortfall promptly and clearly to leaders within VA and to Congress.

The OIG's recommendations are meant to help VA take corrective action on the identified factors and conditions that contributed to the need for VHA to make the supplemental funding requests.[28]

What the OIG Recommended

The OIG made the following recommendations to the under secretary for health:[29]

1. Review the Veterans Health Administration's current methods, assumptions, and approaches used to project medical care budget needs in the annual President's Budget to identify any gaps in the process or data limitations, and develop and implement a plan to strengthen the process.
2. Establish and implement a plan to review current processes and procedures for involving program offices and pertinent subject matter experts in developing the Enrollee Health Care Projection Model inputs for specific areas such as community

[28] See appendix B for more on this report's scope and methodology.

[29] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

care, staffing, pharmacy services, and prosthetics services, and formalize the expectations of their involvement in this process through guidance or protocols.

3. Develop and implement an approach to estimate medical care personnel needs and costs to increase the accuracy and reliability of information included in the annual President's Budget.
4. Institutionalize a regular cycle of at least quarterly fiscal reviews among assistant under secretaries for health, network directors, and program offices that routinely assess key cost drivers and other areas of concern, such as staffing, community care growth, and local initiatives.

VA Management Comments and OIG Response

The acting under secretary for health concurred with three of the four recommendations and concurred in principle with recommendation 3. The OIG found the action plans are acceptable for carrying out all recommendations and will monitor VA's progress. Recommendations will be closed when VA provides adequate documentation to demonstrate sufficient corrective steps have been taken. See appendix C for the full responses from the acting under secretary.

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Contents

Abbreviations

CFO	chief financial officer
EHCPM	Enrollee Health Care Projection Model
FTE	full-time equivalent
FY	fiscal year
IVC	Office of Integrated Veteran Care
MCAS	Medical Center Allocation System
OIG	Office of Inspector General
OMB	Office of Management and Budget
PACT Act	Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act
TEF	Cost of War Toxic Exposures Fund
VBA	Veterans Benefits Administration
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Glossary

community care: Under the VA MISSION Act of 2018, veterans are eligible to receive community care under certain circumstances, such as when a VA medical facility does not provide the requested service or when a healthcare provider determines community care is in a veteran's best medical interest. Consideration is also given to wait times for appointments and the time veterans spend driving to appointments.[30]

Cost of War Toxic Exposures Fund (TEF): The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 expanded available services for veterans exposed to toxic materials. The TEF was established to help pay for health care and other services associated with individuals' exposure to environmental hazards.

Fiscal Responsibility Act of 2023: Congress passed the Fiscal Responsibility Act in June 2023, which created limits, or caps, for discretionary spending across federal agencies. Discretionary spending refers to nonmandatory funding provided in appropriations bills.

pharmacy services: Pharmacy Benefits Management Services' mission is to improve the health status of veterans by encouraging the proper use of medications; it also manages a product list of approved drugs that should be available at all VA pharmacies.

prosthetics services: Rehabilitation and Prosthetics Services provides medical devices and products and promotes advancements in rehabilitative care and evidence-based treatment. The office is responsible for the national policies and programs for medical rehabilitation, as well as prosthetic and sensory aids.

staffing: VHA determines personnel needs using the federal government's full-time equivalent (FTE) employment standard, which calculates work needs based on hours instead of the total number of employees. One FTE equals one fiscal year of work. The number of FTEs in an agency is calculated by determining "the total number of regular straight-time hours worked (that is, not including overtime or holiday hours worked) by employees divided by the number of compensable hours applicable to each fiscal year. Annual leave, sick leave, compensatory time off, and other approved leave categories are considered "hours worked" for the purposes of defining full-time equivalent employment that is reported in the employment summary … [and agencies should base] estimates of personnel resources on the total number of regularly

[30] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2025); 38 C.F.R. § 17.4040 (2025); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019, accessed December 19, 2023. VA also provides health care to veterans' family members and dependents through programs like the Civilian Health and Medical Program. This care is also provided based on specific eligibility requirements, which vary by program.

scheduled straight-time hours (worked or to be worked) in the fiscal year."[31] For convenience, this report refers to one full-time equivalent as a "position" and overall FTE needs as "staffing levels."

[31] Office of Management and Budget (OMB) Circular A-11, "What Terms Do I Need to Know? Full-time equivalent (FTE) employment," July 2024.

Introduction

The Veterans Health Administration (VHA) oversees and provides medical care for eligible veterans who are enrolled in VA's healthcare system. This includes inpatient and outpatient services at VA facilities and in the community, including primary care, specialty care, pharmacy and prosthetics services, mental health care, and long-term care in both institutional and noninstitutional settings. These services are funded through VA's annual budget.

In keeping with that budget process, VHA developed a proposed budget for fiscal year (FY) 2025 that was reviewed by the Office of Management and Budget (OMB) and then integrated into the President's Budget. On March 11, 2024, the FY 2025 President's Budget was published; it asked Congress for about $149.5 billion to fund the total estimated obligations for VHA.[32] One month later, during the House Committee on Veterans' Affairs hearing on VA's budget request for FYs 2025 and 2026, the VA Secretary was asked whether VA's budget for FY 2025 might run short. He responded, "there's no second bite in the budget. We don't anticipate one, but if we need one we'll come back and talk to you guys about it."[33] However, by July 2024—just over two months before the FY 2025 budget was scheduled to take effect—VHA estimated it would need another nearly $12 billion for medical care for the remaining three months of FY 2024 and all of FY 2025.[34] At that time, the higher-than-expected obligations being experienced by VHA did not appear to be supported over the remaining few months in FY 2024 within the current budget. As a result, according to VHA officials, they thought they might need to dip into carryover funds in FY 2024 meant for the next fiscal year. Without that carryover and given continuing higher obligations than anticipated, there would be a shortfall for

[32] *U.S. Department of Veterans Affairs FY 2025 Budget Submission*, vol. 2 of 5, *Medical Programs*, March 2024. The fiscal year for federal budgets runs from October 1 through September 30.

[33] *Hearing on Veterans' Affairs Fiscal Years 2025 and 2026 Budget Request, Before the House Veterans' Affairs Committee,* 118th Cong. (April 11, 2024). A "second bite" refers to the second year in a two-year budget process, when the first year's estimated amount is revised. This process is explained in greater detail in the following sections of the report.

[34] The $12 billion request for supplemental funding was based on revised estimates for both FY 2024 and FY 2025 obligations. FY 2024 estimates increased from about $139.3 billion to $142 billion, and FY 2025 estimates increased from about $148.7 billion to $158.2 billion, excluding funding under Title 7 of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 and other funding that is not generally available for medical care operations. (The PACT Act is discussed later in the report.) VA calculated the estimate by comparing anticipated available resources ($288.2 billion) to revised estimated obligations ($300.2 billion) across FYs 2024 and 2025 using FY 2024 obligations to date. Laura Duke, VHA Chief Financial Officer (CFO), "Veterans Health Administration 2025 Medical Care anomaly request September 2024," PowerPoint presentation, House and Senate Veterans' Affairs Committees and Appropriations-MIL/VA, September 23, 2024. The titles and positions referenced in this document were held as of the time of the review.

FY 2025 as well, amounting to the projected total of $12 billion. This included about $10.2 billion for staffing, community care, and pharmacy and prosthetics services.[35]

Also in July 2024, VA requested supplemental funding of nearly $3 billion to ensure the Veterans Benefits Administration (VBA) could pay disability compensation and pension benefits to veterans and other eligible beneficiaries for the remainder of FY 2024, which Congress approved through legislation on September 20.[36] The legislation also required the VA Office of Inspector General (OIG) to conduct reviews of the factors and conditions that resulted in the VHA supplemental funding request for additional support for the last three months of FYs 2024 and for all of 2025 as well as the request for supplemental VBA funding for FY 2024. Appendix A details the legislative requirements related to VHA and how the OIG addressed them.[37]

The OIG had already begun a review in August 2024 to determine what factors and conditions resulted in VHA's request for about $12 billion in supplemental funding. This report is focused on that VHA request. Another oversight report examines the VBA supplemental funding request.[38]

Process for Developing the VHA Budget Estimate

Since FY 2011, VHA's annual budget request has included medical care funding for the upcoming fiscal year as well as the following fiscal year.[39] Accordingly, funding requests are made over two fiscal years as follows:

- The first part, called the advance appropriations, occurs in the previous year's budget request and provides the bulk of a fiscal year's funding. For FY 2025 funding, the advance appropriations were included in the FY 2024 President's Budget, published in March 2023.
- The second part of a fiscal year's budget, called the revised estimate (or second bite), is a request for additional funding based on more current information. The

[35] The remaining about $2 billion includes nonrecurring maintenance and "all other non-pay" costs. The non-pay category includes costs such as "Travel and Transportation of Persons" and "Transportation of Things." An additional $200 million in TEF funds reduced the overall amount needed.

[36] The Veterans Benefits Continuity and Accountability Supplemental Appropriations Act of 2024, Pub. L. No. 118-82 § 104.

[37] The Veterans Benefits Continuity and Accountability Supplemental Appropriations Act of 2024.

[38] VA OIG, *Review of VA's $2.9 Billion Supplemental Funds Request for FY 2024 to Support Veterans' Benefits Payments*, Report No. 24-03692-76, March 27, 2025.

[39] The Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, authorized VHA to request advance appropriations for medical services, medical support and compliance, and medical facilities appropriations. The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016, Pub. L. No. 114-315, authorized VHA to request advance appropriations for medical community care.

second bite for FY 2025 would have been included in the FY 2025 President's Budget, published on March 11, 2024.

The advance appropriations ensure VHA can continue operating if there is a government shutdown, which occurs when Congress does not pass annual appropriations legislation by the beginning of a fiscal year and does not enact a continuing resolution.[40] Figure 1 shows the two-year process used to formulate the fiscal year budget.

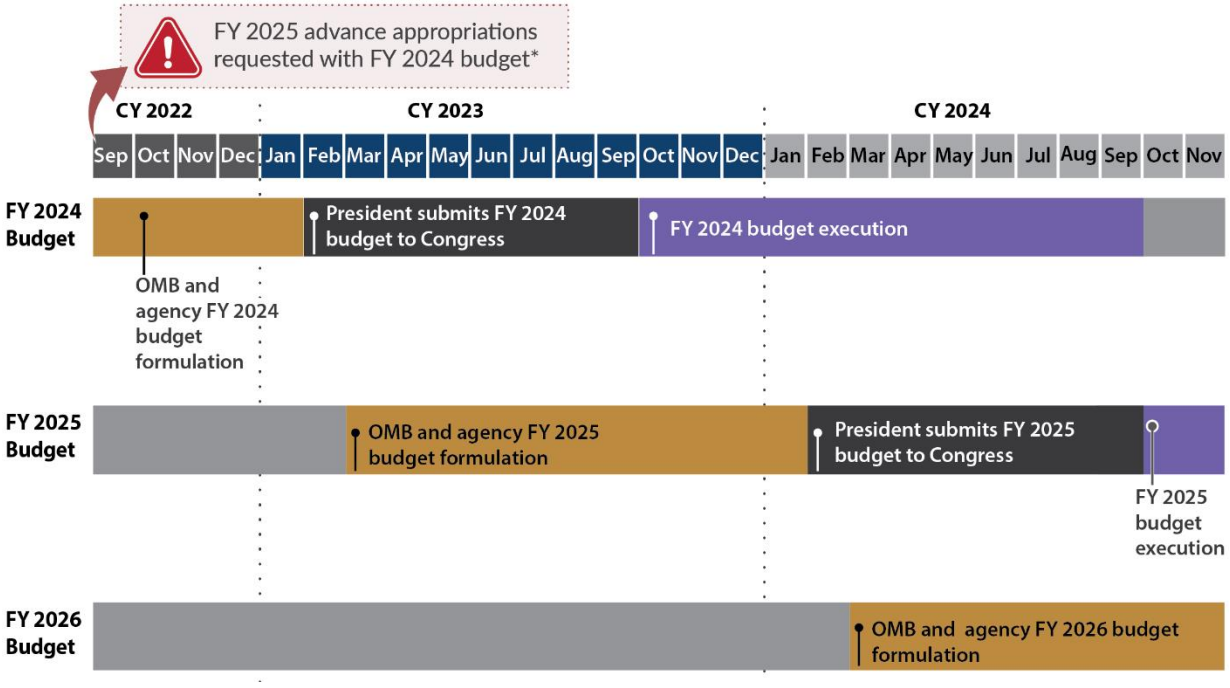

Figure 1. *Conventional stages of fiscal year President's Budget formulations during a calendar year (CY).*
Source: OIG analysis of VHA and OMB documents.
Note: The target dates and the time ranges in this figure indicate goals in the budget process. Budget negotiations and continuing resolutions often delay steps in the process, and in FYs 2024 and 2025, the actual deadlines did not always match those shown in this figure.
** FY 2025's advance appropriations, determined in September 2022, were based on data from FY 2021.*

Because estimating the financial resources VHA needs to provide medical care for a forthcoming fiscal year begins several years before that period starts, there is inherent uncertainty in the process about future conditions. These include surges in costs and in the use of services, new mandates in congressional legislation, and unforeseen economic events. The process involves

[40] Congressional Research Service, *Continuing Resolutions: Overview of Components and Practices*, May 16, 2023, p. 1. The program activities of most federal agencies are generally funded on an annual basis by Congress passing regular appropriations bills. When those are not enacted by the beginning of the fiscal year (October 1), one or more continuing appropriations bills (commonly known as continuing resolutions, or CRs) may be enacted to provide temporary funding to continue certain programs and activities until Congress passes the regular appropriations bills.

collaboration among multiple VHA offices, data inputs from several VA and VHA systems and applications, and the expertise of a contracted actuarial consulting firm.

The VHA Office of Enrollment and Forecasting in the Chief Strategy Office oversees the consulting actuarial firm, acts as the liaison for VHA, gathers the data, and creates various files that are submitted to the consulting actuarial firm to complete the modeled projections. This office, along with VHA's Office of Finance (finance office), use the Enrollee Health Care Projection Model (EHCPM) to estimate most resources VA needs to provide medical care.[41] The EHCPM is a deterministic model, which means it is based on a set of assumptions that affects the model projection output over time. The scenarios used by the model for the VHA budget formulation process produce three primary outputs: (1) enrollment, (2) utilization, and (3) expenditures. Each of these outputs is based on several complex adjustments to account for the distinct characteristics of VA health care and the veterans who access these services.

The EHCPM estimates the amount of funding VHA expects to need for providing healthcare services to its enrolled veterans. These services include ambulatory care, pharmacy services, inpatient care, dental health, mental health, prosthetics services, rehabilitative care, and long-term services and support.[42] Medical care estimates include direct care provided at VA medical facilities as well as care given to enrolled veterans outside VA's own facilities or sites of care that VA pays for, known as community care.[43]

The EHCPM is updated annually using the last full fiscal year of data that are available. VHA's finance office can request that Enrollment and Forecasting personnel work with the consulting actuarial firm to run different scenarios with changes in assumptions several times a year. The EHCPM used for the FY 2024 President's Budget (2022 EHCPM) relied on FY 2021 data (the most recent complete FY data available in 2022) and included the advance appropriations for FY 2025 for medical care. This model accounted for about 87 percent of the FY 2025 VHA advance appropriations budget request that was included in the FY 2024 President's Budget.

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[41] VA, "VA Enrollee Health Care Projection Model," in *FY 2025 Budget Submission*, vol. 2, *Medical Programs and Information Technology Programs*, (March 2024), p. 427. The model projects enrollment, use, and expenditures for the enrolled veteran population in more than 140 categories of healthcare services 20 years into the future. The model accounts for the unique characteristics of the population and the VA healthcare system, as well as environmental factors that impact veteran enrollment and use of VA healthcare services.

[42] Long-term services and support include community living centers, community nursing homes, adult day health care, hospice care, respite care, and homemaker and home health-aid programs.

[43] Under the MISSION Act of 2018, veterans are eligible to receive community care under certain circumstances, such as when a VA medical facility does not provide the requested service or when a provider determines community care is in a veteran's best medical interest. Consideration is also given to wait times for appointments and the time veterans spend driving to appointments. Direct care is medical care provided at VHA medical facilities or at VHA community-based outpatient clinics. John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2025); 38 C.F.R. § 17.4040 (2025); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019, accessed December 19, 2023.

Once the EHCPM budget scenario used to support the budget is completed by the consulting actuarial firm, Enrollment and Forecasting staff submit the estimates to the finance office.

The other resource estimates are based on two additional projection models, accounting for about 3 percent of the FY 2025 advance appropriations estimate for medical care, an adjustment for anticipated funding under the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act (PACT Act) of 2022 (about another 3 percent), and nonmodeled estimates (about 8 percent).[44] Nonmodeled estimates include needs identified by VHA program offices—such as those for program expansions; new legislative or regulatory requirements; and nonrecurring maintenance, such as major repairs to facilities. Once completed, nonmodeled estimates are also sent to the finance office.

The finance office reviews, calculates, and combines both modeled and nonmodeled estimates into an overall VHA estimate for review and approval by the under secretary for health. After this approval, the budget estimate goes to VA's Office of Budget, then the overall estimate goes to VA's assistant secretary for management (who is also the chief financial officer, or VA's CFO). Following that step, the VA Secretary approves and submits the overall budget request to OMB—the agency within the executive branch that develops the President's Budget—sometime around September of each year. Oftentimes, several estimates are developed or refined and considered by VHA and VA; these are based on changing information, input from VHA program offices, briefings to the VHA governance board, and other factors such as the funding needs of VA's other administrations.[45] Figure 2 shows the steps these different offices take to formulate and submit a budget.

[44] The two other projection models used for medical care estimates are the Program of Comprehensive Assistance for Family Caregivers, which estimates caregiver stipends and medical care expenses, and the Civilian Health and Medical Program of the Department of Veterans Affairs, which estimates medical care expenses for the dependents of veterans who meet certain eligibility criteria. These models accounted for about 3 percent of the FY 2024 budget estimates for FY 2025, while adjustments for the PACT Act of 2022, which expanded available services for veterans exposed to toxic materials, accounted for 3 percent of estimates for FY 2025. Numbers are rounded, which is why they sum to over 100 percent. Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Pub. L. No. 117-168, 136 Stat. 1759; 38 U.S.C. § 101.

[45] VHA's governance board is directly accountable to the under secretary for health to ensure outcomes are organized and aligned within a comprehensive strategy. It is VHA policy that the governance board drive decisions on matters within its span of control and make recommendations to the under secretary for health on matters of national strategy, operations, and implementation. The assistant under secretary for health for operations chairs the board. Other voting members are the assistant under secretaries for the following: health for clinical services; patient care services; integrated veteran care; discovery, education, and affiliate networks; quality and patient safety; and support. The chief informatics, financial, and human capital management and strategy officers and all VISN directors also serve on the board. VHA Directive 1217.01(2), *VHA Central Office Governance Board,* amended January 18, 2024.

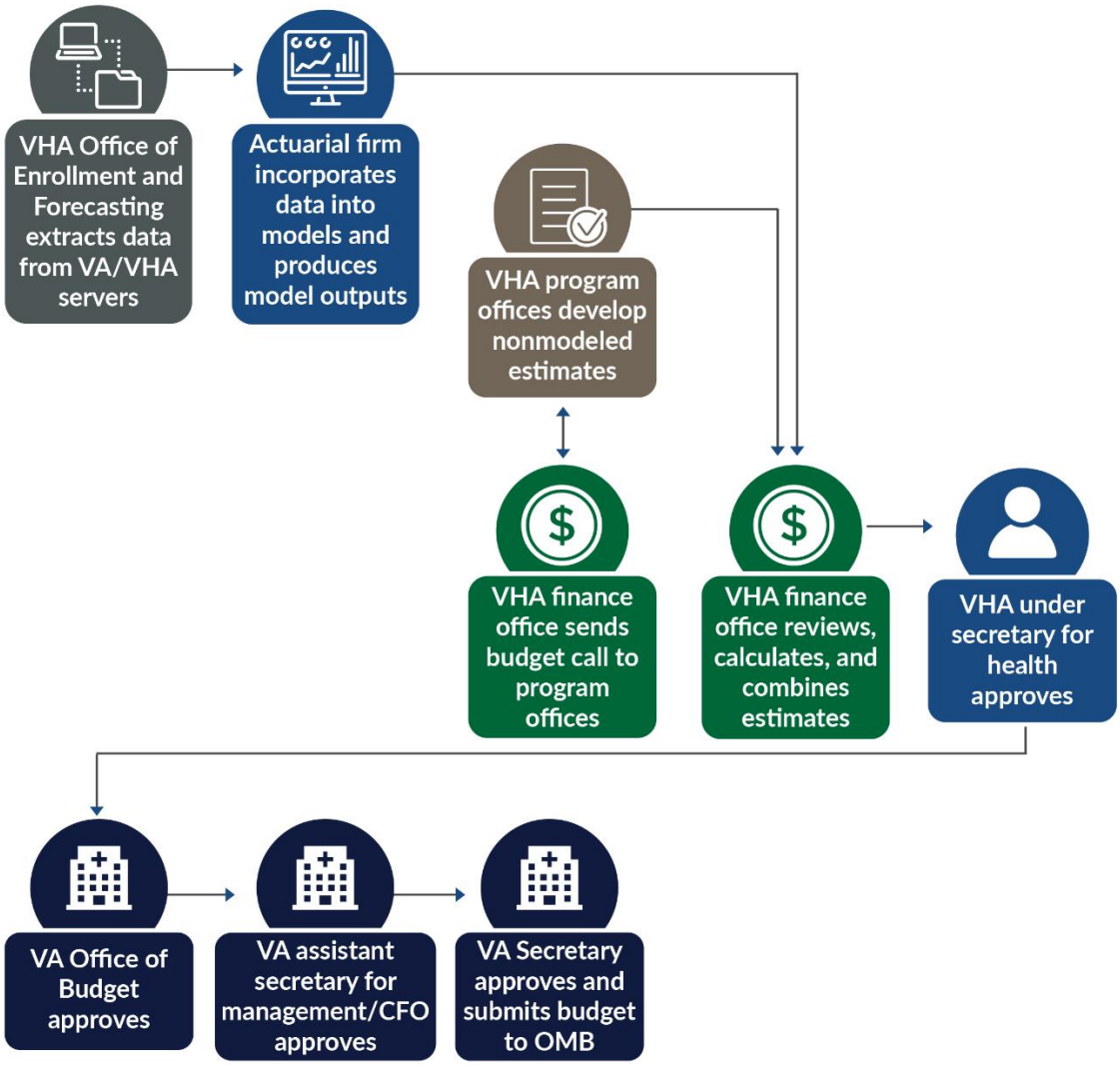

Figure 2. *Roles and responsibilities in the VHA budget estimation process.*
Source: OIG analysis of VHA budget documentation and interview statements.

OMB then reviews VA's request and develops a budget amount that may differ from the requested amount; OMB returns this to VA around November or December of that same year. This return is called the "passback" and includes VHA's approved amount in the President's Budget for the upcoming fiscal year. After the passback, VA has a brief time to appeal this budget amount. The President's Budget by law is to be submitted to Congress by the first Monday in February, although the submission may occur after this date in practice. Congress determines the final budget.[46]

[46] Debate over a fiscal year's budget in Congress sometimes means that appropriations are not passed before October 1, the first day of the new fiscal year. If Congress does not pass a continuing resolution to continue funding the government, a shutdown occurs until either a continuing resolution or appropriations are passed.

Results and Recommendations

Finding: VHA Faced Challenges Staying Within Its Budget, Resulting in a $12 Billion Supplemental Funding Request

VHA faced myriad challenges in staying within its FY 2024 budget. Foremost were significant increases in staffing during FY 2023 and early FY 2024, a higher-than-anticipated growth in community care costs, and surges in costs and demands for pharmacy and prosthetics services. VHA also faced a legislative budget cap established by the Fiscal Responsibility Act, passed in June 2023, that affected FY 2025 medical care funding.[47] Despite these challenges, VHA leaders concluded in September 2023 that they would not need additional funding to support VHA medical care in FY 2025.[48]

Although VHA leaders were aware they could have higher medical care obligations, they believed they could reduce costs to ensure they stayed within their budget. However, as early as November 2023, VHA projected a shortfall for FY 2025.[49] This projected shortfall was because VHA determined actual spending in FY 2023 was higher than predicted in both VA direct care and community care. [redacted] Redacted per OMB Circular A-11].[50]

In January 2024, VHA held a "financial sequester"—an off-site meeting for VHA leaders to discuss budget challenges—to develop ways to stay within the FY 2024 medical care budget. They focused on curbing community care growth and decreasing staffing through attrition. But even with these initiatives, monthly briefings with Veterans Integrated Service Network (VISN) leaders and the VHA finance office indicated VHA leaders were not on track to meet the staffing-level goal needed to control spending and they were also projecting a higher rate of growth in community care than targeted for FY 2024.[51]

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[47] Fiscal Responsibility Act of 2023, Pub. L. No. 118-5, 137 Stat. 10. Discretionary spending refers to nonmandatory funding provided in appropriations bills.

[48] VA leaders concluded in September 2023, [redacted] that the $112.6 billion previously requested would adequately fund the FY 2025 medical care accounts when added to the expected carryover and money from the TEF.

[49] Laura Duke, VHA CFO, "USH Monthly Budget Update," PowerPoint presentation, November 2023.

[50] The redactions in this report were coordinated with OMB. The resulting revisions and redactions to the text throughout this report were made in accordance with OMB guidance and OMB Circular A-11, *Preparation, Submission, and Execution of the Budget* related to the nondisclosure of pre-decisional budget activities and communications.

[51] VHA divides the United States into 18 VISNs: regional systems of care working together to better meet local healthcare needs and provide greater access to care.

According to a VA official, in May 2024, VHA told OMB that actual execution of the budget for staffing and community care was higher than anticipated for FY 2024. VA formally notified OMB in late June 2024 of a potential FY 2025 shortfall. Despite reports of a surge in costs and demands from the program offices to the finance office beginning in January 2024, the under secretary for health said he was unaware of any potential shortfall from pharmacy and prosthetics services until July 2024. VA briefed Congress in July 2024 on VHA's anticipated shortfall of nearly $12 billion and then formally requested the supplemental funding in August.

The OIG's finding details the chronological history of the factors and conditions that led to the $12 billion supplemental funding request to support medical care for the last three months of FY 2024 and for all of FY 2025—an amount equaling about 8 percent of VHA's total estimated obligations of $149.5 billion for FY 2025 in the FY 2025 President's Budget. The finding is based on the following determinations:

- The FY 2024 President's Budget, including the FY 2025 advance appropriations request, relied on data and assumptions available at the time.
- Unexpected budget constraints [redacted] affected VHA's ability to increase its FY 2025 advance appropriations request for the FY 2025 President's Budget.
- VHA leaders expected challenges staying within the FY 2024 President's Budget but believed it could be done.
- VHA developed options to stay within budget.
- VHA's failure to achieve sequester goals exacerbated FY 2025 budget concerns.
- VHA requested supplemental funding for FY 2025 and later lowered its estimates of a potential shortfall.

What the OIG Did

The OIG assessed FY 2023 through FY 2025 VHA obligations, expenditures, and appropriations data to determine what funding was requested, received, carried over, or returned. The team also compared the original FY 2025 advance appropriations request from the FY 2024 President's Budget to the FY 2025 President's Budget. The team interviewed more than 30 VA and VHA leaders to understand the assumptions used in developing the original FY 2025 request and [redacted] when finalizing the FY 2025 President's Budget. The team also discussed with key officials how much VA, VHA, VISN, and facility leaders were aware of and involved with estimates used for the original and revised FY 2025 budget requests. Finally, the team examined VA and VHA documentation—together with emails and other internal communications related to key officials—from April 2023 through August 2024. Appendix B provides additional information about the team's scope and methodology.

The FY 2024 President's Budget, Including the FY 2025 Advance Appropriations Request, Relied on Available Data and Assumptions

Because developing a budget request is a two-year process, the data relied on for the first year of that cycle is often three years old. The two-year budget cycle for VHA's FY 2025 budget began in spring 2022—about halfway through FY 2022—when VHA's finance office sent a "budget call" for information to program offices requesting funding requirements. VHA's Office of Enrollment and Forecasting also began meeting on EHCPM updates for the FY 2025 budget.

The two-year budget process is meant to provide VA a later opportunity to adjust the assumptions that flow from those program and model estimates, but VA still relies on the data and assumptions available at particular points in time. As a result, the assumptions to predict VHA's budget must be continually monitored against actual spending and the use of department resources. Figure 3 outlines the timeline and highlights key steps in the two-year budget cycle for FY 2025. (References to the Cost of War Toxic Exposure Fund (TEF) and various budgetary actions mentioned in the figure are explained in the sections that follow.)[52]

[52] The TEF would help pay for health care associated with exposure to environmental hazards and was established by the PACT Act, which expanded available services for veterans exposed to toxic materials. White House, "President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans" (fact sheet), accessed September 8, 2024.

Figure 3. *Timeline of VHA's request for additional FY 2025 funding.*
Source: OIG analysis of VHA budget documentation and interview statements.
Note: Redactions are pursuant to OMB guidance and OMB Circular A-11.

Summer 2022: VHA Developed the FY 2025 Advance Appropriations

From May through July 2022, VHA used data from FY 2021 in its enrollee model (the 2022 EHCPM) when preparing the FY 2025 advance appropriations request for the FY 2024 President's Budget. This model, along with two others used to predict spending for veteran family members and PACT Act adjustments, accounted for about 92 percent of the VA medical care budget advance appropriations request for FY 2025, included in the FY 2024 President's Budget.[53] In addition, VHA's program offices, including the offices that oversee staffing, community care, and pharmacy and prosthetics services, also submitted their own program office budget needs as *nonmodeled* estimates to the finance office, as requested in the finance office's budget call memorandum.[54] The nonmodeled estimates accounted for about 8 percent of the total advance appropriations request for FY 2025 medical care in the FY 2024 budget.

An official from the Office of Integrated Veteran Care (IVC)—the VHA office that manages community care—said the finance office did not routinely request their input on budget assumptions and estimations that contribute to the *modeled* projections for community care. For example, a leader from IVC told the review team that the assumptions about the split between VA direct care and community care that inform the EHCPM resulted in a lower projected growth rate for community care than what the actual rates have been over the prior few years.[55] As a result, assumptions made about the models' inputs may not be accurate, realistic, or reflect actual spending and obligations.

Relying on the modeled and nonmodeled information, VHA's FY 2024 President's Budget included a total estimate for medical care obligations of $146.8 billion for FY 2025 (including TEF and other resources), with $112.6 billion of that amount from the advance appropriations. This represented VHA's best estimate, using its 2022 EHCPM and other assumptions about medical care, of what it needed for FY 2025 based on FY 2021 data. The FY 2024 budget included the following estimates for FY 2025, as these were the primary drivers of the projected shortfall:[56]

- $68.5 billion for staffing (403,616 total positions)

[53] The 2022 EHCPM accounted for about 84 percent of VA medical care in the FY 2024 budget. In the FY 2025 President's Budget, the 2023 EHCPM accounted for about 87 percent. The PACT Act adjustments were intended to account for the increase in toxic-exposure benefit claims.

[54] VHA chief financial officer, "VHA Program Budget for the Fiscal Year (FY) 2025 Budget Cycle," memorandum to VHA Key Officials, May 31, 2023.

[55] Hillary Peabody, acting assistant under secretary for health for the Office of Integrated Veteran Care, interview with the OIG, August 2, 2024.

[56] Appendix A discusses how these estimates changed from March 2023 through July 2024 and provides the actual obligations as of September 2024.

- $35.4 billion for community care
- $11.4 billion for pharmaceuticals[57]
- $4.3 billion for prosthetics

Because these data were from a time when VHA was responding to the COVID-19 pandemic, they reflect unique needs for staffing, medical services, and other factors. Using these data as a basis for projecting future costs contributed to VHA's original medical care budget underestimating growth in healthcare demands and related obligations for FY 2025—especially concerning staffing levels and the use of both VA direct care and community care.

March 2023: FY 2024 President's Budget Was Published

The FY 2024 President's Budget was published in March 2023. It comprised estimated obligations of

- $141.9 billion for FY 2024, including the $121 billion revised estimate (second bite) for medical care and
- the original total FY 2025 estimate of $146.8 billion, which included advance appropriations of $112.6 billion.

In most years, VHA uses the second bite process to request funding that adds to the advance appropriations requested in the previous year's budget. But for VHA's FY 2024 medical care budget request: Rather than ask for more money, VA officials proposed a cancellation of about $7.1 billion in advance appropriations for medical care in FY 2024—that is, they asked Congress to cancel VHA's authority to use that amount. They did so because, although not typical of a budget cycle, VHA anticipated receiving about $17.1 billion in TEF resources on top of its original advance appropriations of $128.1 billion for FY 2024—before the $7.1 billion cancellation—and about $3.8 billion from other resources such as collections. Even with the proposed cancellation, VHA planned on having $9.8 billion in unobligated carryover funds at the end of FY 2024.[58] Figure 4 details these revised amounts.

[57] VHA's supplemental request only referred to budget object code number 26 for pharmacy and prosthetic services cost increases, so the OIG review team limited its analysis of funding changes for pharmacy and prosthetic services to this code.

[58] Appropriations received from Congress are usually available for one fiscal year, but some appropriations are available for the next year or multiple years or can be used indefinitely. When these resources are not used at the end of a fiscal year but are still available in the next fiscal year, they are referred to as carryover funds.

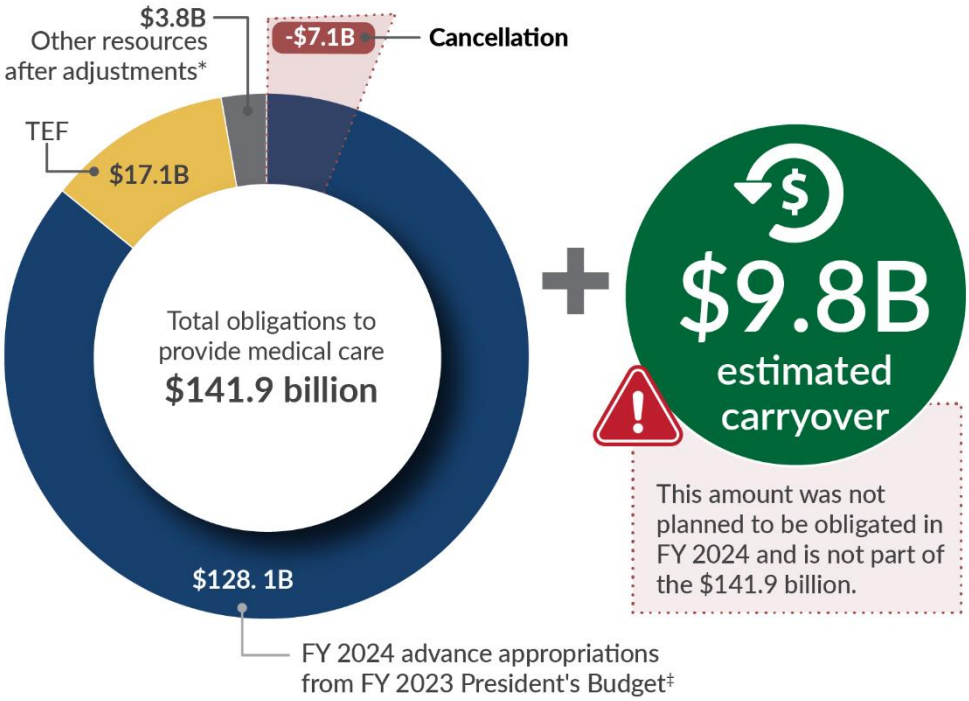

Figure 4. *FY 2024 President's Budget.*

Source: OIG analysis of FY 2024 President's Budget for funding support for FY 2024.

** This amount includes collections, reimbursements, and transfers to non–medical care funds, as well as portions of carryover planned to be obligated in FY 2024.*

‡ The cancellation of $7.1 billion from the $128.1 billion advance appropriations yields the revised estimate of $121 billion.

As shown in figure 5 on the next page, VA requested the advance appropriations of $112.6 billion for medical care in the FY 2024 budget for funding in FY 2025. Though this was much lower than the previous year's advance appropriations (of about $128.1 billion), VA expected the carryover amount from FY 2024 of about $9.8 billion—of which officials planned to use about $8.5 billion in FY 2025—as well as about $21.5 billion from the TEF and other additional resources.

Overall, the FY 2024 President's Budget sought $146.8 billion in total obligations for medical care for FY 2025.

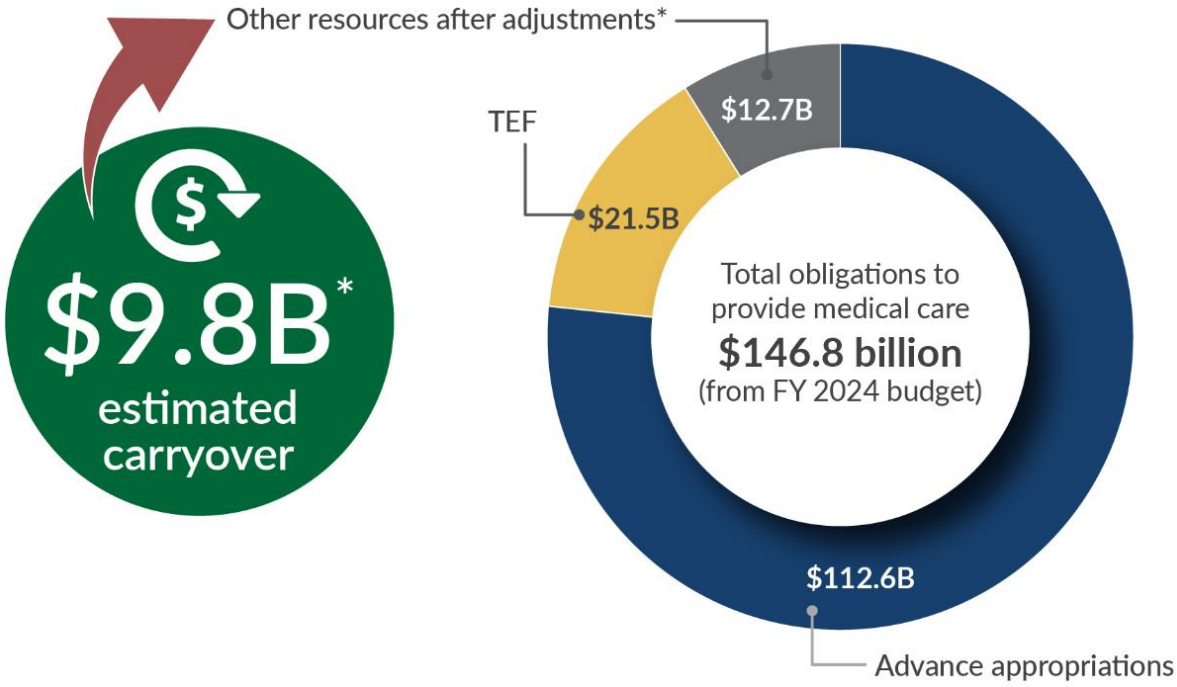

Figure 5. *FY 2025 budget estimate from FY 2024 President's Budget.*

Source: OIG analysis of FY 2024 President's Budget for funding support for FY 2025.

** This amount includes collections, reimbursements, and transfers to non–medical care funds ($4.1 billion), as well as portions of carryover planned to be obligated in FY 2025 ($8.5 billion). Numbers are rounded and do not sum precisely to $12.7 billion.*

As discussed earlier, VHA estimated the following needs in determining aspects of the funding request that was accepted for FY 2024 and FY 2025 in the FY 2024 President's Budget:

- **Staffing** – 386,633 positions for FY 2024 and 403,616 positions for FY 2025, estimated to cost about $61.3 billion and $68.5 billion, respectively. (According to budget documents, VHA intended this staffing level to allow VA to meet continued growth for VA-provided direct services, particularly due to PACT Act implementation.)
- **Community care** – about $32.9 billion for FY 2024 and about $35.4 billion for FY 2025.
- **Pharmacy services** – about $10.3 billion for FY 2024 and $11.4 billion for FY 2025.
- **Prosthetics services** – $3.9 billion for FY 2024 and $4.3 billion for FY 2025.

Unexpected Budget Constraints [redacted] Affected VHA's Ability to Increase Its FY 2025 Advance Appropriations Request for the FY 2025 President's Budget

In the spring and summer of 2023, while VHA was formulating its revised budget request for the FY 2025 President's Budget, Congress passed legislation that affected VHA's ability to request additional funds for FY 2025 as a second bite. As previously noted, in June 2023, Congress passed the Fiscal Responsibility Act—creating limits, or caps, for discretionary spending across federal agencies.[59] For VA specifically, the act also set up the TEF and provided the $17.1 billion for FY 2024 and the $21.5 billion for FY 2025 to help pay for health care associated with exposure to environmental hazards. These were mandatory appropriations not restricted by the caps on discretionary spending.[60]

VA sent VHA's FY 2025 budget request to OMB in September 2023. It included the President's earlier budget request for advance appropriations of $112.6 billion for FY 2025 for medical care. [redacted][61] Figure 6 shows the December passback in relation to the timeline events from June through September 2023 presented in figure 3, which are shaded here.

[59] Discretionary spending refers to nonmandatory funding provided in appropriations bills.

[60] Congressional Research Service, *Overview of Funding Mechanisms in the Federal Budget Process, and Selected Examples*, February 5, 2021, p. 2. Mandatory spending is controlled indirectly by Congress through authorization laws by defining eligibility and setting the payment rules, rather than directly through appropriations bills. Generally, these programs are created and funded in the same law or on a multiyear or permanent basis.

[61] [redacted]

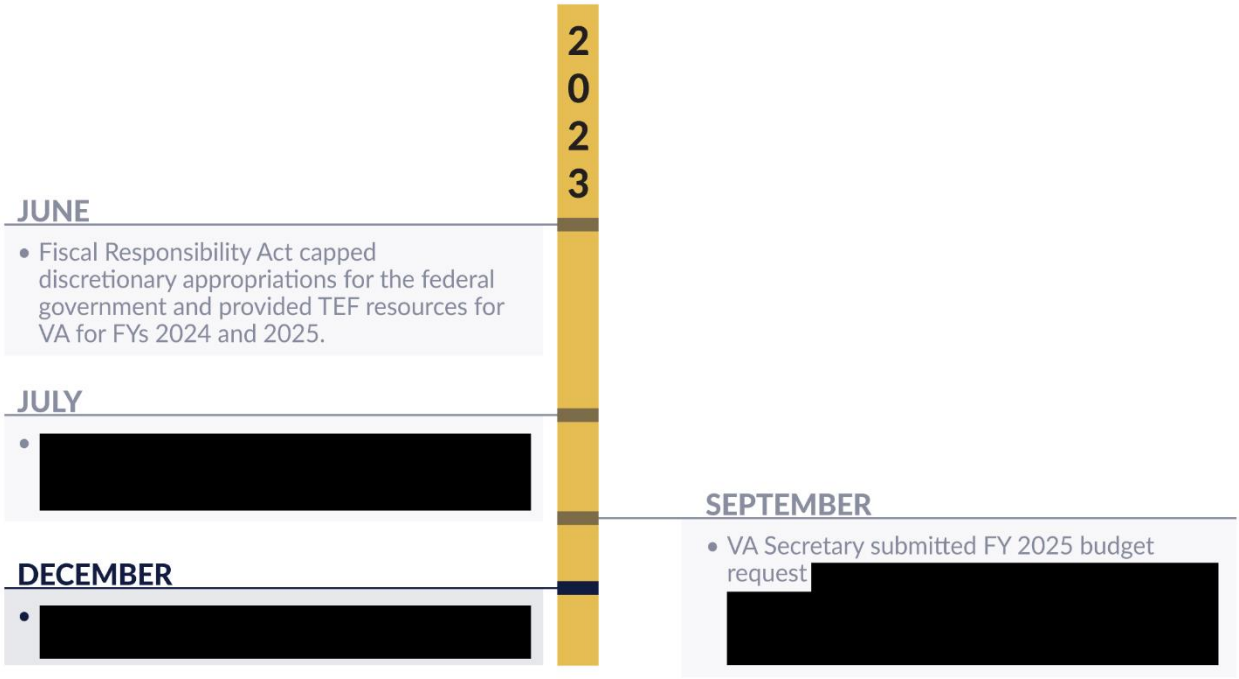

Figure 6. *Timeline for OMB passback to VA* [redacted] *for 2025 funding.*
Source: OIG analysis of VHA budget documentation and interview statements.

June 2023: The Fiscal Responsibility Act Imposed a Budget Cap

VHA's under secretary for health and the assistant secretary for budget told the review team that the passage of the Fiscal Responsibility Act in June 2023 and the 1 percent cap (that discretionary spending for FYs 2024 and 2025 had to remain at 1 percent less than for FY 2023) ultimately affected their FY 2025 second bite (or revised estimate) process when it became apparent the funding was not, in fact, sufficient to meet their needs.[62] As noted, the VHA advance appropriations are considered discretionary spending and subject to the cap.

Historically, the two-year budget process allowed for flexibility in requesting additional resources through the second bite. For years, VA had relied on this process to increase funding requests when submitting a revised budget request—allowing it to reconsider its needs based on updated projection estimates. For example, the FY 2023 estimate increased from about $111.3 billion in the President's FY 2022 budget to about $118.7 billion in the FY 2023 budget. But the Fiscal Responsibility Act limited VHA's ability to revise its original FY 2025 funding request with a second bite. At the time, regardless of the cap, VA internal documents prepared by

[62] Section 102 of the Fiscal Responsibility Act of 2023 states that for the revised defense and nondefense discretionary categories, the cap represents "the amount that is equal to the total budget authority for such category for base funding as published in the Congressional Budget Office cost estimate for the applicable appropriations Acts for the preceding fiscal year (table 1–S of H.R. 2617, published on December 21, 2022), reduced by one percent."

VA's CFO noted [redacted] was "sufficient" to "fully fund Veterans' health care consistent with the needs projected by the Enrollee Health Care Projection Model."[63]

July 2023: [redacted] VA Was to Maintain the Advance Appropriations Amount

Although the Fiscal Responsibility Act imposed limits on increases in discretionary spending, VA and VHA officials acknowledged that VA could have amended its original budget request if it felt additional funds were required. [redacted] The VA Secretary ultimately decided not to request additional funding for medical care.

[redacted]

July and August 2023: VA Internally Deliberated Options to Stay Within Budget

In July 2023, VHA finance office officials were discussing how "are we burning so hot in community care [redacted] … TEF funds will need to support [community care] if that's where the veterans are getting their treatment—not all TEF is for in-house."[64] But given the anticipated FY 2024 carryover of $14.2 billion in addition to about $21.5 billion for medical care from the TEF, VHA and VA leaders concluded the discretionary advance appropriations of $112.6 billion would be sufficient for FY 2025.

According to the VA acting assistant secretary for management and chief financial officer, the Secretary [redacted] felt he could request additional funding if needed but believed at that time VHA could operate within the budget because of the information provided to him by the CFOs of both VA and VHA. VA's CFO corroborated this recollection.

September 2023: VA Submitted FY 2025 Budget Request to OMB

On September 11, 2023, the VA Secretary submitted the budget request to OMB reflecting available resources and caps set by the Fiscal Responsibility Act, maintaining the advance appropriations for FY 2025. [redacted]

[63] Presentation for VA Investment Review Council, July 13, 2023.

[64] Microsoft Teams messages between VHA CFO Laura Duke and VHA deputy CFO, July 5, 2023.

[redacted][65]

VHA Leaders Expected Challenges Staying Within the FY 2024 President's Budget but Believed It Could Be Done

VHA leaders communicated to VA leaders on several occasions from July through November 2023 that they recognized it would be difficult to meet the FY 2025 advance appropriations from the FY 2024 President's Budget but thought they could do so. Yet by fall 2023, leaders in VHA's finance office and the VISNs started to identify greater spending on staffing and community care than originally projected for the FY 2024 budget.

September–November 2023: VHA Finance Office Identified Overspending in Direct Care and Community Care

VHA knew as early as September 2023 that it might spend more in FY 2024 for medical care than planned. During the September 2023 VHA governance board meeting, the under secretary for health noted that community care authorizations and costs had reached historic levels. According to VHA's chief of staff:

> VA Community Care spending has increased in recent years, and [redacted]. The rate of Community Care spending growth is accelerating, and the balance of care is shifting with community care spending expected to reach 40% to 42% of total VA spend this year. Further, Community Care authorizations have more than doubled compared to the year before the pandemic.[66]

In addition, the under secretary shared that because of the "extraordinary successful hiring" in FY 2023, VHA's staffing levels grew by about 6.2 percent, which was more than double its goal of 3 percent.[67] In August 2024, the under secretary for health told the review team in an interview, "What I was prioritizing in FY 2023 was growing our workforce to anticipate significant increases in care demand resulting from the PACT Act."[68]

At the October 2023 governance board meeting, VHA's CFO noted concerning trends showing VHA staffing levels had increased while in-house workload had stagnated or declined. Specifically, the governance board presentation indicated that direct care patient encounters for

[65] [redacted]

[66] Minutes of VHA Governance Board, September 19–20, 2023.

[67] Minutes of VHA Governance Board, September 19–20, 2023.

[68] Shereef Elnahal, under secretary for health, interview with the OIG team, August 29, 2024.

FY 2023 decreased by about 0.3 percent when compared to FY 2022, while healthcare provider staffing increased by about 6.7 percent. At the same time, community care authorizations had grown by about 27.2 percent when compared to FY 2022 levels. On November 14, 2023, VHA's CFO reported to the under secretary for health that actual 2023 obligations were higher than the model projections used for the FY 2024 President's Budget, specifically:

[69]

In a November 21, 2023, monthly budget update to the under secretary for health, VHA's CFO noted that VA's actual FY 2023 expenditures were higher than expected, especially in direct care and community care.[70]

At the November 28, 2023, governance board meeting, VHA's CFO further acknowledged "troubling trends in in-house and community care obligation[s] that are unsustainable."[71] Although she did not provided exact numbers, the CFO noted, "VHA invested in in-house capacity without proportional workload increase" and that its investment in "both in-house capacity and community care" led to "dual [investments in] care."[72] As a result, VHA's CFO noted that VHA would have to reduce funding for initiatives like mental health care or make assumptions about future costs and productivity based on growth trends. The governance board

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[71] Minutes of VHA Governance Board, November 28–29, 2023.

[72] Minutes of VHA Governance Board, November 28–29, 2023.

also formally recommended that VHA host a meeting in January 2024—called a financial sequester—to discuss financial challenges and alternatives.

VHA's CFO and the under secretary for health told the review team in separate interviews that VHA conveyed its updated estimates to VA's CFO [redacted] as of November 2023, flagging budget concerns. [redacted] because VHA believed at this time that they could achieve the FY 2025 advance appropriations from the FY 2024 budget, VHA leaders moved forward to formally host a financial sequester in January 2024 to address the budget challenges. Meanwhile, VHA undertook several initiatives in fall 2023 that were designed to offer veterans more care options at VHA and reduce reliance on community care. For example, starting in fall 2023, VHA implemented strategies to offer more timely services for primary care, specialty care, and mental health treatment.

October and November 2023: VISN Leaders Raised Concerns About FY 2024 Spending Projections

In October 2023, VHA finance officials told the VISNs that the finance office would need to pull back nearly $2 billion in FY 2024 from the VISNs' expected funding due to an anticipated rescission—this was money the VISNs had already incorporated into their budget plans, and it was not factored into their self-reported deficit.[73] Around this same time, some VISN directors started voicing concerns to VHA leaders about shortfalls in FY 2024 that could also affect FY 2025 funds. Cumulatively, the VISNs identified a projected shortfall of about $4 billion for FY 2024 based on their own analyses that identified rates of growth for staffing and community care, including the nearly $2 billion expected rescission. Each of the 18 VISNs self-reported a deficit ranging from about $55 million to about $650 million in FY 2024.

December 2023: [redacted]

[redacted]

[73] This rescission was enacted in the Consolidated Appropriations Act of 2024, Pub. L. No. 118-42, and was separate from the requested cancellation of $7.1 billion in the FY 2024 President's Budget. Although this recission was not signed into law until March 2024, VHA leaders were aware of the potential for it as early as fall 2023. In January 2024, VHA's finance leaders informed the VA Secretary of this anticipated rescission. In March 2024, as part of the FY 2024 annual appropriations bill, Congress rescinded the nearly $2 billion from VHA medical care, in addition to the $7.1 billion cancellation enacted consistent with the FY 2024 President's Budget.

[redacted]

[redacted][74]

[redacted][75]

When asked why VA did not request additional medical care funding when its leaders became aware of overbudget staffing costs and higher-than-projected community care expenditures, the under secretary for health told the review team in an August 2024 interview that [redacted][76] as of December 2023, he still felt they could develop strategies to work within the budget.

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74 [redacted]

75 [redacted]

76 [redacted]

VHA Developed Options to Stay Within Budget

VHA hosted its financial sequester on January 3 and 4, 2024, to strategize how to meet its budget estimates.[77] VHA also adjusted its estimates for staffing and community care spending (based on related actions on lowering overall staffing and using more in-house care) to try to stay within budget. Three months later, in April 2024, VHA began monthly VISN financial reviews to discuss challenges complying with VHA's budgetary demands, to provide feedback and suggestions, and to share best practices after meeting with each VISN during the month.

The January financial sequester produced the following recommended strategies to help VHA stay within the FY 2024 budget obligations and the FY 2025 advance appropriations from the FY 2024 President's Budget:[78]

- Require program offices to internally review and identify resources that could be redirected to support field operations.
- Reduce nonrecurring maintenance to $2 billion to supplement field operation funds.[79]
- Hold staffing at the FY 2023 level through attrition and meet emergent needs through strategic hiring.
- Hold community care growth to 10 percent over the FY 2023 level for FYs 2024 and 2025 by improving management of care referrals and initiative implementation (specifically the Referral Coordination Initiative discussed later in this finding).[80]
- Apply additional VISN-level cost-management strategies, such as requiring VISNs to submit monthly deficit projections to the finance office.

During a January 17, 2024, governance board meeting, VHA's CFO and a VISN director presented the recommendations from the sequester to the board, including the following to help achieve the goals:[81]

[77] Presentation for VHA Financial Sequester Workgroup, "VHA Financial Sequester Background," January 3, 2024.

[78] This financial sequester was led by VHA's CFO and the VISN 1 director and included several other key participants from VHA's program offices. Laura Duke, VHA CFO, and the VISN 1 network director, "Discussion: Financial Sequester Recommendations for FY24 and FY 25," PowerPoint presentation, Governance Board, January 17, 2024.

[79] By comparison, VHA spent over $3.2 billion in this category in FY 2023.

[80] "VHA Referral Coordination Initiative Implementation Checklist," VHA Referral Coordination Initiative SharePoint site, accessed August 20, 2021. (This internal VA website is not publicly accessible.) The checklist says "100% implementation required by June 30, 2021." The Office of Integrated Veteran Care (IVC) relied on its Referral Coordination Initiative to improve scheduling for specialty care.

[81] Laura Duke, VHA CFO, "Governance Board Budget Update," January 17, 2024.

- Increase telehealth availability for urgent and emergency care at VA facilities.
- Fully implement the Referral Coordination Initiative across all VISNs.
- Optimize clinic capacity to improve access to VA care, resulting in less reliance on community care.

Also during this meeting, VHA's CFO compared end-of-month data from December 2022 to December 2023 and presented two concerning trends:

- VHA's staffing levels had grown by nearly 8 percent during this period (from 366,676 positions to about 394,403, equivalent to an increase from about $53.7 billion to about $62.3 billion), while the sequester goal called for zero growth.[82]
- VHA's community care obligations had increased by around 20 percent (from about $7.1 billion for December 2022 to about $8.5 billion for December 2023), exceeding the sequester goal of 10 percent.

A day later, on January 18, 2024, at another governance board meeting, members approved all sequester recommendations for immediate action. [redacted] When asked about the community care goal, VA's deputy assistant secretary for budget told the OIG review team that VA had decided to "challenge ourselves to see if we can slow the rate of growth in community care from what had been around 15–16 percent per year down to about 12 percent per year."[83]

On January 2, 2024, one day before the financial sequester began, VHA finance leaders briefed the under secretary for health on two strategies to stay within the FY 2024 President's Budget.[84] The options focused on revising its two biggest cost drivers: staffing and community care. One strategy was to use attrition to lower VHA staffing and set the community care spending growth rate goal at 15 percent for FYs 2024 [redacted]. The under secretary for health chose the second strategy, which was to support "steady state staffing" (a consistent workforce level across VA) and assume the spending for community care growth rate at less than 10 percent. The under

[82] Cost estimates are based on VHA's estimates from a July 2024 VA briefing to congressional staff from the House and Senate Veterans' Affairs Committees, "Medical Care 2025 Budget Update" in *Veterans Benefits Administration and Veterans Health Administration Potential Shortfalls, July 2024*.

[83] Deputy assistant secretary for budget, interview with the OIG team, August 14, 2024.

[84] This included about $112.6 billion in advance appropriations [redacted]

secretary reviewed and approved this strategy during the finance office discussions. However, a briefing document from the finance office that was shared with the under secretary acknowledged that a 10 percent growth rate was much lower than actual increases over the last few years. No details were provided on how the rate would be reduced to 10 percent. The under secretary told the review team that he believed the initiatives implemented after the financial sequester would help stem the growth of community care (and related costs).

January–March 2024: VHA Struggled to Stay Within the Budget

VHA tried to meet the budget goals it had set for staffing and community care, relying on initiatives developed during the January 2024 sequester. However, doing so proved challenging.

Staffing

VHA's human capital management chief recalled that conflicting guidance and the timing of its release to the facilities and VISNs on how to limit hiring may have hampered such efforts. The chief told the review team that after the zero-growth goal was decided, her office was charged with developing subgoals and specific tasks needed to accomplish the goal. The chief said she started to develop guidance in January 2024 to explain how facilities should manage and track their staffing levels, including how to rescind job offers. However, this guidance was not officially issued until May 2024 because of the level of review required.

Prior to this guidance being released, the assistant under secretary for health and operations told the review team in an email that she asked each VISN and medical facility to start reviewing "positions in recruitment to ensure hiring actions are supportable and strategic" due to "the organization's budgetary position."[86] VHA officials told the review team they had extended job offers that were in the works that had been initiated months in advance-—complicating their ability to respond to changing needs and to rescind job offers, if necessary.

The assistant under secretary for health for operations had sent a memo to VISN and facility directors on January 23, 2024, asking facilities to pause rescinding tentative or final job offers until the end of the month. The memo said the pause would allow the Human Capital Management Office to develop a process and guidance to mitigate any negative impact caused by rescinding job offers. In addition, specific to staffing, the assistant deputy under secretary for health for patient care services wrote in a January 2024 email to the assistant under secretary for health for patient care services that the goal of zero growth in staffing would mean that levels

[redacted]

[86] Assistant under secretary for health for operations, email message to OIG review team, October 17, 2024.

would stay at "essentially [the] same number … as of October 1, 2023," and expressed concerns that the zero-growth goal would not be met.

In a February email message to all VHA staff, the under secretary for health said that VHA was "not in a hiring freeze."[87] This communication seemingly contradicted VHA's stated plan to reduce staffing levels. Adding to the confusion, the email was sent before Human Capital Management provided VISNs and facilities with key guidance to drive staffing decisions.

On February 16, the assistant under secretary for health for operations and the chief of human capital management sent a memo with the key guidance to VISN and facility directors, recommending that "facilities and VISNs regularly monitor local FTE [staffing] trends" as "program offices will be submitting this data as part of the Monthly Leadership Financial Status Report that is critical to ensuring budgetary actions taken are providing the necessary impact across the enterprise."[88] This memo said additional "guidance will be forthcoming to provide strategies to aid in accomplishing the FTE target for FY 2024."

In addition to setting a goal to reduce hiring, VHA had anticipated a 9–10 percent attrition rate in FY 2024 based on historical data, but attrition was actually lower than expected—at about 6 percent, according to the human capital management chief.[89] The OIG review team analyzed VHA's staffing levels from October 2023 through February 2024 to evaluate the extent to which attrition rates limited VHA's ability to meet the staffing goal from the FY 2024 President's Budget for FY 2024.[90] As shown in table 1, the team found that as of February 2024, over 9,400 positions exceeded the FY 2024 budget estimate that could not be explained by the lower-than-expected attrition rates.

Table 1: Personnel Levels Above the FY 2024 President's Budget Estimate for FY 2024 of 386,633 Positions for October 2023 Through February 2024

Personnel level description	October 2023	November 2023	December 2023	January 2024	February 2024
Number of staff above FY 2024 budget goal of 386,633	7,051	6,485	9,809	13,380	15,376
Less, number of staff lost due to attrition in FY 2022 compared to FY 2024* (cumulative)	1,787	2,720	2,723	5,171	5,951

[87] Under Secretary for Health Shereef Elnahal, email message to all VHA staff, February 5, 2024.

[88] VHA under secretary for health and chief of human capital management, "FY 2024 FTE Target Definition and Data Source," memorandum to VISN directors, February 16, 2024.

[89] Chief of human capital management, interview with the OIG team, August 8, 2024.

[90] The review team used FY 2022 attrition rates as a benchmark to conduct their analysis because FY 2022 had the highest attrition rates over the last six fiscal years and represented the highest number that could be attributable to attrition.

Personnel level description	October 2023	November 2023	December 2023	January 2024	February 2024
Total number of staff above FY 2024 President's Budget estimate not explained by attrition	5,264	3,765	7,086	8,209	9,425

Source: OIG analysis of expenditure and staffing data and human resources turnover data from VHA Support Service Center.

** The review team used FY 2022 as a benchmark for attrition because it had the highest attrition over the previous six years.*

VHA's human capital management chief recalled to the review team that, in March 2024, her office had started "tracking the [staffing] data and seeing that we were not really moving the needle in the direction that leadership wanted." The chief went on to say that part of the issue is that "it takes so long for us to hire" so they had "people in the queue for a long time" and if you "turn off the hiring faucet, it takes a while to actually see the water stop flowing. And that's what we had been working towards."[91]

Community Care

For community care, increased costs were anticipated due to PACT Act enrollment and use of VA health care, long-term services, and support as the veteran population continues to age, as well as program costs for certain dependents and survivors of disabled or deceased veterans. VHA's CFO said the EHCPM projects how much care veterans are likely to need in a year and applies a cost for that care when projecting estimates. VHA leaders assumed that veterans preferred and desired VA care and would use it if it were available to them.

Coming out of the financial sequester in January 2024, VHA tried to stem the growth of community care by implementing utilization management strategies, optimizing VA clinic capacity to reduce community care referrals, and fully implementing the Referral Coordination Initiative. The OIG determined that VHA leaders relied on the initiative to curb community care growth, but that potential was not fully realized.

IVC launched this initiative in 2019 and expected all VA medical facilities to have created coordination teams and implemented the initiative in all specialties by June 30, 2021. This initiative has been designed to provide veterans with key information, such as VA and community care wait times, so they can make informed decisions about whether to receive their care within VA facilities or in the community. VHA originally anticipated this initiative would help increase veterans' use of VA care and decrease the use of community care before FY 2024 began, enabling VHA to rebalance related spending. However, facilities did not implement the initiative at the rate VHA had hoped. VHA was aware of this issue by October 2022 (about five months before its initial budget estimates for FY 2025) after the OIG issued a report that found

[91] Chief of human capital management, interview with the OIG team, August 28, 2024.

no facilities had fully implemented the Referral Coordination Initiative as of June 2022.[92] As one way to increase veterans' use of VA care and decrease community care spending, VHA refocused the initiative with a VISN-level approach intended to look at services across all facilities in the VISN to offer veterans the most VHA options for care as possible.

Although VHA was relying on the referral initiative to increase direct care stemming from the January 2024 sequester, it was not until June 2024 that IVC's acting assistant under secretary for health sent a memo to VISN directors that outlined VISN responsibilities related to implementing the Referral Coordination Initiative. In addition, an IVC leader told the review team in September 2024 that the initiative was still in its "baby stages."[93] The IVC leader stated that IVC had internal discussions about how the achievability of lowering the growth of community care to 10 percent was unrealistic, given that the actual growth rate for community care had ranged from 16 percent to over 18 percent from FY 2021 to FY 2023. Although this leader also told the team that IVC is not always included in decisions about model assumptions and IVC was not asked for its input on the growth rate for community care, VHA's Office of Enrollment and Forecasting told the review team that it does hold meetings with the relevant program offices to discuss trends in the use of community care, pharmacy, and prosthetics to help inform model assumptions.

Coming out of the January 2024 sequester, in addition to carrying out the Referral Coordination Initiative, IVC also responded to the lower growth goal by encouraging facilities to focus on clinic optimization and to increase the use of interfacility consults, telehealth appointments, e-consults, and the use of VA Clinical Resource Hubs. The review team did not evaluate how well facilities implemented these initiatives or whether they were successful in reducing community care referrals as intended.

March 2024: VHA Initiated Monthly VISN Financial Reviews

The VA Secretary told the review team that he was surprised by the community care spending at the end of FY 2023 compared to what had been budgeted, and he requested at the end of calendar year 2023 that the under secretary for health monitor month-to-month spending. The under secretary told the review team that in March 2024, he was displeased with VHA's progress toward meeting both the community care and staffing goals. Community care referrals grew by 22 percent since the beginning of FY 2024, while the goal set at the financial sequester was 10 percent. Staffing had grown 3.1 percent since the beginning of FY 2024, when the goal was set to zero percent growth. Because of these concerns, the under secretary directed multiple VHA

[92] VA OIG, *Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative*, Report No. 21-03924-234, October 27, 2022.

[93] Hillary Peabody, acting assistant under secretary for health for the Office of Integrated Veteran Care, interview with the OIG team on September 5, 2024.

leaders to hold monthly financial reviews with VISNs starting in April. The under secretary explicitly requested that these monthly reviews include updates related to

- staffing levels, community care referrals, and dollars obligated for direct care and community care, among other specific metrics;
- key performance indicators for establishing robust VISN-level referral initiatives (in addition to the Referral Coordination Initiative) and for establishing and delivering telehealth for urgent and emergency care; and
- any other indicators determined to be most relevant.

According to a VISN director, the reviews were established partly because VISNs were not hitting their staffing targets, and levels were still climbing. The deputy assistant under secretary for health for operations held these monthly reviews with each VISN beginning in April. The deputy assistant under secretary used the information gathered in these meetings to provide the under secretary with updated metrics and trends to identify recent positive outcomes or areas of concern—such as staffing, community care growth, and initiatives designed to provide veterans with access to more timely care from a VA provider. According to the Secretary, the under secretary for health briefed him on the results of these monthly financial reviews. The Secretary said these reviews helped him better defend the budget, hold senior managers accountable, and reduce surprises and anticipate challenges.

March 2024: VA's FY 2025 President's Budget Was Published

VHA's final submission included in the FY 2025 President's Budget maintained the approved medical care advance appropriations amount of $112.6 billion from the FY 2024 President's Budget. Table 2 shows the FY 2025 estimates from the FY 2024 and FY 2025 President's Budgets and highlights the differences.

Table 2: Advance Appropriations and Final Budget for FY 2025

Funding category	FY 2024 budget request advance appropriations	FY 2025 budget request final
Advance appropriations for medical care	$112.6 billion	$112.6 billion
Toxic Exposures Fund	$21.5 billion (anticipated)	$21.5 billion
Other resources and adjustments*	$12.7 billion	$15.5 billion
Total obligations for medical care‡	**$146.8 billion (from FY 2024 budget)**	**$149.5 billion (revised from FY 2025 budget)**

Source: OIG analysis of the FY 2024 and FY 2025 Medical Care Budget Justification and documentation provided by VHA that were used to negotiate the FY 2025 budget.

** This amount includes collections, reimbursements, transfers to non–medical care funds, and portions of the carryover planned to be obligated in the fiscal year. VHA initially planned to use $8.5 billion from the*

$9.8 billion carryover, but in the revised budget for FY 2025, VHA planned to use $11.3 billion of the $14.6 billion carryover, and another almost $2 billion was expected to be rescinded.

‡ *Numbers do not sum due to rounding.*

The total estimated funding of $149.5 billion for medical care for the FY 2025 budget was about $2.7 billion more than the original estimate of $146.8 billion from the FY 2024 budget. This included an increase of over $800 million for discretionary funding and $1.9 billion for mandatory funding overall, across all discretionary and mandatory budget accounts. (In addition, the published FY 2025 President's Budget still included the $2 billion that Congress had rescinded days earlier as part of the anticipated carryover funds from FY 2024 to FY 2025.)[94] VA leaders believed that this budget, if successfully implemented, would have allowed VHA to stay within its FY 2024 and FY 2025 budget levels included in the FY 2025 President's Budget, without a second bite for FY 2025 medical care.

The overall revised submission included the following VHA estimated needs for FY 2025:

- **Staffing** – 383,186 positions, down from 403,616 in the FY 2024 budget (associated with a cost of about $64 billion, down from about $68.5 billion)
- **Community care** – about $40.9 billion, up from about $35.4 billion in the FY 2024 budget
- **Pharmacy services** – about $11.8 billion, up from about $11.4 billion in the FY 2024 budget
- **Prosthetics services** – $4.5 billion, up from about $3.9 billion in FY 2024 budget

Considering VHA's staffing level was about 400,013 as of January 2024, the OIG concluded that meeting the FY 2024 or FY 2025 staffing goals of 392,610 and 383,186, respectively, did not seem feasible. In addition to limits on hiring, this decrease would require a high rate of attrition. While VA's FY 2025 President's Budget noted the department would continue to focus its hiring in key areas, such as mental health care, it did not discuss strategies to decrease staffing levels.

VHA said in its FY 2025 budget submission that personnel estimates were revised and lowered for the FY 2025 President's Budget because VHA staffing levels increased throughout the COVID-19 pandemic. The higher staffing levels, combined with reduced direct care workload, led to a significant increase in direct care unit costs over the course of the pandemic. This trend persisted into FY 2022. VHA modeled a decrease in projected staffing levels for FY 2025 and FY 2026 to reflect VHA's response to that trend.[95]

[94] VA had planned to carryover the $2 billion from FY 2026 into FY 2027 in the FY 2025 budget since it had not been rescinded at the time VA submitted its budget to OMB.

[95] *U.S. Department of Veterans Affairs FY 2025 Budget Submission*, vol. 2, p. 27.

In addition, community care growth rates were assumed to trend downward with the implementation of various initiatives to provide veterans with more care from a VA provider, with an estimated rate of 14.8 precent for FY 2024 and 12 percent for FY 2025. As reflected in the FY 2025 budget request, these rates were lower than the actual community care growth rates of between 16 percent and over 18 percent from FY 2021 to FY 2023. [redacted][96] VHA's deputy assistant secretary for budget told the review team that the community care budget was a "really tough number for us to live with" because the lowered projected growth rate was a "much smaller rate of growth than we had seen previously."[97] But because VHA had hired so many positions for direct care, VHA decided to "see if we can meet that lower rate of growth because we have to live in these budget targets."

When originally planning for the FY 2025 funding in the FY 2024 President's Budget, VHA had expected that veterans with newly identified conditions or increased ratings under the PACT Act would use more of its direct care services at VA facilities.[98] This assumption was based on historical data and an actuarial analysis that showed enrolled veterans with higher service-related medical conditions are more reliant on VHA for care.[99]

Later sections of this report detail how the estimates for staffing, community care, pharmacy services, and prosthetics became factors in announcing a potential budget shortfall.

April 2024: Congress Held Budget Hearing

VHA maintained ongoing actions to address budget levels, which appeared increasingly difficult to achieve at the time of VA's congressional budget hearing for FYs 2025 and 2026, held on April 11, 2024.[100] Leading up to this hearing, VHA leaders and the VA Secretary knew they were not on track to meet their staffing and community care growth goals. For example, during the March 2024 governance board meeting, VHA's CFO said both staffing and pharmacy services costs had increased and that slowing down hiring was proving to be challenging.[101] The Secretary told the OIG review team that as of April 2024, he and VHA's leaders still thought that

[96] [redacted]

[97] Deputy assistant secretary for budget, interview with the OIG team, August 14, 2024.

[98] *U.S. Department of Veterans Affairs FY 2024 Budget Submission*, vol. 2 of 5, *Medical Programs*, March 2023, pp. 431–435.

[99] White House, "President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans" (fact sheet), accessed September 8, 2024.

[100] *Hearing on Veterans' Affairs Fiscal Years 2025 and 2026 Budget Request, Before the House Veterans' Affairs Committee*.

[101] Minutes of VHA Governance Board, March 19–20, 2024.

their ongoing initiatives would help them meet the budgetary demands.[102] For example, they were in the middle of a strategic pause on hiring and were working to expand the Referral Coordination Initiative, as well as one other initiative to decrease the use of community care—including revising community care access standards and emergency room notification processes. The Secretary told the review team that VHA did not express concern or desire for a second bite, but VHA leaders wanted him to be supportive if they ended up needing more. The Secretary recalled that as he prepared for the hearing, VA's former CFO recommended, "Why don't we just make clear what is true and what we had been saying to OMB and others, which is: If we need a second bite we'll come back to you?"[103] The Secretary heeded this advice, telling the House Committee on Veterans' Affairs in response to the chairman's statement, "there's no second bite in the budget. We don't anticipate one, but if we need one we'll come back and talk to you guys about it."[104]

May 2024: VA and VHA Began Discussions [redacted] About a Potential Budget Shortfall

According to a VA official, in May 2024, VHA told OMB that actual execution for staffing and community care was higher than anticipated for FY 2024. VA formally notified OMB in late June 2024 of a potential FY 2025 shortfall. [redacted] Significantly, these communications with OMB did not yet include revised estimates for pharmacy or prosthetics services but noted a risk that the other "non-pay" costs could grow faster than projected, such as for new high-cost drugs.[105]

[102] Denis McDonough, VA Secretary, interview with the OIG, October 29, 2024.

[103] *Hearing on Veterans' Affairs Fiscal Years 2025 and 2026 Budget Request, Before the House Veterans' Affairs Committee*.

[104] *Hearing on Veterans' Affairs Fiscal Years 2025 and 2026 Budget Request, Before the House Veterans' Affairs Committee*.

[105] From Laura Duke, VHA CFO [redacted] When projecting fiscal obligations VA categorizes the projected costs as being for "Full-Time Equivalent," "Community Care," "Non-Pay," and "Non-Recurring Maintenance."

VHA's Failure to Achieve Sequester Goals Exacerbated FY 2025 Budget Concerns

From May through August 2024, VHA moved forward with its planned initiatives for staffing and community care. Of note, the VHA finance office did not report spending increases in pharmacy services until March 2024 and prosthetics services until June 2024; these delays contributed to VHA's projected shortfall for the FY 2025 budget.

Pharmacy and prosthetics program leaders told the review team that they were projecting and communicating potential shortfalls to VHA's finance office months earlier. But the under secretary for health told the team in October 2024 that he was unaware of budgetary concerns related to pharmacy or prosthetics services until June or July 2024.

Staffing

To provide guidance on VHA's FY 2024 approach to hiring and attrition, the under secretary for health sent a memo on May 31, 2024, to VISN and facility directors that said, "While we continue to hire strategically in many key areas, the FY25 budget requires that VHA reduce cumulative staff … this memo provides guidance on how to make those key decisions" and that VHA should be strategic about "which positions we should be hiring, filling, or managing through attrition."[106] Also on May 31, the under secretary for health sent memos to VISN and facility directors related to specific purpose–funded positions and activities—noting that those positions must be executed as intended in the FY 2024 budget and not used to try to stem personnel growth.[107]

Over a month later, in July 2024, VHA's associate CFO said in an internal message to the VHA CFO that VHA was still relying on attrition to meet the zero-growth goal, although no details were provided on why this method would be effective.

On August 19, 2024, the deputy assistant under secretary for health for operations briefed the under secretary for health on VHA's financial health, noting that "most VISNs have established a consistent, desired negative trajectory towards [staffing] goals" and that "zero growth has been emphasized and implemented." But the deputy added that achieving zero growth across VHA was unlikely before the end of FY 2024—which, by mid-August, was about six weeks away.[108] The August briefing document to the under secretary for health also emphasized that low

[106] VHA under secretary for health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network directors (10N1-10N23), medical center directors (00), and VHACO program office leaders, May 31, 2024

[107] VHA under secretary for health, "Specific Purpose Funded Positions and Activities (Homelessness, Suicide Prevention and Women's Health)," memorandum to Veterans Integrated Service Network directors (10N1-10N23), medical center directors (00), and VHACO program office leaders, May 31, 2024.

[108] Alfred Montoya, deputy assistant under secretary for health for operations, "VHA Financial Health," PowerPoint presentation, USH Small Group, August 19, 2024.

attrition rates across VHA continued to make zero growth difficult to achieve. Yet there was no indication that the zero-growth goal had changed by August 2024.

Community Care

The under secretary for health and the VHA chief of staff told the review team that they both assumed that the goal to expand direct care would reduce veterans' reliance on community care in FY 2024. But direct care did not increase at a pace that would make the community care estimates for FYs 2024 or 2025 in the FY 2024 President's Budget an accurate reflection of community care funding needs.

Based on interviews with the under secretary for health and VHA's chief of staff, the review team learned that VHA thought as early as 2023 that its investment in direct care would have decreased veterans' use of community care by opening up more opportunities to receive VA care in person or virtually. However, VHA did not provide the OIG with evidence of a clear plan or strategy to show how the referral and other related initiatives were expected to decrease reliance on community care.

In a May 2024 email regarding VHA's strategic priorities, the under secretary for health told VHA's chief of staff that he was frustrated because IVC did not have "clear and consistent data that presented a clear picture of our performance in the category of [community care] referrals … now more than halfway through the fiscal year."

During a VHA financial health meeting in June 2024, VHA's deputy assistant under secretary for health for operations reported to the under secretary for health several themes from the monthly meetings with VISN leaders, such as "balancing in-house capabilities against community care referrals continues to be a challenge." [redacted]

VHA's deputy assistant under secretary for health for operations reported to the under secretary for health in August 2024 that the community care "growth rate [was] on track to be slower than FY 2023 … however, the magnitude of the impact is not yet enough to affect spending significantly." Specifically, growth in the use of community care slowed to 16 percent from October through July 2024 compared to 17.9 percent from October through July 2023.[109] The deputy attributed the positive trend to increases in the use of VHA's initiatives to reduce community care and provide better access to direct care, including progress implementing a VISN-approach to the Referral Coordination Initiative and increasing the use of telehealth for urgent care needs.

[109] Alfred Montoya, "VHA Financial Health."

However, many of IVC's initiatives to limit community care growth were not expected to be implemented until late 2024 and 2025, which would have made little to no impact to the FY 2024 and FY 2025 budget cycles. An IVC leader told the OIG team that IVC knew the growth rate goals that VHA leaders had set (15 percent for FY 2024 and 12 percent for FY 2025) were unrealistic but that facilities did their best to decrease community care spending.

Pharmacy Services

In the FY 2025 President's Budget, VHA adjusted its estimate for pharmacy services to $11.8 billion for FY 2025, an increase from the $11.4 billion submitted a year prior. However, after the FY 2025 President's Budget request was developed, additional drugs had become available to VA patients—many of whom were expected to meet eligibility requirements for them in 2024. VHA's finance office did not quantify or report such increases until about June 2024, although the program office raised concerns starting about a year earlier.

The deputy chief of pharmacy services told the review team that pharmacy services personnel expressed specific concerns about the financial impact of weight-management medications becoming available for a greater number of eligible veterans during a meeting with pharmacy services leaders as early as June 2023. While these drugs were first approved for general use in 2021, the deputy chief said budget forecasting for them is a challenge because of the difficulty in predicting what percentage of eligible patients would actually use them. The pharmacy deputy chief contacted the chief of fiscal services in the Office of Patient Care Services in January 2024 by email to let him know about the potential availability of two different high-cost medications and the anticipated impact on the budget. Specifically, the pharmacy deputy chief informed the chief of fiscal services that

> preliminary analysis by my team found that if 10 percent of eligible VA patients were converted to one of these (weight-management) drugs, the spend would be about [$]2 billion. The second drug is resmiterom [*sic*]. … While the price of the drug is unknown, it is anticipated to be high, and VA has a huge population of patients.[110]

Furthermore, in that same January email, the pharmacy deputy chief asked the chief of fiscal services for advice on how to embed a contact from the finance office in pharmacy services so "that they aren't caught unaware once these drugs take off."[111] The chief of fiscal services in the Office of Patient Care Services responded immediately with a contact from the finance office and asked specifically whether the impact would be most felt among VA's mail-order

[110] Pharmacy Benefits Management Services deputy chief consultant (the deputy chief of pharmacy services), email message to the chief of fiscal services in the Office of Patient Care Services, January 26, 2024. Resmetirom is the first treatment for an inflammation of the liver caused by excess fat cells.

[111] Pharmacy Benefits Management Services deputy chief consultant, email message to the chief of fiscal services in the Office of Patient Care Services, January 26, 2024.

pharmacies or Meds by Mail programs. The pharmacy deputy chief responded on February 8, confirming that she would contact the VHA finance office and clarified that pharmacy services does not "have a projected budget impact for [VA's mail-order pharmacies and Meds by Mail] yet because there are severe supply constraints on these drugs, so there is a lot of unknown." The pharmacy deputy chief further wrote that she "will be able to refine this better once I see what usage and supply looks like."[112] In March 2024, the deputy chief emailed the VHA finance office about pharmacy services' budgetary concerns related to two high-cost drugs and the potential impact on patient care. For weight-management medications, the deputy chief informed the finance office's deputy associate CFO that

> [w]ith VA pricing, these drugs cost roughly $6,500 to $7,700 per patient per year, and there are over 2 million patients that meet the criteria for being overweight or obese. … The estimated budget impact is over $1.7 billion annually. … That is the best case scenario, as there are many patients with lower [body mass index] that would also meet clinical criteria.[113]

The pharmacy deputy chief also informed the finance office on the impact of a second drug, Resmetirom. "Based on our initial estimates of the patients that have this condition, the spend could be over $1 billion annually and potentially higher," the deputy chief said.[114]

During an interview with the review team, the deputy associate CFO confirmed that pharmacy services reached out to the finance office months after the January 2024 sequester, informing them of "high-cost pharmacy drugs that are coming to market … and that they were bracing for an impact on what that meant to the medical centers in terms of … double-digit growth year over year in those drugs."[115]

On July 5, 2024, the assistant under secretary for health for patient care services followed up in an email to the VHA finance office about the March communication regarding the budgetary concerns and the impact to pharmacy services. The two groups met on July 29, 2024, and according to the finance office's summary of the meeting, the financial impact of the expanded use of these expensive drugs would range from about $3 billion to $12 billion—plus a possible long-term impact due to the rising average cost of community care prescriptions and the growing demand for the two high-cost drugs discussed. The summary also noted that community care

[112] Pharmacy Benefits Management Services deputy chief consultant, email message to the chief of fiscal services in the Office of Patient Care Services, February 8, 2024.

[113] Pharmacy Benefits Management Services deputy chief consultant, email message to the deputy associate chief financial officer, March 22, 2024.

[114] Pharmacy Benefits Management Services deputy chief consultant, email message to the deputy associate chief financial officer, March 22, 2024.

[115] Deputy associate chief financial officer interview with the OIG team, September 12, 2024.

prescriptions cost more than twice as much as in-house prescriptions and are "still trending upwards."

The deputy chief of pharmacy told the review team that she did not have input on the estimates used for the FY 2025 President's Budget request.

> [The projection model was] using actual data which was based for this very broad class of drugs that's then had significant shortage. Essentially no availability for several years. And I kept saying to them, someday these drugs are going to be available and this is going to be a problem … [redacted]

The executive director of pharmacy services also noted that he was not involved in the estimations for the budget. He noted that the pharmacy deputy chief had been doing briefings with VHA finance and the under secretary for health related to the weight-loss drugs and the national shortage.[116] The deputy chief further explained that pharmacy services had briefed different groups on the pharmacy budget concerns since at least the beginning of 2024, including the under secretary and the VHA leadership team. "I was concerned about the lack of response from anyone, especially about the weight management medications. I think that people kept assuming this wasn't a problem because these drugs were on shortage. … I think the frustrating point for me is that [pharmacy services] wasn't really pulled in until this was already a crisis and someone had testified that we needed more money."[117] Conversely, the under secretary for health told the review team that he was not aware of potential increases in the cost of pharmaceuticals (and prosthetics) until July due to a "lack of a system that allows for more real-time information on budget execution … leading to projections being inaccurate." When asked whether he got a sense that this was an issue that had come forward before then, but that he was not briefed, he said he "can't answer that question. All I can tell you is I first learned about this concern in the June/July time frame when we were formulating the anomaly request."[118]

[redacted] OMB asked pharmacy leaders in August 2024 to provide more details on the factors driving increases in pharmacy expenditures. Pharmacy leaders estimated an additional need of over $700 million for FY 2024 and of about $1.7 billion for FY 2025 from the estimates

[116] Pharmacy Benefits Management Services executive director, interview with the OIG team, August 28, 2024.

[117] Pharmacy Benefits Management Services deputy chief consultant, interview with the OIG team, August 15, 2024.

[118] Shereef Elnahal, under secretary for health, interview with the OIG, October 31, 2024. The anomaly request refers to VA's supplemental budget request.

included in the FY 2025 President's Budget. Pharmacy leaders reported that the increase was attributable to

- more community care appointments resulting in more prescriptions;[119]
- the costs of single-source drugs, such as brand-name drugs without generic alternatives, increasing due to inflation; and
- other high-cost medications, such as weight-management drugs and Resmetirom, driving up costs.

Prosthetics Services

In the FY 2025 President's Budget, VHA adjusted its estimate for prosthetics services to $4.5 billion for FY 2025, an increase from $3.9 billion submitted a year prior. While VHA's finance office did not quantify or report a prosthetics budget shortfall until about June 2024, the prosthetics services office raised concerns months earlier.

According to the executive director for prosthetics and sensory aids, in January 2024, prosthetics services began discussions about the potential budget shortfall via email with the chief of fiscal services in the Office of Patient Care Services and separately during documented budget review meetings that included the deputy associate CFO from VHA's finance office. During a meeting of the prosthetics leadership board's finance committee that same month, prosthetics service leaders projected a combined shortfall of about $766 million in FY 2024, according to a VHA official. During interviews with the review team, both the deputy CFO and the deputy associate CFO confirmed that prosthetics services communicated this with the VHA finance office as early as January 2024.

A February 2024 email from a management and policy analyst for the prosthetics and sensory aids service to the deputy associate CFO acknowledged that the projected deficit was down for FY 2024 to about $750 million.[120]

The deputy associate CFO told the OIG review team,

> It really solidified in [the] March–April time frame when we got through the six months of the year and saw those trends were holding. It really took a while because you could have a spike in one month and it changes your projections. But when you have six

[119] The executive director for pharmacy benefits management explained that community care providers' prescriptions may cost more to dispense because they do not always follow the VA formulary, which is a list of medications and supplies that are covered under VA pharmacy benefits. VA OIG, *Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times*, Report No. 23-01583-183, August 15, 2024.

[120] Management analyst, Prosthetic Services, email message to the deputy associate chief financial officer, VHA, February 2024.

> months for the data, that's pretty reliant—that yes, we were going to have a significant shortfall in prosthetics.[121]

By June 2024, the VISNs were projected to exceed their FY 2024 prosthetics budget but only by over $35 million—far less than originally predicted in part because additional allocations from VHA to the VISNs had been distributed between January and June 2024. The projected shortage also gradually decreased throughout the year because the program office estimated its fiscal year spending by extrapolating the actual spending to date, and the actual spending in October and November 2023 (the first two months of the fiscal year) was far greater than the expected spending that month. Whereas the actual spending in the remaining months was similar or more-than-expected spending.

During a VISN prosthetics representative meeting in June, the finance office told prosthetics services to continue using specific purpose funds until they ran out. Later that month, prosthetics services sent a memo to the VISNs requesting that facilities project their budget needs for FY 2025. The memo emphasized the importance of these projections in ensuring sufficient funding for the facilities. It said local facilities and VISNs would be responsible for any shortfalls after the funds were dispersed. VISN and facility leaders were required to review, sign, and acknowledge the budget request and accompanying documentation.

According to the executive director for prosthetics and sensory aids, several factors contributed to the rise in prosthetics spending, including vendors' inability to meet contractual demand, which requires procuring from alternative sources; clinical prescriptions that incorporate emerging and costly technologies; continued growth in the veteran population accessing care; and general inflation.

Prosthetics services' data for FYs 2022, 2023, and 2024 revealed the following increases in patients and average cost per patient.[122]

- FY 2022: 3 million patients, with an average cost of $898 per patient
- FY 2023: 3.1 million patients, with an average cost of $1,011 per patient
- FY 2024: 3.2 million patients, with an average cost of $1,115 per patient

VHA noted that the total change in cost for FY 2024 was expected to be over $502 million, with $165 million attributed to the increase in the number of veterans and $337 million attributable to the change in spending per veteran.

According to its executive director, prosthetics services made three separate requests to the finance office for more funding from June through September 2024. In a September 2024

[121] Deputy associate chief financial officer interview with the OIG team, September 12, 2024.

[122] Data shown here for each fiscal year are through three quarters. The total number of veterans served by prosthetics services was over 3.5 million during FY 2023.

briefing to Congress, VHA estimated it needed an additional $87 million for prosthetics services for FY 2024 and more than $367 million for FY 2025.[123]

VHA Requested Supplemental Funding for FY 2025 and Later Lowered Its Estimates of a Potential Shortfall

From spring into summer 2024, VHA shifted funds to try to meet its FY 2024 budget. For example, VHA reallocated some program office funds and planned to shift these funds to the VISNs. While still making these adjustments, VA briefed Congress in July on the almost $12 billion potential shortfall for the remainder of FY 2024 and for FY 2025.[124] According to the VA deputy assistant secretary for budget, the presidential administration at the time submitted to Congress a continuing resolutions anomaly (supplemental funding) request in August for FY 2025, asking for the $12 billion to cover VHA's potential medical care shortfall.

As of October 2024, VHA determined it actually ended FY 2024 close to the FY 2024 estimate in the FY 2025 President's Budget request. The under secretary for health told the OIG review team at the end of October that the anticipated shortfall would end up being less than the initial $12 billion estimate but did not provide a specific amount.

May–August 2024: VHA Shifted Funds to Assist VISNs

VHA shifted dollars among accounts to try to meet its FY 2024 budget. From May through August 2024, the VISNs received nearly $3.1 billion in additional funds based on their self-reported needs. This included $580 million from program office accounts that VHA distributed to the VISNs in June 2024. From May through July, VHA distributed an additional $88 million from program office accounts to the VISNs. In August, VHA distributed the remaining funding of almost $2.5 billion, comprising about $1.3 billion from funds that had not yet been allocated, including initiative funds and specific purpose funds and an estimated $1.1 billion from funds meant for carryover to FY 2025, after VA officials notified the congressional appropriations committees of VA's plans to release the needed carryover funds.[125]

The release of funds to the VISNs was intended to prevent the VISNs' facilities from running out of money and to sustain them for the remainder of FY 2024. According to VHA's CFO, "We were making VISNs whole who needed to be made whole as opposed to just giving everybody an equal share."[126] For example, some funds were sent on an emergency basis when VISN CFOs

[123] Veterans Health Administration, "2025 Medical Care Anomaly Request," September 2024.

[124] VA briefing to Congress, "Medical Care 2025 Budget Update," July 2024.

[125] Numbers in this paragraph may not sum precisely due to rounding. Only specific purpose funds that were not able to be obligated by VA medical facilities in FY 2024 were reallocated, and this was coordinated with a congressional notification letter. VHA under secretary for health, "Fiscal Year (FY) 2024 Program Office Specific Purpose Funds," memorandum.

[126] Laura Duke, VHA CFO, interview with the OIG team, August 27, 2024.

notified the finance office that they were in danger of running out of money. Others were funded through the routine VISN-allocation process.

July and August 2024: VA and VHA Briefed Congress and OMB on the Estimated $12 Billion Potential Shortfall and Requested Supplemental Funding

In July 2024, VA briefed Congress on the potential $12 billion shortfall for the remainder of FY 2024 and for FY 2025. VA attributed the causes to higher-than-expected staffing levels and community care growth. In addition, a VA briefing document noted that "revised Pharmacy and Prosthetics estimates account for $3.821 billion of the identified shortfall" and "costs for drugs and prosthetic devices are higher than anticipated due to market pressures."[127]

[redacted] VA briefed Congress on July 15 regarding its anticipated budget shortfall for VHA of about $12 billion.[128] Table 3 presents the increased funding amounts VHA said it needed to avoid a shortfall for the remainder of FY 2024 and FY 2025.

[127] VA briefing to Congress, "Medical Care 2025 Budget Update," July 2024.

[128] Four Corners Brief, *VHA Workforce: FTE Definitions and Goals for FY 2024*, July 15, 2024.

Table 3: VHA's Budget Shortfall Estimate in July 2024, by Category

Areas requiring increased funding	FY 2024 additional funding needs	FY 2025 additional funding needs	Combined shortfall
Staffing	$900 million	$3.5 billion	$4.4 billion
Community care	$100 million	$1.8 billion	$1.9 billion
Pharmacy services	$700 million	$2.7 billion	$3.4 billion
Prosthetics services	$100 million	$400 million	$500 million
Nonrecurring maintenance	$200 million	$0	$200 million
All other*	$500 million	$1.2 billion	$1.7 billion
Total increase	**$2.5 billion**	**$9.6 billion**	**$12.1 billion**

Source: OIG analysis of VHA's 2025 Medical Care Anomaly Request.

Note: Total obligations do not include PACT Act Title 7 funding or other funding that is generally unavailable for medical care operations. Amounts do not sum to the $12 billion referenced in the text due to rounding.

** The "all other" category includes areas such as "Travel and Transportation of Persons" and "Transportation of Things."*

VHA's CFO told the review team that the process to develop the eventual shortfall estimate was not based on a model and that the determination for the additional staffing positions used average personnel costs and was not "scientific." Instead, according to the CFO, VHA estimated medical care needs and backed into the staffing level from that.

According to the VA deputy assistant secretary for budget, on August 29, 2024, the presidential administration at the time submitted a supplemental appropriations request for FY 2025 to Congress.[129] In this request, the administration asked for $12 billion to cover VHA's potential medical care shortfall for the remainder of FY 2024 and for FY 2025. The request said that due to the "Fiscal Responsibility Act (FRA) discretionary caps, VA identified the TEF, a mandatory account, as a solution to address the 2025 medical care shortfall." Because Congress established the TEF in part to deliver health care to veterans exposed to environmental hazards, in September, VHA confirmed that "all of the $12 billion would be used to provide for the delivery of Veterans' health care associated with exposure to environmental hazards." Without the additional funds for other healthcare purposes, VHA said it would face a funding shortfall in FY 2025, potentially impacting medical care operations for veterans as early as the first quarter of the fiscal year, which began October 1, 2024.

[129] FY 2025 Continuing Resolution (CR) Appropriations Issues, p. 24.

September–November 2024: VHA Continued to Assess Its Potential Shortfall and Lowered Its Estimates

On September 19, 2024, VHA's CFO told the under secretary for health that VA's budget leaders and VHA's finance office briefed OMB about VHA's shortfall, and OMB asked about updated estimates. [redacted][130] [redacted][131]

The following week, on September 23, 2024, VHA's CFO presented to Congress an enhanced version of the prior July briefing to provide additional details and answer members' questions about the almost $12 billion original request.[132] [redacted]

On September 26, 2024, Congress passed a continuing resolution through December 20, 2024, which did not include VHA's $12 billion request.[133]

In October 2024, VHA assessed its preliminary end-of-year FY 2024 data and determined it ended the year closer to what was originally estimated for FY 2024 in the FY 2025 President's Budget instead of the subsequent higher estimates. According to the Secretary, VHA's CFO briefed him in October that the shortfall estimate was less than the initial $12 billion, and the Secretary and VHA communicated that information to OMB, saying they would follow up with a revised estimate. VHA determined it had carried over about $50 million more into FY 2025 than anticipated and spent over $1 billion less on equipment than budgeted for in the FY 2025 President's Budget.

VHA's CFO told the OIG team that VHA provided an additional briefing to Congress in October 2024 to explain the pharmacy and prosthetics services shortfall in more detail.

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130 [redacted]

131 [redacted]

132 VHA CFO Laura Duke, "Veterans Health administration 2025 Medical Care Anomaly Request September 2024," PowerPoint Presentation, Congressional Committees on Veterans' Affairs and Appropriations, September 23, 2024.

133 Continuing Appropriations and Extensions Act, 2025, Pub. L. No. 118-83 (2024).

[redacted][134]

[redacted]

On November 26, 2024, VHA provided Congress with a budget update briefing that VHA needed $6.6 billion for veterans' medical care instead of the $12 billion it had previously communicated to Congress in July 2024.[135] VHA explained that FY 2024 efforts to control spending resulted in VHA carrying over $2.5 billion more in operational medical care costs in FY 2025 than anticipated when building the original supplemental request. In addition, the total medical care needs for FY 2025 ended up being $2.8 billion less than estimated in the original supplemental request. After revisiting its FY 2025 funding requirements, and in light of the end of FY 2024 actual spending amounts, VHA's revised shortfall estimate fell to $6.6 billion from $12 billion for FY 2025 (see table 4).

Table 4: Calculating Potential Shortfall from the Original Request to the Updated Request

Description	Request amount
Original supplemental request	$12 billion
Reduction in estimated FY 2025 obligations	-$2.8 billion
Additional operations carryover into FY 2025	-$2.5 billion
Updated supplemental request	**$6.6 billion**

Source: Re-created from VHA's VA Medical Care FY 2025 Budget Update.
Note: Dollar values are rounded and so do not sum to $6.6 billion.

This estimate was developing using actual data on FYs 2023 and 2024 spending, the amount that was carried over from FY 2024 into FY 2025, a revised estimate calculated on actual costs per staff, and updated information on the costs of expensive drugs.

[134] [redacted]

[135] VHA briefing to Congress, *VA Medical Care FY 2025 Budget Update*, November 26, 2024.

Specifically, the updated November 2024 $6.6 billion request

- maintained the same revised personnel level for FY 2025 of 405,490 from the August 2024 supplemental funding request but accounted for the actual lower average cost per staff in 2024;
- assumed that community care obligations would grow by 14.8 percent in FY 2025;[136]
- included an updated equipment estimate of $2.6 billion;
- had an additional $2 billion for high-cost drugs to treat weight loss and steatohepatitis (associated with metabolic dysfunction); and
- estimated prosthetics costs at an additional $160 million.

The under secretary for health detailed the revised request amount and reiterated reasons for it in testimony at a December 5, 2024, hearing before the House Committee on Veterans' Affairs. He stated that VHA was able to stay within its FY 2024 budget due to efforts to manage spending, including cost-savings that will not be sustainable, however—such as the delayed replacement of equipment. He also said that although the requested amount had decreased, "if VA medical care does not receive additional funding early in FY25, VA will be forced to make difficult decisions to remain within the current budget."[137]

On December 20, 2024, Congress passed a second continuing resolution through March 14, 2025, which also did not include VHA's supplemental request.[138] Just weeks before publishing this report, Congress passed a continuing resolution in mid-March to provide $6 billion in mandatory funding to VHA's Toxic Exposures Fund to address the remaining funding requirements for FY 2025.[139]

Conclusion

VHA's original budget request to support FY 2025 funding was included in the FY 2024 President's Budget submission, which relied on data and assumptions from 2021 (the most recent data available at the time). There were several factors that contributed to VHA not requesting more funding when those numbers could be revised (the second bite process): (1) VHA leaders thought they could stay within the proposed budget using various strategies, (2) there was an unanticipated legislative budget cap they did not want to exceed, and [redacted]

[136] VHA briefing to Congress, *VA Medical Care FY 2025 Budget Update*, November 26, 2024. The community care growth rate of 14.8 percent was an increase from the 12 percent in the FY 2025 President's Budget, but a decrease from the just over 16 percent assumed in the original supplemental funding request.

[137] *Fact and Fiction: Getting to the Bottom of the VA Budget Shortfall, Before the House Committee on Veterans' Affairs*, 118th Cong. (December 5, 2024) (statement of Shereef Elnahal, MD, MBA, Under Secretary for Health, Veterans Health Administration).

[138] American Relief Act, 2025, Pub. L. No. 118-158.

[139] Full-Year Continuing Appropriations and Extensions Act, 2025, H.R. 1968, 119th Cong. § 11110 (2025) (enacted).

[redacted]. VHA and VA leaders believed the previously approved amount of $112.6 billion plus other funding and anticipated carryover would be sufficient to fund medical care in FY 2025.

VHA developed various options and set goals to stay within budget—which included reducing both hiring and the use of community care while building in-house healthcare capacity from January 2024 through FY 2025 (ending September 30, 2025). Non-pay expenses were also slashed for equipment and other accounts.

Despite these efforts, VHA failed to achieve the cost-reduction goals. Challenges faced by VHA included managing staffing costs after experiencing significant growth during FY 2023 and early FY 2024, a higher-than-anticipated increase in community care while in-house investments mounted (failing to achieve efforts to shift more care in the community to direct VA care), and substantial increases in costs and demand for pharmacy and prosthetics services. In July 2024, VA briefed Congress on VHA's potential shortfall of nearly $12 billion and, according to the VA deputy assistant secretary for budget, the presidential administration at the time later requested the supplemental funding in August through a continuing resolution anomaly (supplemental funding). In November 2024, VHA had revised this shortfall down to $6.6 billion, based on updated actual spending data from FY 2024.

There are many causes and conditions that led to the need for a supplemental funding request. As the report indicates, not all stakeholders were fully engaged in the process to form budget assumptions and assist with estimates. The financial management systems, processes, and projections were limited by the availability of data that is sometimes years old. In addition, ongoing changes to budget estimates made it difficult to communicate the extent of the potential shortfall promptly and clearly to leaders within VA and to Congress. The recommendations that follow are meant to help make sure VHA has sufficient funds to effectively and efficiently serve veterans while making the best use of taxpayer dollars.

Recommendations 1–4

The OIG made the following recommendations to the under secretary for health:[140]

1. Review the Veterans Health Administration's current methods, assumptions, and approaches used to project medical care budget needs in the annual President's Budget to identify any gaps in the process or data limitations, and develop and implement a plan to strengthen the process.
2. Establish and implement a plan to review current processes and procedures for involving program offices and pertinent subject matter experts in developing the

[140] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

Enrollee Health Care Projection Model inputs for specific areas such as community care, staffing, pharmacy services, and prosthetics services, and formalize the expectations of their involvement in this process through guidance or protocols.

3. Develop and implement an approach to estimate medical care personnel needs and costs to increase the accuracy and reliability of information included in the annual President's Budget.
4. Institutionalize a regular cycle of at least quarterly fiscal reviews among assistant under secretaries for health, network directors, and program offices that routinely assess key cost drivers and other areas of concern, such as staffing, community care growth, and local initiatives.

VA Management Comments

The acting under secretary for health concurred with three of the four recommendations and concurred in principle with recommendation 3. An action plan was also submitted for all recommendations. Appendix C includes the full text of the comments, which are summarized here.

For recommendation 1, VHA will review the processes, assumptions, and approaches it uses to project budget needs for medical care to identify opportunities for improvement. For recommendation 2, VHA's Office of Enrollment and Forecasting will review the processes for involving relevant subject matter experts in determining inputs for modeled budget projections and develop standardized guidance detailing program office engagement. For recommendation 4, VHA will implement regular fiscal reviews at least quarterly with VHA, VISN, and program office officials to assess key cost drivers and other areas of concern, such as staffing, community care growth, and local initiatives.

The acting under secretary concurred in principle with recommendation 3, noting that VA does not request an appropriation specific to personnel costs. Instead, estimates are included in the annual VA Congressional Justification. VHA states there are a number of factors involved in trying to more accurately estimate medical care personnel needs and costs that can cause differences between budget estimates and actual spending. These include external factors out of VHA's control and internal factors such as leadership guidance and operational policies, requiring a focus on whether estimates are based on valid assumptions. VHA's action plan noted that it will develop and implement a more reliable approach to estimate medical care personnel needs and costs for the annual President's Budget with protocols that determine the validity of assumptions for future estimates.

OIG Response

The acting under secretary for health provided acceptable action plans for all four recommendations. All recommendations remain open at this time. The OIG will continue to evaluate VHA's actions and close recommendations when VHA provides complete documentation and sufficient evidence addressing the intent of the recommendations and the issues identified.

Appendix A: OIG Actions in Response to PL 118-82 Oversight Requirement

In September 2024, Congress passed the Veterans Benefits Continuity and Accountability Supplemental Appropriations Act, requiring the VA Office of Inspector General (OIG) to examine the Veterans Health Administration's (VHA) announced medical care funding shortfall for fiscal year (FY) 2025.[141] This appendix details how the OIG addressed these requirements during its review of VHA's supplemental budget request.[142] The specific requirements are as follows:

- **Part A:** The OIG "shall conduct a review of the circumstances surrounding and the underlying causes of the announced funding shortfall" for VHA in FY 2025 described in the letter to Congress from VA Secretary on July 31, 2024.
- **Part B:** Relating to the expected shortfall in VHA's funding in FY 2025, the review "shall include, but not be limited to: a comparison of monthly obligations and expenditures in relevant accounts against the spend plan of the Department; the reasons for any significant diversions of obligations or expenditures from the spend plan; an analysis of the accuracy of projections and estimates relevant to such diversions; and any other matter determined relevant" by the OIG.
- **Part C:** Relating to the expected shortfall in VHA's funding in FY 2025, "the review also shall include: any changes, abnormalities, or significant events as determined significant by the [OIG] … in the transfer, reallocation, or other movement of funding between or within the Central Office, a Veterans Integrated Service Network, a facility, a program or office, a special purpose fund, the Veterans Equitable Resource Allocation process, or the Medical Center Allocation System."
- **Part D:** Actions VA "can take to improve the accuracy of supporting information submitted under section 1105(a) of title 31, United States Code, with respect to the Department of Veterans Affairs and to prevent funding shortfalls for the Department."

The OIG has fulfilled parts A and D within the narrative of this report. This appendix addresses parts B and C to include more detailed data and information with related tables and explanations.

[141] The Veterans Benefits Continuity and Accountability Supplemental Appropriations Act of 2024, Pub. L. No. 118-82, 138 Stat. 1521.

[142] The law also included requirements for the OIG to review the Veterans Benefits Administration's shortfall for FY 2024. That review is included in a separate OIG oversight report.

Part B: Comparison of Obligations and Expenditures Against the Spend Plan

For FY 2024, the OIG team identified personnel costs, community care, nonrecurring maintenance, pharmaceuticals, and prosthetic devices as the accounts that drove shortfalls underlying VHA's medical care supplemental request. The team compared FY 2024 actual obligation amounts to the spend plan and analyzed monthly trends in obligations and expenditures.[143] For Part B, the review team considered changes in the overall VHA medical care budget greater than or equal to 1 percent, or $1.395 billion of $139.5 billion because those changes would have an impact on the overall amounts. The OIG did not identify any deviations from the spend plan for these accounts equal to or greater than 1 percent of the total VHA medical care budget. In addition to showing this comparison, table A.1 shows the evolution of budget estimates from March 2023 through July 2024.[144]

Table A.1. FY 2024 Budget Estimates Compared to Actual Obligations, by Relevant Account

Relevant account	Estimate in FY 2024 President's Budget (March 2023)	Estimate in FY 2025 President's Budget (March 2024)	Shortfall estimate* (July 2024)	Actual obligations (September 2024)	Estimate in FY 2025 President's Budget less actual obligations
Payroll	$61.3 billion	$62.2 billion	$63.1 billion	$61.9 billion	$294 million
Community care	$32.9 billion	$36.5 billion	$36.7 billion	$36.6 billion	-$32 million
Nonrecurring maintenance	$5.8 billion	$2.0 billion	$2.2 billion	$2.3 billion	-$318 million
Pharmaceuticals	$10.3 billion	$10.7 billion	$11.5 billion	$11.1 billion	-$393 million
Prosthetic devices	$3.9 billion	$4.1 billion	$4.2 billion	$4.2 billion	-$95 million
All others	$27.7 billion	$24.0 billion	$24.3 billion	$23.0 billion	$934 million
Total medical care*	**$141.9 billion**	**$139.5 billion**	**$142.0 billion**	**$139.1 billion**	**$391 million**

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis. Community care aligns with community care appropriations. The remaining medical care appropriations are then categorized

[143] For the purposes of this appendix, the OIG considers the spend plan to be FY 2024 budget estimates outlined in the FY 2025 budget.

[144] VHA's President's Budget does not identify expenditures and did not show monthly obligation amounts; therefore, the OIG could not compare expenditures or monthly obligations to the spend plan. Instead, the OIG compared the total annual FY 2024 obligation with the FY 2024 budget estimates in the FY 2025 President's Budget to be responsive to the request for more information about how the budget estimates compared to the spend plan and actual obligations.

based on their object class or budget object codes. Payroll is object class 10. Nonrecurring maintenance is object class 32 within cost center 854200. Pharmaceuticals is budget object code 2631 and 2636. Prosthetic devices is 2674 and 2692.

Note: Amounts are based on transactions that occurred during FY 2024 and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA. "All others" includes items such as equipment, travel, transportation, rent, supplies, and materials.

** VHA's revised estimates that exceeded the spend plan did not include obligations under Title 7 of the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022. Totals do not sum exactly due to rounding.*

Personnel

The actual personnel costs were below the spend plan and the revised estimate used to determine the potential shortfall, even though the average staffing level for the year was 6,553 higher than the spend plan.

- March 2023: The estimate was about $600 million *less* than the actual obligations.
- March 2024: The estimate was about $300 million *more* than the actual obligations.
- June 2024: The estimate was about $1.2 billion *more* than the actual obligations.

VHA determined personnel cost estimates by multiplying the estimated average annual staffing level by an average annual cost per employee. The actual average annual cost per employee in FY 2024 was less than estimated, which resulted in the lower personnel costs. Table A.2 compares the FY 2024 estimated personnel costs and staffing levels against the actual obligations (about $61.9 billion).

Table A.2. 2024 Personnel Cost Estimates Compared to Actual Obligations

Relevant account	Estimate in FY 2025 President's Budget (March 2024)	Shortfall estimate* (July 2024)	Actuals (September 2024)	Estimate in FY 2025 President's Budget less actuals
Staffing level	392,610	399,301	399,163	-6,565
Cost per employee	$158,381	$158,055	$155,043	$3,342
Personnel costs	$62,181,915,000	$63,111,576,000	$61,887,488,980	-$294,426,020

Source: VHA Support Service Center Obligation and Expenditure report, FY 2025 President's Budget, VHA shortfall estimates, and OIG analysis.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA.

The OIG reviewed the FY 2024 monthly obligation and expenditure amounts for personnel costs, as shown in figure A.1 and did not identify any deviations during FY 2024.

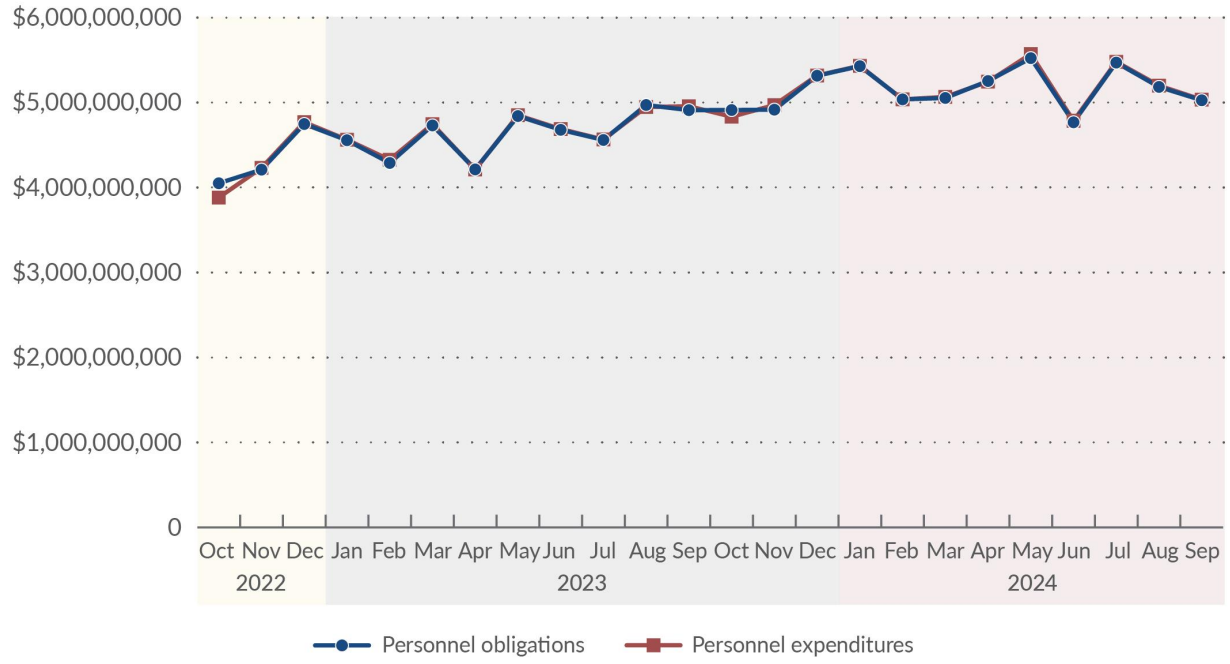


Figure A.1. *Monthly personnel obligations and expenditures.*

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA. According to VHA's Office of Finance, monthly amounts may vary based on how many workdays are in each month. For example, June 2024 included twenty workdays whereas May and July 2024 had twenty-three workdays resulting in a dip in obligations and expenditures.

Community Care

As shown previously in table A.1, VHA's community care estimates increased from March 2023 ($32.9 billion) through July 2024 ($36.7 billion), which were close to the actual FY 2024 community care obligations (about $36.6 billion).

- March 2023: The estimate was about $3.7 billion *less* than actual obligations.
- March 2024: The estimate was about $100 million *less* than the actual obligations.
- July 2024: The estimate was about $100 million *more* than the actual obligations.

The OIG reviewed FY 2024 monthly obligations and expenditures for medical community care and identified a notable deviation from February through April 2024. This deviation occurred because of a cybersecurity intrusion in February 2024 that severely delayed VA medical claims

processing, resulting in a backlog of claims payments.[145] Figure A.2 breaks down the FY 2024 monthly obligations and expenditures for medical community care.[146]

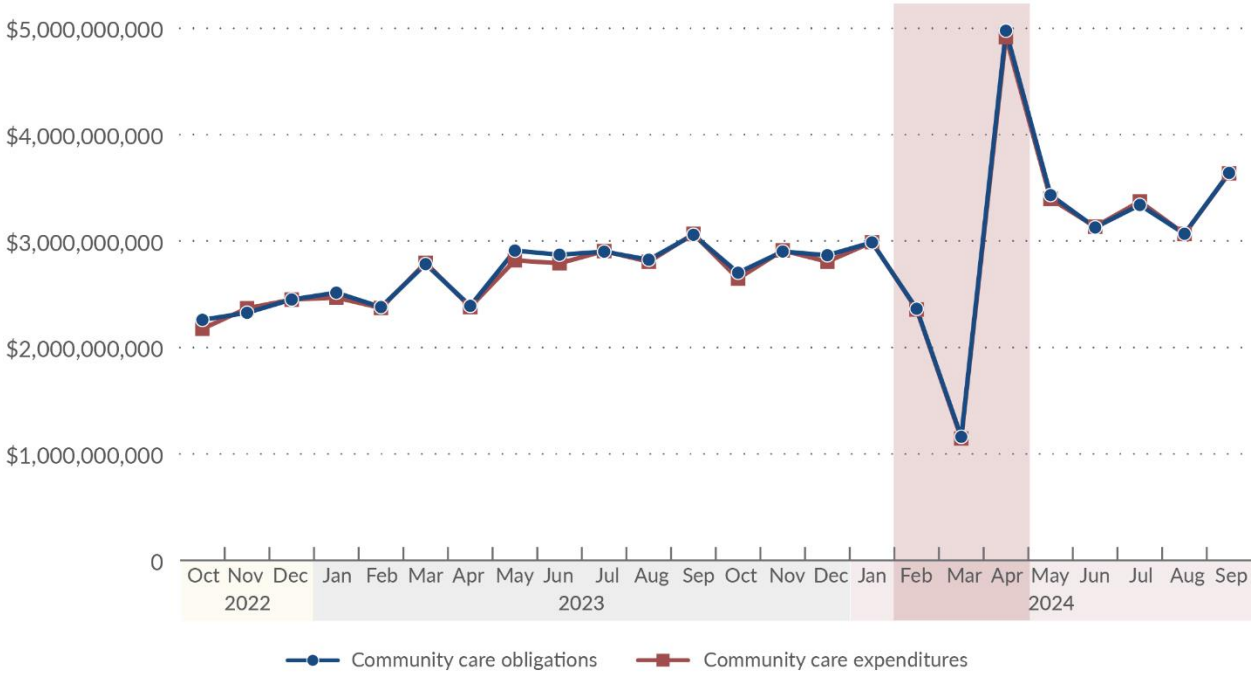


Figure A.2. *Monthly community care obligations and expenditures.*

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA.

Nonrecurring Maintenance

As shown previously in table A.1, the FY 2024 estimates for nonrecurring maintenance decreased by nearly $3.8 billion in the FY 2025 budget as of March 2024.

- March 2023: The estimate was about $3.5 billion *more* than the actual obligations.
- March 2024: The estimate was about $300 million *less* than the actual obligations.
- July 2024: The estimate was about $100 million *less* than the actual obligations.

According to VHA's CFO, this decrease occurred because the obligation levels in the FY 2024 budget as of March 2023 depended on VHA being able to transfer around $3.9 billion from the medical community care appropriation and around $850 million from the medical support and

[145] The attack was related to a clearinghouse for medical insurance claims transactions and other healthcare-related services.

[146] For community care, VA obligates when claims are paid, not when appointments are scheduled.

compliance appropriation. Because those transfers did not occur, VHA did not have the funding to support those obligation levels for nonrecurring maintenance.

FY 2024 monthly obligation and expenditure amounts for nonrecurring maintenance followed similar patterns as seen in FY 2023. Figure A.3 breaks down FY 2023 and FY 2024 monthly obligation and expenditure amounts for nonrecurring maintenance.

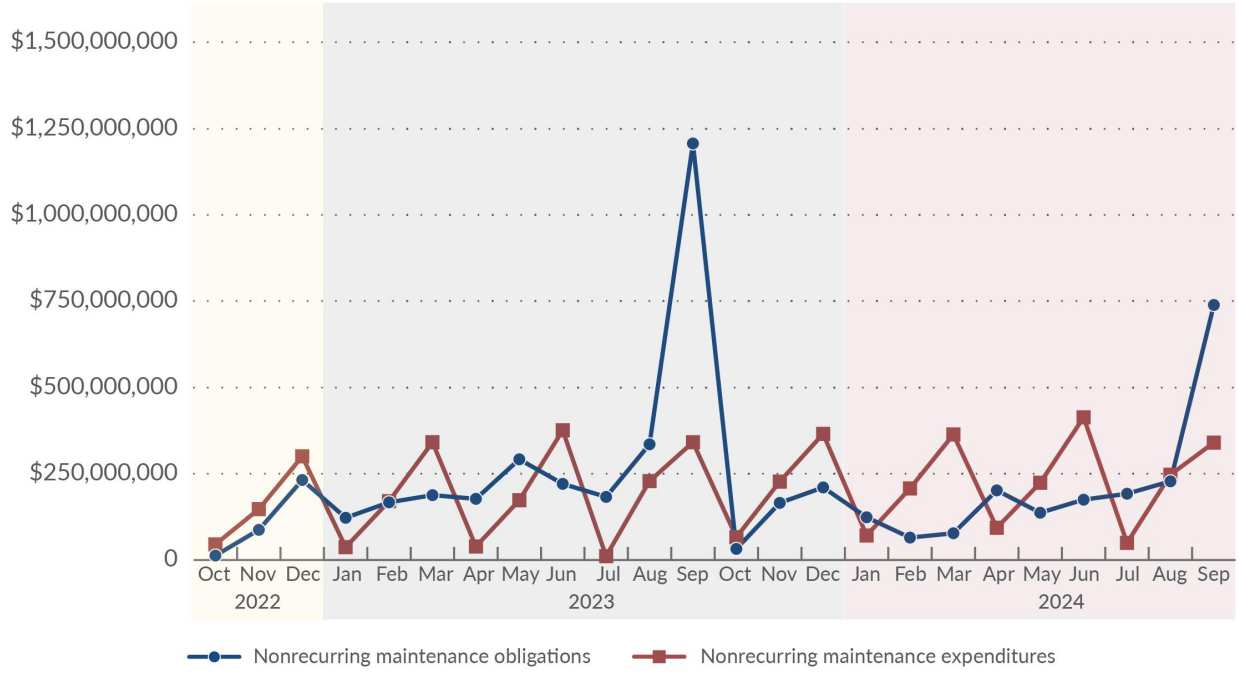


Figure A.3. *Monthly obligations and expenditures for nonrecurring maintenance.*

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA. According to VHA's Office of Finance, VHA historically has higher obligations at the end of the fiscal year. Projects are prioritized and obligated when funding is freed up at the end of the fiscal year.

Pharmaceuticals

As shown previously in table A.1, VHA's estimates for pharmaceuticals increased from March 2023 through July 2024 and actual obligations in FY 2024 (about $11.1 billion) were more than the spend plan.

- March 2023: The estimate was about $800 million *less* than the actual obligations.
- March 2024: The estimate was about $400 million *less* than the actual obligations.
- July 2024: The estimate was about $400 million *more* than the actual obligations.

While VHA anticipated an increase in pharmaceutical costs during this period, actual costs were greater than expected. The reasons for the increases in pharmaceutical costs are explained in the finding section of this report.

The OIG reviewed the FY 2024 monthly obligation and expenditure amounts for pharmaceutical costs, as shown in figure A.4, and did not identify any deviations.

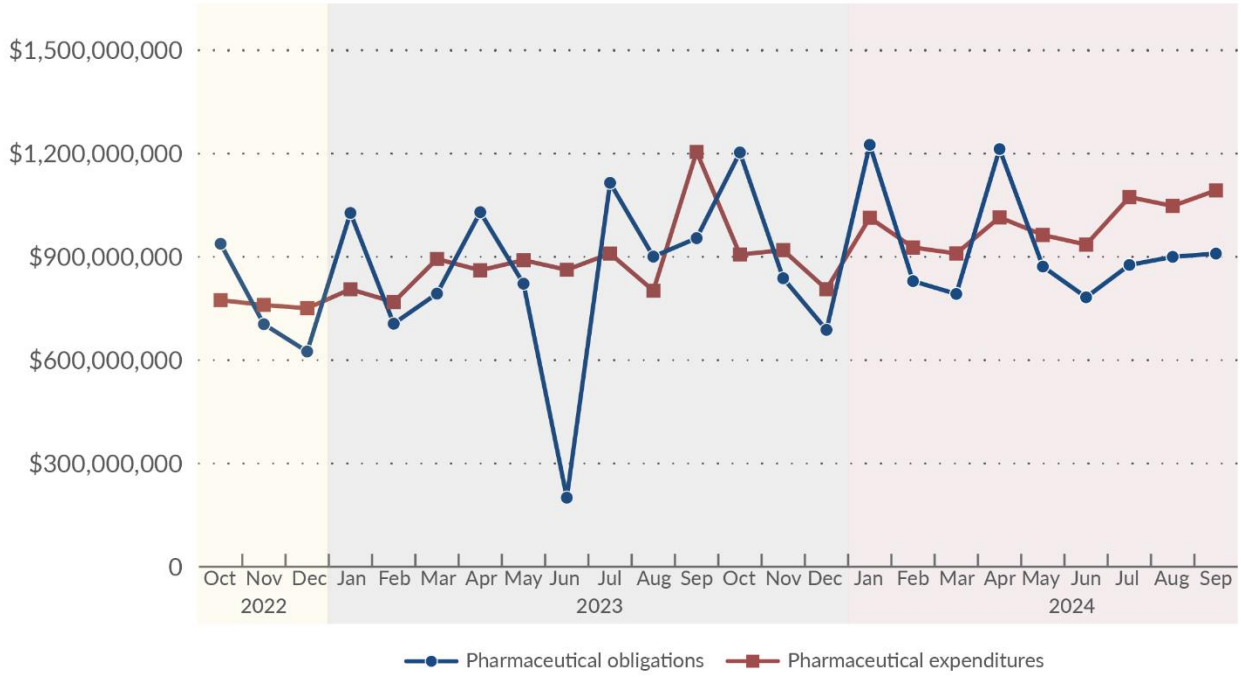


Figure A.4. *Monthly pharmaceutical obligations and expenditures.*

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA. According to the VHA Office of Finance, lower obligations in June 2023 were a result of a de-obligation of $515 million that was processed to comply with audit findings.

Prosthetic Devices

As shown previously in table A.1, actual obligations for prosthetic devices in FY 2024 (about $4.2 billion) were about $100 million more than anticipated in the March 2024 spend plan.

- March 2023: The estimate was about $300 million *less* than the actual obligations.
- March 2024: The estimate was about $100 million *less* than the actual obligations.
- July 2024: The estimate was about the same as the actual obligations.

VHA effectively predicted costs for prosthetic devices during this period. The OIG also reviewed the FY 2024 monthly obligation and expenditure costs for prosthetic devices, as shown in figure A.5 and did not identify any deviations.

Figure A.5. *Monthly prosthetic devices obligations and expenditures.*

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis. Equipment is object class 31.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA.

All Others: Equipment

The OIG reviewed items within the "all others" category and identified changes in equipment spending as the main driver.[147] Actual obligations for equipment in FY 2024 (about $1.3 billion) were more than $1 billion less than the March 2024 spend plan. As part of the revised estimates in July 2024, VHA determined equipment costs could be reduced by about $200 million, as shown in figure A.6 on the next page.

- March 2023: The estimate was about $1.0 billion *more* than the actual obligations.
- March 2024: The estimate was about $1.0 billion *more* than the actual obligations.
- July 2024: The estimate was about $900 million *more* than the actual obligations.

The OIG also reviewed the FY 2023 and FY 2024 monthly obligation and expenditure amounts for equipment and found similar patterns. Figure A.6 breaks down FY 2023 and FY 2024 monthly obligation and expenditure amounts for equipment.

[147] Equipment comprises items of a "durable nature" that are expected to have "a period of service of a year or more after being put into use without material impairment of its physical condition or functional capacity." OMB Circular A-11, *Preparation, Submission, and Execution of the Budget*, July 25, 2024.

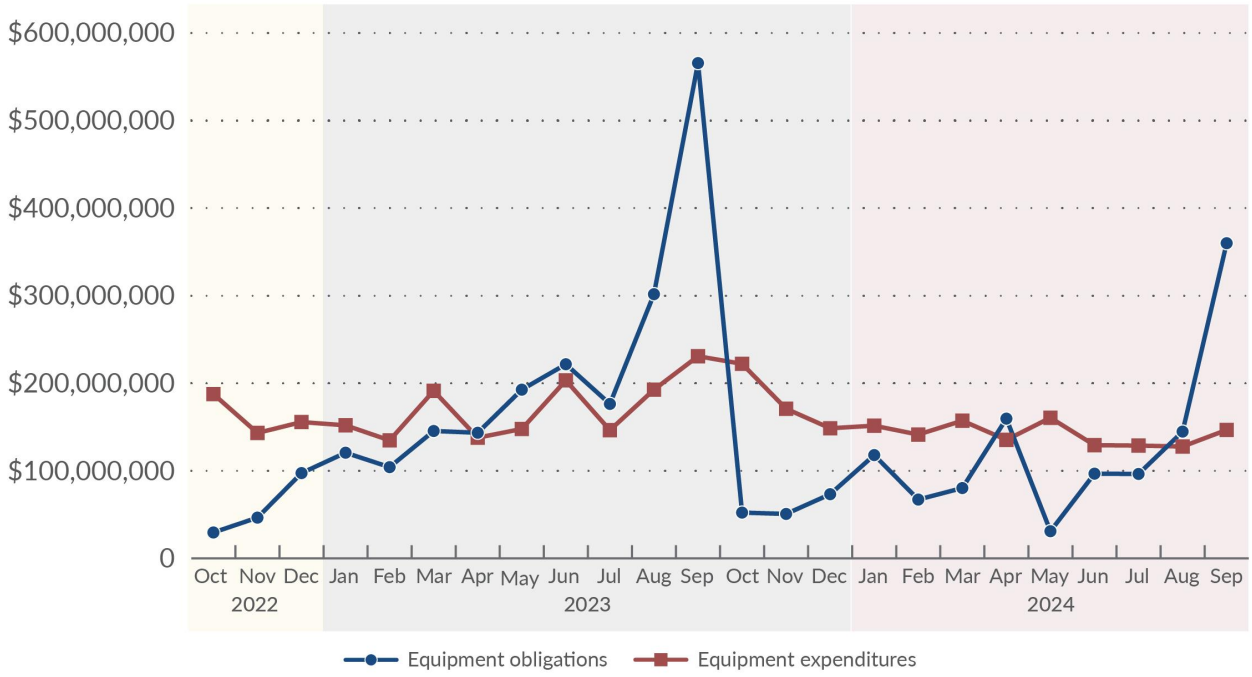


Figure A.6. *Monthly equipment obligations and expenditures.*

Source: VHA Support Service Center Obligation and Expenditure report and OIG analysis.

Note: Amounts are based on transactions that occurred during the fiscal year and do not include end-of-year adjustments; therefore, these numbers may vary slightly from amounts reported by VHA. According to VHA's Office of Finance, VHA historically has higher equipment obligations at the end of the fiscal year. Equipment is prioritized and obligated when funding is freed up at the end of the fiscal year.

Part C: Identified VHA Program Office, Veterans Integrated Service Network (VISN), and Medical Facility Changes, Abnormalities, and Events in the Transfers, Reallocations, or Other Movement of Funds

As the Veterans Benefits Continuity and Accountability Supplemental Appropriations Act required, for FY 2024, the OIG evaluated "the transfer, reallocation, or other movement of funding between or within" the VA central office, a Veterans Integrated Service Network (VISN), a facility, a program or office, a specific purpose fund, the Veterans Equitable Resource

Allocation (VERA) process, or the Medical Center Allocation System (MCAS) to identify "any changes, abnormalities, or significant events" the OIG determined to be significant.[148]

The OIG took two approaches for this analysis. The first approach evaluated the movement of funding for program offices, whereas the second approach evaluated the movement of funding for VISNs and medical facilities in comparison to the VERA and MCAS models.[149]

VHA Program Offices

To evaluate the transfer, reallocation, or other movement of funds among program offices, the OIG compared the allocation amounts distributed in the first quarter of FY 2024, which was about 85 percent of the total estimated needs for the fiscal year, to the changes that occurred in the following three quarters.

During the final three quarters of the fiscal year, a net total movement of nearly $552 million in funds was pulled back from the program offices by VHA's Office of Finance. VHA pulled these funds back so that it could send more general purpose funding to the VISNs and medical facilities to close gaps in their projected funding needs. Table A.3 compares these overall amounts for the VHA program office's budget.

Table A.3. FY 2024 VHA Program Offices Budget and Allocations (in Thousands)

Organization	Estimates used for VERA	Quarter 1 allocations	Quarters 2–4 movement of funding	Total allocations
VHA Program Offices	$14,643,000	$12,381,000	-$552,000	$11,829,000

Source: VHA Automated Allotment Control System, VERA documentation, and OIG analysis.

The OIG performed this analysis by program office to determine whether any program office experienced deviations during the final three quarters of fiscal year 2024. The review team considered changes in program office amounts of more than 1 percent of the overall program offices budget, or $146.4 million, because those changes would have an impact on the overall amounts.

[148] Allocations are delegations of authority to obligate budget authority and outlay funds. These allocations can be for a certain program (known as specific purpose funds) or for general use (known as general purpose funds). VHA uses the VERA model at the beginning of the fiscal year to determine how to apportion general purpose funds among the VISNs. The VISNs then use MCAS as a guide to distribute those general purpose allocations to the medical centers. VISN leaders have flexibility to alter the allocations based on local initiatives and requirements. VERA does not apportion specific purpose funds to the VISNs, but the VERA package contains a summary of estimated specific purpose allocations by VISN. While the legislation asked for movement between VHA central office and program office, VHA does not have one central office—therefore, the OIG review team examined transfers among all program offices.

[149] Specific purpose funds were evaluated in both approaches.

The OIG identified three offices that experienced deviations of greater than 1 percent.[150] VHA's Office of Finance and Office of Care Management and Social Work Services experienced decreases in funding, whereas the Office of Community Care programs managed by the VHA Office of Finance had an increase in funding.[151]

- As stated by VHA's director of the Allocation Resource Center, VHA's Office of Finance returned about $36.5 million to the VHA finance office so VHA could direct more money to the VISNs and medical centers, transferred about $101.5 million to other program offices, and returned $42 million to VHA as excess at the end of the fiscal year.
- The Office of Care Management and Social Work Services returned about $179.8 million to the VHA finance office for caregiver stipend funds that had gone unspent.
- The community care programs managed by the VHA finance office received about $221 million in additional allocations from VHA for the payment of Civilian Health and Medical Program of the Department of Veterans Affairs benefits and about $89 million in additional allocations for the foreign medical program.[152]

VISN and Medical Facilities

At the beginning of each fiscal year, general purpose and some medical community care allocations are distributed to the VISNs through the VERA process.[153] After each VISN receives its annual VERA allocation, medical community care and most general purpose allocations are then distributed to the medical centers using MCAS. The VISN retains the VERA allocations received for both specific and general purposes related to VISN administrative expenses, reserves, initiatives, and capital. The OIG examined deviations by funding type and noted those that were greater than 1 percent of total FY 2024 VERA allocations for general purpose (around $76.5 billion), specific purpose (around $12.9 billion), and medical community care (around $29.3 billion).

The OIG determined the actual FY 2024 general purpose allocations exceeded the VERA allocations by about $3.7 billion. The additional allocation occurred in 17 out of 18 current

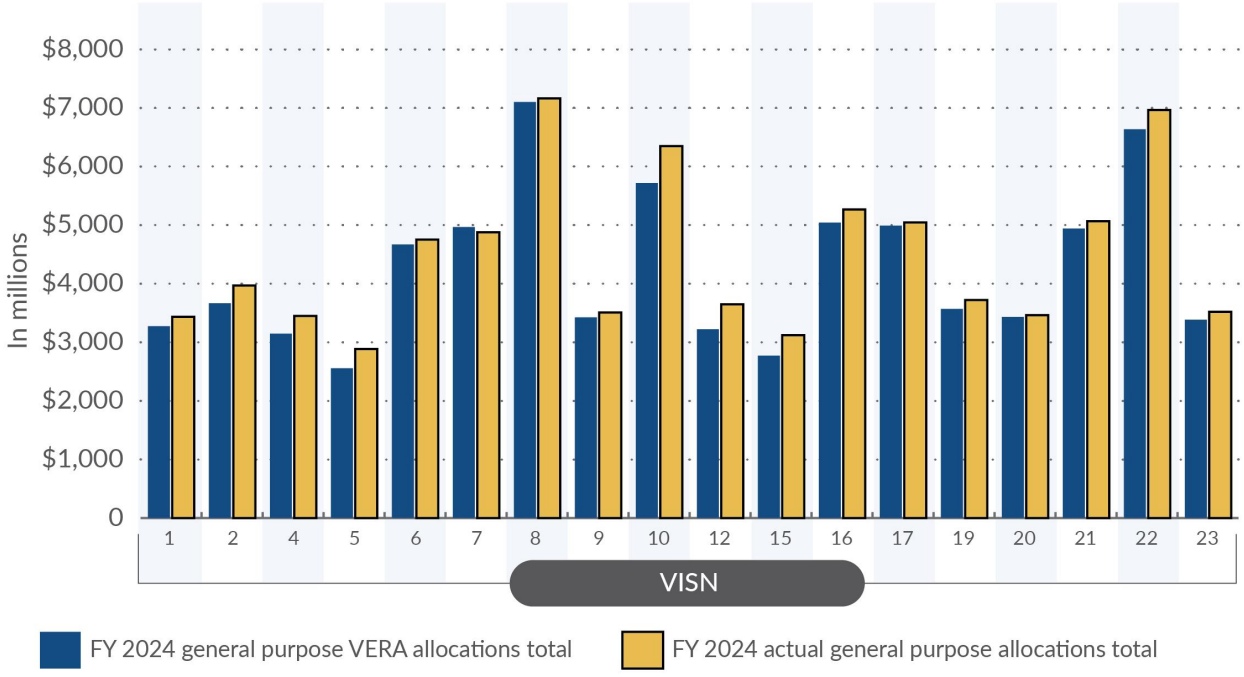
[150] The OIG determined two other offices experienced a deviation of greater than 1 percent, and they offset one another. The deviations were not discussed because they were due to an organizational structure change as stated by VHA's Allocation Resource Center director.

[151] The VHA Office of Finance manages veterans' family member programs, including the Civilian Health and Medical Program, caregiver, spina bifida, Camp LeJuene family, and foreign medical program.

[152] The Civilian Health and Medical Program provides medical care benefits to dependents of veterans meeting certain disability requirements. The foreign medical program pays for certain medical services associated with veterans' service-connected conditions while they are living or traveling overseas.

[153] Medical community care has specific purpose and general purpose components in VERA but is allocated only as specific purpose. Due to this limitation, the OIG evaluated medical community care separately and all further references to general purpose do not include these allocations.

VISNs.[154] However, none of the VISNs exceeded 1 percent of total FY 2024 VERA allocations for general purpose (about $765 million), as shown in figure A.7.



Figures A.7. *VISN general purpose allocations.*
Source: VHA Automated Allotment Control System and OIG analysis. VERA allocations occur at the beginning of the fiscal year and actual allocations at the end of the fiscal year.

In contrast, actual FY 2024 specific purpose allocations were less than the specific purpose allocations in the VERA package by about $125 million, which occurred in 13 of 18 VISNs. VISNs 4, 9, 10, 17, and 19 were allocated funds above the model allocations. The OIG identified two deviations: VISN 10's allocation was short about $130.2 million, and VISN 12 was given an additional allocation of $152.2 million, as shown in figure A.8 on the next page.

[154] Actual FY 2024 general purpose allocations for VISN 7 were under their estimated VERA allocations.

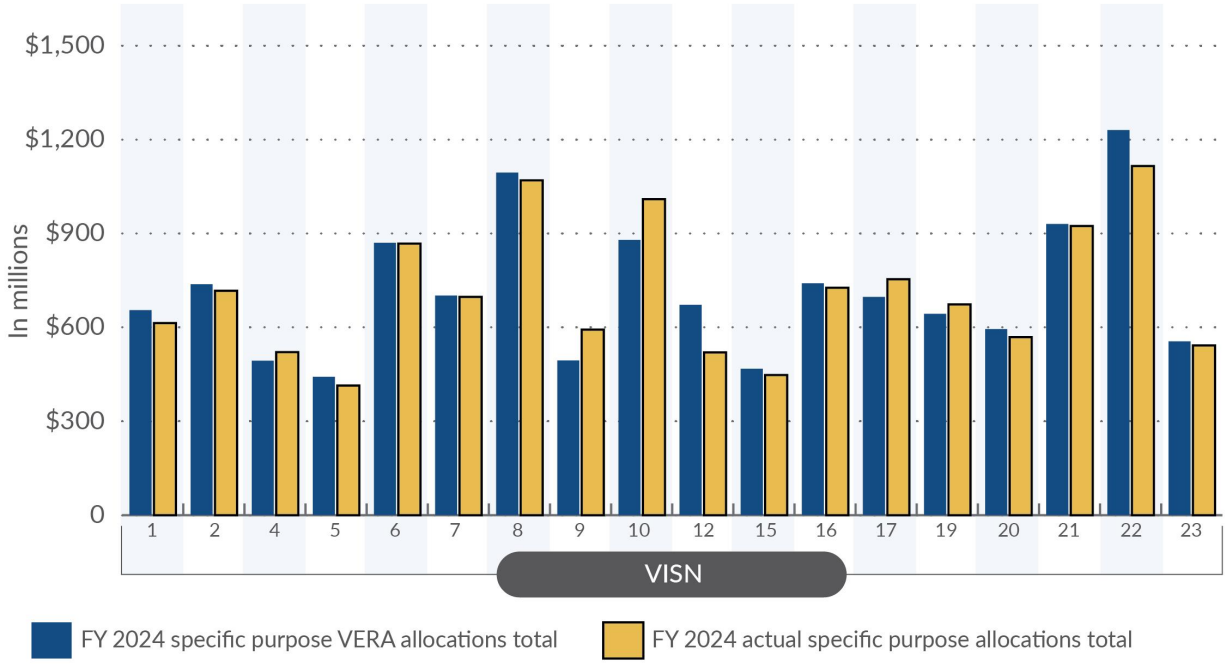


Figure A.8. *VISN specific purpose allocations.*
Source: VHA Automated Allotment Control System and OIG analysis.

Notably, for medical community care, actual FY 2024 allocations exceeded the VERA allocations by about $2.1 billion. The additional allocation occurred in 15 of 18 VISNs.[155] The OIG identified additional allocations in VISN 7 (about $352.3 million) and VISN 17 (about $525.7 million). The main drivers for VISN 7 were related to funding for medical facilities in Atlanta, Georgia; Columbia, South Carolina; and central Alabama. For VISN 17, the additional allocations were associated with funding for medical facilities in Dallas and El Paso, Texas. For more details, see figure A.9 on the next page.

[155] Actual FY 2024 medical community care allocations for VISNs 2, 4, and 23 were under their VERA allocations.

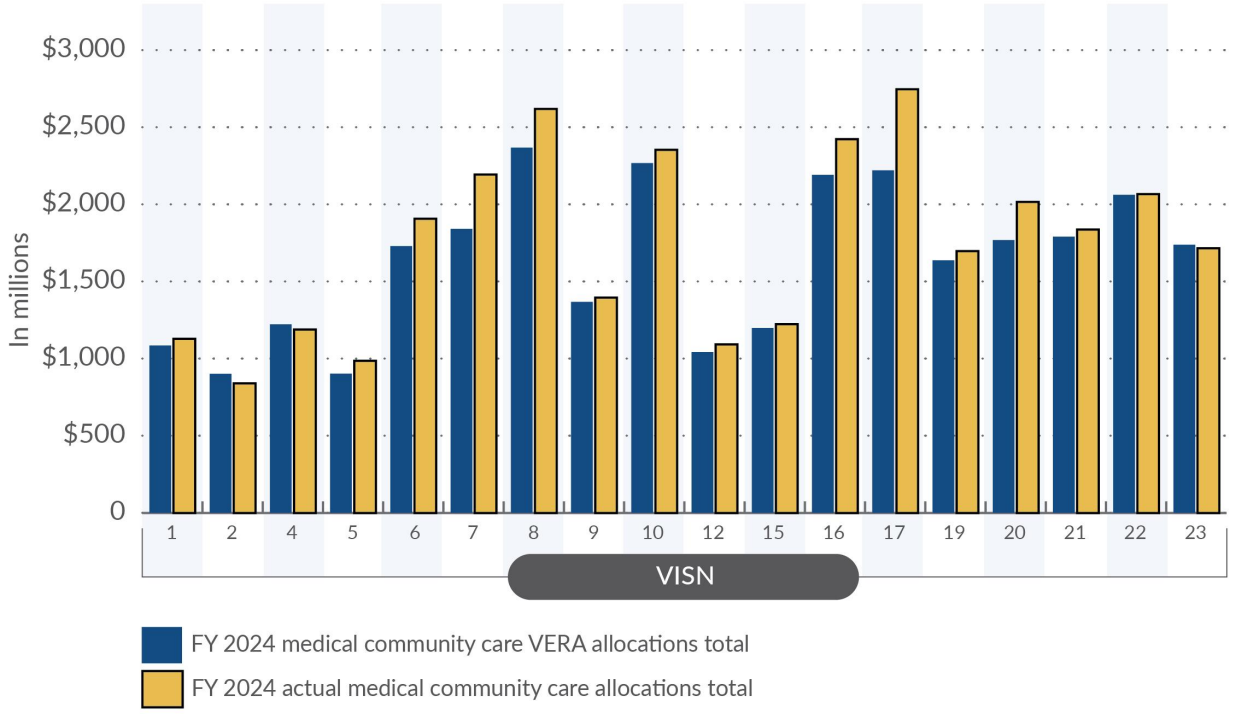


Figure A.9. *Medical community care allocations.*
Source: VHA Automated Allotment Control System and OIG analysis.

The OIG also identified the FY 2024 allocations made using the MCAS process. The OIG compared FY 2024 final allocations to the VERA or MCAS allocations, as applicable, and identified the differences shown in tables A.4 to A.21.[156] (In these tables, the abbreviation SP means specific purpose funds, GP means general purpose funds, and MCC means medical community care.)

Table A.4. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 1 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 1	SP	732	704	28	4%
	GP*	223	69	154	69%
	Subtotal	***955***	***773***	***182***	***19%***
Togus, ME	GP	375	386	-12	-3%
	MCC	221	229	-8	-4%

[156] The general purpose amounts shown in these tables include reimbursements and nonrecurring maintenance clinic-specific initiatives.

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
White River Junction, VT	GP	226	264	-37	-16%
	MCC	111	132	-21	-19%
Bedford, MA	GP	224	238	-14	-6%
	MCC	51	44	7	15%
Boston, MA	GP	848	1,016	-168	-20%
	MCC	138	106	32	23%
Manchester, NH	GP	199	218	-19	-9%
	MCC	157	183	-26	-17%
Central Western Massachusetts	GP	215	215	1	0%
	MCC	136	174	-38	-28%
Providence, RI	GP	322	331	-9	-3%
	MCC	96	80	16	17%
Connecticut	GP	641	699	-58	-9%
	MCC	177	182	-5	-3%
—	***Subtotal***	***4,137***	***4,496***	***-359***	***-9%***
	Grand total	**5,092**	**5,269**	**-177**	**-3%**
	Total GP	**3,274**	**3,436**	**-162**	**-5%**
	Total MCC	**1,086**	**1,129**	**-43**	**-4%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.5. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 2 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 2	SP	$834	$834	$0	0%
	GP*	$206	$143	$64	31%
	Subtotal	***$1,041***	***$977***	***$64***	***6%***
Bronx, NY	GP	$352	$384	-$33	-9%
	MCC	$24	$32	-$8	-34%
Albany, NY	GP	$274	$27	$246	90%
	MCC	$96	$84	$12	12%
Finger Lakes, NY	GP	$272	$32	$240	88%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	MCC	$169	$153	$16	9%
Western New York	GP	$396	$1,328	-$932	-235%
	MCC	$97	$103	-$7	-7%
Syracuse, NY	GP	$377	$47	$330	88%
	MCC	$150	$135	$15	10%
New Jersey	GP	$572	$634	-$62	-11%
	MCC	$149	$156	-$7	-4%
Hudson Valley, NY	GP	$250	$265	-$16	-6%
	MCC	$46	$46	$0	0%
New York Harbor	GP	$611	$719	-$108	-18%
	MCC	$42	$41	$2	4%
Northport, NY	GP	$356	$389	-$33	-9%
	MCC	$128	$89	$40	31%
—	***Subtotal***	***$4,362***	***$4,666***	***-$304***	***-7%***
	Grand total	**$5,402**	**$5,643**	**-$240**	**-4%**
	Total GP	**$3,666**	**$3,969**	**-$303**	**-8%**
	Total MCC	**$902**	**$840**	**$62**	**7%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

Note: According to the VHA Office of Finance, the data used for actual allocations do not accurately reflect allocations for the Albany Health Care System; Finger Lakes, NY Health Care System; Syracuse Health Care System; and Western New York Health Care System individually. Therefore, to make comparisons, they should be added together. It may appear that Western New York Health Care System allocations were about $932 million more than MCAS, which was not the case.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.6. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 4 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 4	SP	$563	$613	-$50	-9%
	GP*	$280	$96	$184	66%
	Subtotal	***$843***	***$709***	***$134***	***16%***
Wilmington, DE	GP	$267	$294	-$27	-10%
	MCC	$140	$146	-$5	-4%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
Altoona, PA	GP	$171	$235	-$64	-37%
	MCC	$111	$114	-$3	-3%
Butler, PA	GP	$125	$148	-$24	-19%
	MCC	$57	$51	$6	10%
Coatesville, PA	GP	$182	$197	-$14	-8%
	MCC	$61	$61	-$1	-2%
Erie, PA	GP	$135	$165	-$29	-22%
	MCC	$87	$91	-$5	-5%
Lebanon, PA	GP	$369	$438	-$69	-19%
	MCC	$226	$228	-$3	-1%
Philadelphia, PA	GP	$632	$708	-$76	-12%
	MCC	$206	$200	$6	3%
Pittsburgh, PA	GP	$703	$842	-$139	-20%
	MCC	$170	$127	$43	25%
Wilkes-Barre, PA	GP	$284	$328	-$44	-16%
	MCC	$166	$171	-$5	-3%
—	***Subtotal***	***$4,090***	***$4,543***	***-$453***	***-11%***
	Grand total	**$4,933**	**$5,252**	**-$320**	**-6%**
	Total GP	**$3,147**	**$3,450**	**-$303**	**-10%**
	Total MCC	**1223**	**1190**	**33**	**3%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.7. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 5 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 5	SP	$466	$440	$26	6%
	GP*	$258	$91	$167	65%
	Subtotal	**$724**	**$531**	**$193**	**27%**
Baltimore, MD	GP	$654	$806	-$152	-23%
	MCC	$199	$228	-$29	-15%
Beckley, WV	GP	$107	$161	-$54	-50%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	MCC	$79	$96	-$17	-22%
Clarksburg, WV	GP	$179	$256	-$77	-43%
	MCC	$102	$117	-$14	-14%
Huntington, WV	GP	$259	$320	-$62	-24%
	MCC	$192	$207	-$15	-8%
Martinsburg, WV	GP	$379	$417	-$39	-10%
	MCC	$134	$126	$8	6%
Washington, DC	GP	$723	$832	-$109	-15%
	MCC	$197	$213	-$16	-8%
—	***Subtotal***	***$3,203***	***$3,779***	***-$577***	***-18%***
	Grand total	**$3,927**	**$4,310**	**-$384**	**-10%**
	Total GP	**$2,558**	**$2,884**	**-$326**	**-13%**
	Total MCC	**$903**	**$986**	**-$84**	**-9%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.8. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 6 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 6	SP	$919	$920	-$1	0%
	GP*	$360	$132	$228	63%
	Subtotal	***$1,279***	***$1,052***	***$227***	***18%***
Durham, NC	GP	$793	$865	-$72	-9%
	MCC	$280	$269	$11	4%
Fayetteville, NC	GP	$574	$601	-$27	-5%
	MCC	$305	$343	-$38	-13%
Hampton, VA	GP	$533	$543	-$10	-2%
	MCC	$187	$234	-$48	-25%
Asheville, NC	GP	$470	$524	-$54	-12%
	MCC	$214	$209	$5	2%
Richmond, VA	GP	$818	$882	-$64	-8%
	MCC	$198	$238	-$40	-20%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
Salem, VA	GP	$358	$379	-$21	-6%
	MCC	$157	$172	-$15	-10%
Salisbury, NC	GP	$764	$827	-$62	-8%
	MCC	$391	$443	-$52	-13%
—	***Subtotal***	***$6,040***	***$6,529***	***-$488***	***-8%***
	Grand total	**$7,319**	**$7,580**	**-$261**	**-4%**
	Total GP	**$4,670**	**$4,753**	**-$83**	**-2%**
	Total MCC	**$1,731**	**$1,907**	**-$177**	**-10%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.9. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 7 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 7	SP	$809	$821	-$12	-2%
	GP*	$367	$127	$240	65%
	Subtotal	***$1,175***	***$948***	***$227***	***19%***
Atlanta, GA	GP	$1,146	$1,163	-$17	-1%
	MCC	$384	$491	-$108	-28%
Augusta, GA	GP	$529	$558	-$29	-5%
	MCC	$168	$198	-$30	-18%
Birmingham, AL	GP	$644	$679	-$35	-5%
	MCC	$253	$268	-$14	-6%
Charleston, SC	GP	$730	$763	-$33	-5%
	MCC	$252	$273	-$21	-8%
Columbia, SC	GP	$663	$666	-$3	0%
	MCC	$322	$409	-$87	-27%
Dublin, GA	GP	$325	$366	-$41	-13%
	MCC	$180	$181	-$2	-1%
Central Alabama	GP	$383	$361	$22	6%
	MCC	$216	$301	-$85	-40%
Tuscaloosa, AL	GP	$181	$196	-$14	-8%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	MCC	$67	$72	-$5	-8%
—	***Subtotal***	***$6,443***	***$6,945***	***-$502***	***-8%***
	Grand total	**$7,618**	**$7,893**	**-$275**	**-4%**
	Total GP	**$4,968**	**$4,878**	**$90**	**2%**
	Total MCC	**$1,842**	**$2,194**	**-$352**	**-19%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.10. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 8 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 8	SP	$1,156	$1,150	$6	1%
	GP*	$187	$167	$19	10%
	Subtotal	***$1,343***	***$1,317***	***$26***	***2%***
Bay Pines, FL	GP	$1,040	$1,018	$22	2%
	MCC	$470	$514	-$44	-9%
Miami, FL	GP	$655	$693	-$38	-6%
	MCC	$144	$127	$16	11%
West Palm Beach, FL	GP	$595	$597	-$2	0%
	MCC	$177	$204	-$27	-16%
Gainesville, FL	GP	$1,363	$1,335	$28	2%
	MCC	$513	$683	-$170	-33%
San Juan, PR	GP	$726	$812	-$86	-12%
	MCC	$134	$116	$18	14%
Tampa, FL	GP	$1,332	$1,331	$1	0%
	MCC	$430	$436	-$6	-1%
Orlando, FL	GP	$1,203	$1,211	-$8	-1%
	MCC	$501	$538	-$38	-8%
—	***Subtotal***	***$9,283***	***$9,617***	***-$334***	***-4%***
	Grand total	**$10,626**	**$10,934**	**-$308**	**-3%**
	Total GP	**$7,101**	**$7,164**	**-$63**	**-1%**
	Total MCC	**$2,368**	**$2,619**	**-$251**	**-11%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.11. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 9 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 9	SP	$561	$678	-$116	-21%
	GP*	$196	$103	$92	47%
	Subtotal	***$757***	***$781***	***-$24***	***-3%***
Lexington, KY	GP	$433	$485	-$52	-12%
	MCC	$145	$136	$9	6%
Louisville, KY	GP	$475	$506	-$31	-6%
	MCC	$178	$203	-$25	-14%
Memphis, TN	GP	$569	$621	-$52	-9%
	MCC	$261	$256	$5	2%
Mountain Home, TN	GP	$617	$615	$1	0%
	MCC	$283	$318	-$35	-12%
Middle Tennessee	GP	$1,137	$1,179	-$41	-4%
	MCC	$502	$483	$19	4%
—	***Subtotal***	***$4,599***	***$4,801***	***-$202***	***-4%***
	Grand total	**$5,355**	**$5,582**	**-$226**	**-4%**
	Total GP	**$3,426**	**$3,508**	**-$83**	**-2%**
	Total MCC	**$1,369**	**$1,396**	**-$27**	**-2%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.12. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 10 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 10	SP	$926	$1,069	-$143	-15%
	GP*	$320	$119	$200	63%
	Subtotal	***$1,246***	***$1,188***	***$58***	***5%***
Ann Arbor, MI	GP	$616	$697	-$81	-13%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	MCC	$175	$171	$5	3%
Battle Creek, MI	GP	$322	$367	-$45	-14%
	MCC	$211	$238	-$27	-13%
Chillicothe, OH	GP	$237	$319	-$82	-35%
	MCC	$146	$143	$4	2%
Cincinnati, OH	GP	$499	$598	-$99	-20%
	MCC	$169	$169	$0	0%
Cleveland, OH	GP	$1,276	$1,337	-$62	-5%
	MCC	$366	$354	$12	3%
Dayton, OH	GP	$471	$541	-$70	-15%
	MCC	$200	$189	$11	6%
Detroit, MI	GP	$399	$504	-$105	-26%
	MCC	$121	$124	-$2	-2%
Indianapolis, IN	GP	$632	$762	-$130	-21%
	MCC	$195	$200	-$5	-3%
Northern Indiana	GP	$342	$390	-$47	-14%
	MCC	$219	$240	-$21	-10%
Saginaw, MI	GP	$263	$312	-$49	-19%
	MCC	$214	$243	-$29	-14%
Columbus, OH	GP	$342	$403	-$61	-18%
	MCC	$250	$282	-$32	-13%
—	***Subtotal***	***$7,667***	***$8,584***	***-$917***	***-12%***
	Grand total	**$8,912**	**$9,772**	**-$859**	**-10%**
	Total GP	**$5,718**	**$6,349**	**-$631**	**-11%**
	Total MCC	**$2,268**	**$2,354**	**-$86**	**-4%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.13. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 12 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 12	SP	$729	$589	$141	19%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	GP*	$262	$93	$168	64%
	Subtotal	***$991***	***$682***	***$309***	***31%***
Chicago, IL	GP	$552	$665	-$114	-21%
	MCC	$157	$165	-$8	-5%
Danville, IL	GP	$242	$279	-$37	-15%
	MCC	$143	$173	-$29	-21%
Hines, IL	GP	$759	$896	-$137	-18%
	MCC	$170	$135	$35	21%
Iron Mountain, MI	GP	$140	$161	-$21	-15%
	MCC	$122	$135	-$13	-11%
Madison, WI	GP	$402	$483	-$81	-20%
	MCC	$139	$115	$24	17%
Tomah, WI	GP	$199	$238	-$39	-19%
	MCC	$143	$170	-$27	-19%
Milwaukee, WI	GP	$667	$830	-$164	-25%
	MCC	$220	$201	$20	9%
—	***Subtotal***	***$4,056***	***$4,647***	***-$591***	***-15%***
	Grand total	**$5,047**	**$5,329**	**-$282**	**-6%**
	Total GP	**$3,223**	**$3,647**	**-$424**	**-13%**
	Total MCC	**$1,094**	**$1,093**	**$1**	**0%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.14. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 15 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 15	SP	$533	$529	$5	1%
	GP*	$176	$93	$83	47%
	Subtotal	***$710***	***$622***	***$88***	***12%***
Columbia, MO	GP	$393	$505	-$112	-28%
	MCC	$154	$155	-$1	-1%
Eastern Kansas	GP	$323	$414	-$91	-28%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	MCC	$140	$138	$2	1%
Kansas City, MO	GP	$465	$494	-$28	-6%
	MCC	$163	$176	-$12	-8%
Wichita, KS	GP	$276	$328	-$53	-19%
	MCC	$138	$134	$5	3%
Marion, IL	GP	$322	$339	-$17	-5%
	MCC	$220	$228	-$7	-3%
St. Louis, MO	GP	$637	$771	-$134	-21%
	MCC	$223	$225	-$3	-1%
Poplar Bluff, MO	GP	$179	$177	$2	1%
	MCC	$161	$168	-$7	-4%
—	***Subtotal***	***$3,795***	***$4,252***	***-$457***	***-12%***
	Grand total	**$4,505**	**$4,874**	**-$369**	**-8%**
	Total GP	**$2,772**	**$3,122**	**-$350**	**-13%**
	Total MCC	**$1,200**	**$1,224**	**-$24**	**-2%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.15. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 16 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 16	SP	$869	$874	-$5	-1%
	GP*	$233	$127	$106	45%
	Subtotal	***$1,102***	***$1,001***	***$101***	***9%***
Alexandria, LA	GP	$243	$250	-$7	-3%
	MCC	$200	$246	-$46	-23%
Gulf Coast, MS	GP	$614	$632	-$18	-3%
	MCC	$375	$447	-$72	-19%
Fayetteville, AR	GP	$440	$470	-$30	-7%
	MCC	$322	$342	-$20	-6%
Houston, TX	GP	$1,460	$1,533	-$74	-5%
	MCC	$475	$501	-$26	-5%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
Jackson, MS	GP	$398	$418	-$21	-5%
	MCC	$181	$195	-$14	-8%
Little Rock, AR	GP	$725	$845	-$120	-17%
	MCC	$216	$193	$23	11%
New Orleans, LA	GP	$569	$617	-$48	-8%
	MCC	$240	$278	-$38	-16%
Shreveport, LA	GP	$361	$377	-$15	-4%
	MCC	$183	$221	-$38	-21%
—	***Subtotal***	***$7,001***	***$7,565***	***-$564***	***-8%***
	Grand total	**$8,103**	**$8,566**	**-$464**	**-6%**
	Total GP	**$5,042**	**$5,269**	**-$226**	**-4%**
	Total MCC	**$2,192**	**$2,424**	**-$232**	**-11%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.16. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 17 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 17	SP	$786	$862	-$76	-10%
	GP*	$288	$101	$187	65%
	Subtotal	***$1,074***	***$963***	***$111***	***10%***
Amarillo, TX	GP	$272	$301	-$29	-11%
	MCC	$146	$194	-$48	-33%
Big Spring, TX	GP	$162	$174	-$12	-7%
	MCC	$155	$200	-$45	-29%
Dallas, TX	GP	$1,531	$1,610	-$78	-5%
	MCC	$624	$860	-$235	-38%
San Antonio, TX	GP	$1,183	$1,284	-$101	-9%
	MCC	$347	$357	-$10	-3%
Temple, TX	GP	$936	$990	-$54	-6%
	MCC	$389	$397	-$8	-2%
	GP	$336	$316	$21	6%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
Texas Valley Coastal Bend	MCC	$308	$381	-$73	-24%
El Paso, TX	GP	$282	$271	$11	4%
	MCC	$250	$357	-$107	-43%
—	***Subtotal***	***$6,924***	***$7,692***	***-$768***	***-11%***
	Grand total	**$7,998**	**$8,655**	**-$657**	**-8%**
	Total GP	**$4,991**	**$5,047**	**-$56**	**-1%**
	Total MCC	**$2,221**	**$2,747**	**-$526**	**-24%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.17. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 19 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 19	SP	$835	$898	-$63	-8%
	GP*	$433	$134	$299	69%
	Subtotal	***$1,268***	***$1,032***	***$236***	***19%***
Montana	GP	$288	$351	-$63	-22%
	MCC	$251	$285	-$34	-14%
Cheyenne, WY	GP	$187	$252	-$65	-35%
	MCC	$108	$117	-$10	-9%
Aurora, CO	GP	$832	$861	-$29	-3%
	MCC	$375	$353	$23	6%
Grand Junction, CO	GP	$149	$217	-$69	-46%
	MCC	$95	$102	-$7	-7%
Muskogee, OK	GP	$389	$430	-$41	-11%
	MCC	$264	$281	-$17	-6%
Oklahoma City, OK	GP	$626	$744	-$118	-19%
	MCC	$229	$250	-$21	-9%
Salt Lake City, UT	GP	$546	$594	-$48	-9%
	MCC	$237	$234	$4	2%
Sheridan, WY	GP	$120	$137	-$17	-14%

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	MCC	$79	$76	$3	4%
—	***Subtotal***	***$4,775***	***$5,284***	***-$509***	***-11%***
	Grand total	**$6,043**	**$6,316**	**-$273**	**-5%**
	Total GP	**$3,570**	**$3,720**	**-$150**	**-4%**
	Total MCC	**$1,638**	**$1,698**	**-$59**	**-4%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.18. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 20 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 20	SP	$689	$691	-$3	0%
	GP*	$147	$141	$6	4%
	Subtotal	***$836***	***$832***	***$4***	***0%***
Anchorage, AK	GP	$157	$170	-$12	-8%
	MCC	$259	$308	-$50	-19%
Boise, ID	GP	$337	$353	-$17	-5%
	MCC	$134	$121	$13	10%
Portland, OR	GP	$964	$945	$19	2%
	MCC	$380	$401	-$22	-6%
Roseburg, OR	GP	$225	$236	-$12	-5%
	MCC	$175	$196	-$21	-12%
Puget Sound, WA	GP	$1,057	$1,047	$10	1%
	MCC	$408	$395	$13	3%
Spokane, WA	GP	$275	$300	-$25	-9%
	MCC	$228	$287	-$58	-26%
Walla Walla, WA	GP	$123	$116	$7	6%
	MCC	$125	$169	-$43	-35%
White City, OR	GP	$147	$155	-$8	-5%
	MCC	$115	$140	-$25	-22%
—	***Subtotal***	***$5,108***	***$5,339***	***-$231***	***-5%***
	Grand total	**$5,944**	**$6,170**	**-$227**	**-4%**

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
	Total GP	**$3,432**	**$3,463**	**-$31**	**-1%**
	Total MCC	**$1,823**	**$2,016**	**-$193**	**-11%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.19. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 21 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 21	SP	$1,005	$1,008	-$2	0%
	GP*	$242	$137	$105	43%
	Subtotal	***$1,248***	***$1,145***	***$103***	***8%***
Manila, PI	GP	$9	$10	-$1	-9%
	MCC	$0	$0	$0	
Honolulu, HI	GP	$345	$363	-$17	-5%
	MCC	$217	$267	-$50	-23%
Fresno, CA	GP	$364	$386	-$22	-6%
	MCC	$166	$185	-$19	-12%
Las Vegas, NV	GP	$662	$707	-$45	-7%
	MCC	$326	$325	$1	0%
VA N Cal, CA	GP	$964	$1,021	-$57	-6%
	MCC	$478	$528	-$50	-11%
Palo Alto, CA	GP	$1,186	$1,210	-$24	-2%
	MCC	$210	$156	$54	26%
Reno, NV	GP	$362	$373	-$11	-3%
	MCC	$142	$121	$21	15%
San Francisco, CA	GP	$808	$860	-$52	-6%
	MCC	$252	$255	-$3	-1%
—	***Subtotal***	***$6,491***	***$6,767***	***-$275***	***-4%***
	Grand total	**$7,739**	**$7,912**	**-$173**	**-2%**
	Total GP	**$4,943**	**$5,067**	**-$124**	**-3%**
	Total MCC	**$1,791**	**$1,837**	**-$46**	**-3%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.20. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 22 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 22	SP	$1,297	$1,196	$101	8%
	GP*	$426	$120	$306	72%
	Subtotal	***$1,722***	***$1,316***	***$407***	***24%***
New Mexico	GP	$566	$597	-$31	-5%
	MCC	$202	$240	-$37	-18%
Long Beach, CA	GP	$817	$930	-$113	-14%
	MCC	$158	$129	$29	18%
Loma Linda, CA	GP	$826	$913	-$87	-11%
	MCC	$283	$320	-$37	-13%
Phoenix, AZ	GP	$925	$992	-$67	-7%
	MCC	$447	$451	-$4	-1%
Northern Arizona	GP	$255	$297	-$42	-17%
	MCC	$190	$198	-$8	-4%
San Diego, CA	GP	$946	$1,020	-$75	-8%
	MCC	$258	$249	$8	3%
Southern Arizona	GP	$675	$742	-$67	-10%
	MCC	$213	$199	$14	7%
Greater Los Angeles, CA	GP	$1,202	$1,354	-$151	-13%
	MCC	$310	$280	$30	10%
—	***Subtotal***	***$8,274***	***$8,912***	***-$638***	***-8%***
	Grand total	**$9,996**	**$10,228**	**-$231**	**-2%**
	Total GP	**$6,637**	**$6,965**	**-$328**	**-5%**
	Total MCC	**$2,062**	**$2,067**	**-$4**	**0%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Table A.21. FY 2024 VERA/MCAS Allocations vs. Actual Funds Allocations, VISN 23 (in millions)

VISN or healthcare system	Fund type	VERA/ MCAS allocations	Actual allocations	Difference, dollars	Difference, percent
VISN 23	SP	$672	$681	-$9	-1%
	GP*	$139	$131	$8	6%
	Subtotal	***$811***	***$812***	***-$1***	***0%***
Fargo, ND	GP	$268	$273	-$5	-2%
	MCC	$206	$211	-$5	-2%
Sioux Falls, SD	GP	$224	$242	-$18	-8%
	MCC	$134	$159	-$25	-19%
Black Hills, SD	GP	$203	$221	-$18	-9%
	MCC	$128	$129	-$1	-1%
Minneapolis, MN	GP	$1,020	$1,032	-$11	-1%
	MCC	$430	$415	$15	4%
Central Iowa	GP	$303	$325	-$22	-7%
	MCC	$142	$135	$7	5%
Iowa City, IA	GP	$407	$458	-$51	-12%
	MCC	$204	$246	-$43	-21%
Nebraska-W Iowa	GP	$461	$494	-$33	-7%
	MCC	$244	$209	$34	14%
St. Cloud, MN	GP	$360	$345	$15	4%
	MCC	$252	$211	$41	16%
—	***Subtotal***	***$4,985***	***$5,105***	***-$120***	***-2%***
	Grand total	**$5,796**	**$5,917**	**-$121**	**-2%**
	Total GP	**$3,385**	**$3,521**	**-$136**	**-4%**
	Total MCC	**$1,739**	**$1,716**	**$23**	**1%**

Source: OIG analysis of Veterans Equitable Resource Allocation and the Automated Allotment Control System.

** Includes VISN reserves, initiatives funding, and capital.*

Also, the OIG determined the FY 2024 beginning, average, and ending full-time-equivalent (FTE) staffing numbers by medical center to show where growth continued to occur. Overall, VHA medical care FTE grew by about 16,000 (4 percent) during FY 2024. The OIG identified VISNs 2, 6, and 7 as having the largest growth percentage in FTE during FY 2024. Tables A.22 to A.39 show FTE staffing in each VISN.

Table A.22. FY 2024 Beginning, Average, and Ending FTE, VISN 1

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 1	459	458	493
Togus, ME	1,839	1,841	1,833
Bedford, MA	1,311	1,414	1,552
Boston, MA	4,378	4,463	4,917
Manchester, NH	1,081	1,067	1,028
Central Western Massachusetts	1,105	1,122	1,059
Providence, RI	1,587	1,626	1,586
Connecticut	3,184	3,250	3,136
Total	**14,943**	**15,240**	**15,605**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.23. FY 2024 Beginning, Average, and Ending FTE, VISN 2

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 2	567	653	690
Bronx, NY	811	1,766	1,663
Albany, NY	1,347	1,402	1,397
Finger Lakes, NY	1,596	1,626	1,571
Western New York	2,366	2,411	2,389
Syracuse, NY	1,744	1,781	1,693
New Jersey	3,019	3,091	3,023
Hudson Valley, NY	1,364	1,417	1,407
New York Harbor	2,993	3,092	3,093
Northport, NY	1,675	1,860	1,814
Total	**17,480**	**19,099**	**18,739**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.24. FY 2024 Beginning, Average, and Ending FTE, VISN 4

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 4	548	596	608
Wilmington, DE	1,411	1,519	1,604

VISN or healthcare system	FTE beginning	FTE average	FTE end
Altoona, PA	1,271	1,351	1,381
Butler, PA	779	820	855
Coatesville, PA	1,103	1,208	1,374
Erie, PA	935	942	996
Lebanon, PA	2,231	2,222	2,125
Philadelphia, PA	2,940	2,986	3,101
Pittsburgh, PA	4,068	4,132	3,787
Wilkes-Barre, PA	1,539	1,645	1,721
Total	**16,823**	**17,421**	**17,553**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.25. FY 2024 Beginning, Average, and Ending FTE, VISN 5

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 5	525	557	575
Baltimore, MD	3,629	3,711	3,701
Beckley, WV	894	942	946
Clarksburg, WV	1,195	1,282	1,309
Huntington, WV	1,491	1,579	1,558
Martinsburg, WV	2,098	2,143	2,157
Washington, DC	2,971	3,275	3,339
Total	**12,803**	**13,490**	**13,586**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.26. FY 2024 Beginning, Average, and Ending FTE, VISN 6

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 6	708	589	517
Durham, NC	3,591	3,856	3,903
Fayetteville, NC	2,771	2,935	3,011
Hampton, VA	2,563	2,742	2,846
Asheville, NC	2,320	2,461	2,521
Richmond, VA	3,851	4,111	4,240
Salem, VA	1,726	1,825	1,884

VISN or healthcare system	FTE beginning	FTE average	FTE end
Salisbury, NC	3,527	3,793	3,923
Total	**21,056**	**22,311**	**22,845**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.27. FY 2024 Beginning, Average, and Ending FTE, VISN 7

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 7	709	910	1,286
Atlanta, GA	4,816	5,054	5,116
Augusta, GA	2,693	2,804	2,686
Birmingham, AL	3,074	3,267	4,390
Charleston, SC	3,127	3,302	3,292
Columbia, SC	3,042	3,093	3,068
Dublin, GA	2,103	1,996	1,952
Central Alabama	2,035	2,083	2,074
Tuscaloosa, AL	1,208	1,232	1,200
Total	**22,807**	**23,742**	**25,064**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.28. FY 2024 Beginning, Average, and Ending FTE, VISN 8

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 8	868	914	949
Bay Pines, FL	4,058	4,466	4,514
Miami, FL	2,920	3,109	3,179
West Palm Beach, FL	2,814	2,840	2,790
Gainesville, FL	6,592	6,452	6,675
San Juan, PR	3,998	4,039	4,134
Tampa, FL	6,487	6,562	6,741
Orlando, FL	5,531	5,724	5,843
Total	**33,268**	**34,105**	**34,826**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.29. FY 2024 Beginning, Average, and Ending FTE, VISN 9

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 9	614	696	734
Lexington, KY	2,302	2,376	2,353
Louisville, KY	2,396	2,398	2,042
Memphis, TN	2,494	2,620	2,585
Mountain Home, TN	2,865	2,940	2,925
Middle Tennessee	4,924	5,166	5,067
Total	**15,595**	**16,196**	**15,705**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.30. FY 2024 Beginning, Average, and Ending FTE, VISN 10

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 10	855	882	926
Ann Arbor, MI	3,140	3,275	3,224
Battle Creek, MI	1,953	2,045	2,019
Chillicothe, OH	1,592	1,634	1,619
Cincinnati, OH	2,528	2,660	2,638
Cleveland, OH	5,818	5,981	5,910
Dayton, OH	2,569	2,568	2,674
Detroit, MI	2,345	2,469	2,490
Indianapolis, IN	3,382	3,413	3,428
Northern Indiana	1,965	2,117	2,086
Saginaw, MI	1,615	1,666	1,656
Columbus, OH	1,758	1,822	1,815
Total	**29,520**	**30,532**	**30,486**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.31. FY 2024 Beginning, Average, and Ending FTE, VISN 12

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 12	537	676	576
Chicago, IL	3,071	3,242	3,315
Danville, IL	1,677	1,608	1,650

VISN or healthcare system	FTE beginning	FTE average	FTE end
Hines, IL	4,395	4,297	4,311
Iron Mountain, MI	824	860	876
Madison, WI	2,255	2,398	2,298
Tomah, WI	1,335	1,350	1,339
Milwaukee, WI	3,945	4,114	4,065
Total	**18,039**	**18,545**	**18,431**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.32. FY 2024 Beginning, Average, and Ending FTE, VISN 15

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 15	525	559	569
Columbia, MO	1,867	1,985	1,974
Eastern Kansas	1,923	2,066	2,048
Kansas City, MO	2,481	2,441	2,421
Wichita, KS	1,584	1,630	1,594
Marion, IL	1,526	1,683	1,675
St. Louis, MO	3,343	3,443	3,489
Poplar Bluff, MO	1,054	1,097	1,102
Total	**14,303**	**14,904**	**14,873**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.33. FY 2024 Beginning, Average, and Ending FTE, VISN 16

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 16	652	696	714
Alexandria, LA	1,171	1,240	1,242
Gulf Coast, MS	3,003	3,095	3,044
Fayetteville, AR	2,249	2,294	2,261
Houston, TX	5,964	6,110	6,070
Jackson, MS	1,900	1,961	1,931
Little Rock, AR	3,878	3,944	3,655
New Orleans, LA	2,533	2,525	2,495
Shreveport, LA	1,760	1,833	1,827

VISN or healthcare system	FTE beginning	FTE average	FTE end
Total	23,110	23,699	23,240

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.34. FY 2024 Beginning, Average, and Ending FTE, VISN 17

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 17	658	723	750
Amarillo, TX	1,513	1,597	1,612
Big Spring, TX	893	947	939
Dallas, TX	6,655	6,578	6,559
San Antonio, TX	5,403	5,641	5,665
Temple, TX	4,473	4,729	4,667
Texas Valley Coastal Bend	1,522	1,615	1,639
El Paso, TX	1,371	1,473	1,485
Total	**22,488**	**23,303**	**23,316**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.35. FY 2024 Beginning, Average, and Ending FTE, VISN 19

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 19	894	950	977
Montana	1,572	1,651	1,654
Cheyenne, WY	1,308	1,370	1,368
Aurora, CO	3,711	3,805	3,770
Grand Junction, CO	848	991	980
Muskogee, OK	2,102	2,163	2,134
Oklahoma City, OK	3,116	3,179	3,223
Salt Lake City, UT	2,682	2,783	2,770
Sheridan, WY	738	764	758
Total	**16,971**	**17,655**	**17,632**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.36. FY 2024 Beginning, Average, and Ending FTE, VISN 20

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 20	817	883	814
Anchorage, AK	724	546	781
Boise, ID	1,832	1,941	2,060
Portland, OR	3,886	3,976	3,811
Roseburg, OR	1,189	1,257	1,342
Puget Sound, WA	4,367	4,527	4,505
Spokane, WA	1,399	1,457	1,470
Walla Walla, WA	583	640	696
White City, OR	858	913	980
Total	**15,656**	**16,140**	**16,459**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.37. FY 2024 Beginning, Average, and Ending FTE, VISN 21

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 21	820	883	910
Manila, PI	70	72	74
Honolulu, HI	1,715	1,828	1,899
Fresno, CA	1,833	1,864	1,855
Las Vegas, NV	4,296	3,548	3,507
VA N Cal, CA	4,132	4,283	4,377
Palo Alto, CA	3,803	4,902	4,752
Reno, NV	1,785	1,793	1,764
San Francisco, CA	3,486	3,469	3,437
Total	**21,940**	**22,642**	**22,576**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.38. FY 2024 Beginning, Average, and Ending FTE, VISN 22

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 22	761	794	812
New Mexico	2,950	2,985	2,983
Long Beach, CA	3,844	3,992	3,997

VISN or healthcare system	FTE beginning	FTE average	FTE end
Loma Linda, CA	3,622	3,700	3,806
Phoenix, AZ	4,325	4,408	4,492
Northern Arizona	1,490	1,554	1,578
San Diego, CA	3,902	4,043	4,094
Southern Arizona	3,395	3,372	3,415
Greater Los Angeles, CA	4,319	5,261	5,031
Total	**28,606**	**30,108**	**30,209**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Table A.39. FY 2024 Beginning, Average, and Ending FTE, VISN 23

VISN or healthcare system	FTE beginning	FTE average	FTE end
VISN 23	482	536	600
Fargo, ND	1,203	1,372	1,383
Sioux Falls, SD	1,254	1,331	1,342
Black Hills, SD	1,253	1,306	1,315
Minneapolis, MN	4,416	4,583	4,493
Central Iowa	1,661	1,705	1,676
Iowa City, IA	1,805	1,850	1,861
Nebraska-W Iowa	2,711	2,758	2,757
St. Cloud, MN	1,779	1,976	2,030
Total	**16,565**	**17,416**	**17,458**

Source: OIG analysis of VHA Support Service Center Expenditures and FTE.

Appendix B: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) review team conducted its work from August 2024 through February 2025. This review evaluated the factors and conditions that led the Veterans Health Administration (VHA) to request an additional $12 billion for medical care for fiscal year (FY) 2025. The scope of this review included assessing VHA's process for developing and finalizing the budget, the efforts it made to stay within the budget, and its estimated need for $12 billion in supplemental funding.

Methodology

The review team identified and reviewed VHA budget documents for FY 2023 through FY 2025, including obligations, expenditures, and appropriations to determine what VHA requested, received, returned, or carried over during that period. The team also compared VHA's original advance appropriations request for FY 2025 in the FY 2024 President's Budget to the final FY 2025 President's Budget. Furthermore, the team assessed VHA's efforts to stay within its funding levels for the FY 2024 President's Budget and the factors that led to the $12 billion supplemental funding request for FY 2025. The team interviewed over 30 VA, VHA, and Veterans Integrated Service Network leaders who had a role in developing, finalizing, or managing VHA's budget. The team also reviewed VA and VHA documentation as well as emails and other internal communications for key officials from March 2023 through August 2024.

Internal Controls

The team determined that performing an internal control step was not necessary unless internal control deficiencies were noted during the review. The team did not find any significant internal control deficiencies.

Data Reliability

The team used computer-processed data obtained from the Financial Management System through VHA Support Service Center. To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. The review team's assessment determined the data the team relied on were complete, accurate, and relevant for supporting the review objective and results.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix C: VA Management Comments, Acting Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: March 5, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Failures to Accurately Project FYs 2024 and 2025 Budget Needs and to Implement an FY 2024 Spending Plan Led to a $12 Billion Supplemental Funding Request (VIEWS 12816746)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG draft report, Failures to Accurately Project FYs 2024 and 2025 Budget Needs and to Implement an FY 2024 Spending Plan Led to a $12 Billion Supplemental Funding Request. The Veterans Health Administration (VHA) concurs with recommendations one, two, and four made to the Under Secretary for Health and concurs in principle with recommendation three and provides an action plan in the attachment.

2. VHA appreciates the OIG's recognition of the contributing factors that led to the identification of a need to request additional funding and the work that VHA undertook to develop action plans to stay within its allotted budget in FY 25.

3. VHA is committed to ensuring that Veterans continue to receive the timely, world-class, care that they have earned and that funding requests best reflect future needs. We appreciate the recommendations from the VA OIG and will ensure that actions are taken to address all recommendations.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, MD, MBA, FACHE

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Review of VHA's FY 2025 Supplemental Budget Request

(Project Number 2024-03127-AE-0112)

Recommendation 1. Review the Veterans Health Administration's current methods, assumptions, and approaches used to project medical care budget needs in the annual President's Budget to identify any gaps in the process or data limitations, and develop and implement a plan to strengthen the process.

VHA Comments: Concur

VHA will review its current methods, assumptions, and approaches used to project medical care budget needs in the annual President's Budget to identify any gaps in the process or data limitations and develop and implement a plan to strengthen the process.

Status: In Progress Target Completion Date: March 2026

Recommendation 2. Establish and implement a plan to review current processes and procedures for involving program offices and pertinent subject matter experts in developing the Enrollee Health Care Projection Model inputs for specific areas such as community care, staffing, pharmacy services, and prosthetics services, and formalize the expectations of their involvement in this process, through guidance or protocols.

VHA Comments: Concur

The Office of Enrollment and Forecasting will review the current processes and procedures for involving pertinent program offices and subject matter experts in the Enrollee Health Care Projection Model (EHCPM) annual update. The Office of Enrollment and Forecasting will identify promising practices to consider in the development of a standardized guidance document on VHA program office engagement protocols for the EHCPM annual update.

Target Completion Date: October 2025

Recommendation 3. Develop and implement an approach to estimate medical care personnel needs and costs to increase the accuracy and reliability of information included in the annual President's Budget

VHA Comments: Concur in Principle

VHA notes that VA does not request an appropriation from Congress specific to personnel costs, nor does it allocate funding in its financial management system for personnel costs. Instead, both the FTE level and personnel costs published in the annual VA Congressional Justification are estimates. In execution, many factors may create a divergence between budget estimates and actual values, including leadership guidance and operational policies, as well as external factors outside of an agency's control. Because of this uncertainty, the factors within an agency's control with regards to developing budget estimates are whether those estimates are based on valid assumptions.

VHA will develop and implement an approach to estimate medical care personnel needs and costs and will use this approach to determine the estimates included in the annual President's Budget. VHA's approach will include establishing a protocol to determine that the assumptions underpinning the estimates are valid, thereby improving the reliability of the information included in the annual President's Budget.

Status: In Progress Target Completion Date: March 2027

Recommendation 4. **Institutionalize a regular cycle of at least quarterly fiscal reviews among assistant under secretaries for health, network directors, and program offices that routinely assess key cost drivers and other areas of concern, such as staffing, community care growth, and local initiatives.**

VHA Comments: Concur

VHA will implement a regular cycle of at least quarterly fiscal reviews among assistant under secretaries for health, network directors, and program offices that routinely assess key cost drivers and other areas of concern, such as staffing, community care growth, and local initiatives.

Status: In Progress Target Completion Date: September 2025

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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