SEMIANNUAL REPORT to Congress

Issue 91 | October 1, 2023–March 31, 2024

The OIG honors the sacrifice of surviving families of service members killed in combat. Gold Star Spouses Day is recognized annually on April 5.

US DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

U.S. DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

VISION

To perform audits, inspections, investigations, and reviews that improve the efficiency, effectiveness, and integrity of the Department of Veterans Affairs' programs and services.

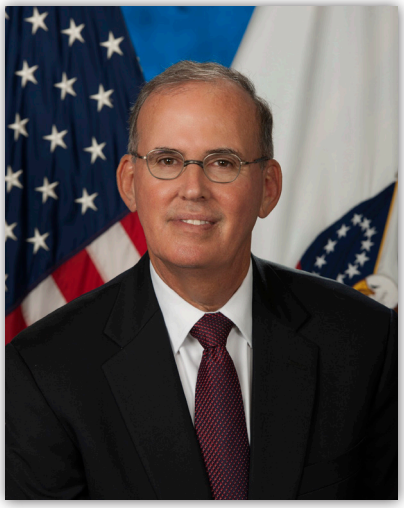
To achieve this vision, the Office of Inspector General (OIG) will

- identify and prioritize work that will have the greatest impact on the lives of veterans, their families and caregivers, and on VA resources and operations;
- prevent and address fraud and other crimes, waste, and abuse, as well as advance efforts to hold responsible individuals accountable;
- help ensure eligible veterans and other beneficiaries receive prompt and high-quality health care, services, and benefits by issuing accurate, timely, and objective reports; and
- make meaningful data- and evidence-driven recommendations that enhance VA programs or operations and promote the appropriate use of taxpayer dollars.

VALUES

- Protect individuals who allege wrongdoing and treat them with respect and dignity
- Promote diversity, equity, and inclusion within the OIG and a climate that attracts and retains the highest-quality staff
- Meet the highest standards of integrity, professionalism, and accountability
- Safeguard the OIG's independence and maintain transparency
- Honor veterans and all those who serve them by continually striving for excellence

A Message from the Inspector General



I am honored to submit this Semiannual Report to Congress on the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) from October 1, 2023, through March 31, 2024. As this report is being released, our office is completing its 45th year as an independent oversight office. I could not be more proud of the progress our staff (and those on whose shoulders they stand) have made in achieving our mission to serve veterans and the public by conducting meaningful, fair, and evidence-driven oversight of VA. OIG personnel, many of whom are veterans themselves or whose family have served, are deeply committed to improving the efficiency, effectiveness, and integrity of VA to significantly improve the lives of veterans, their families, caregivers, and survivors.

As the cover of this report reflects, gold star spouses are recognized every April 5th. The OIG honors the losses that they have suffered. We never lose sight of why we do our work: to ensure that veterans, their survivors, and others served by VA receive the care, services, and support they need and deserve. It is our hope that the oversight work reflected in this report continues to assist efforts by dedicated VA personnel to make continuous improvements to the department's programs, operations, and services. For this six-month period, we published 112 reports with more than 396 recommendations for corrective actions. We also enhanced our transparency with a growing number of podcasts, monthly highlights of criminal investigations and other activities, and additional communications. The OIG identified more than $1.45 billion in monetary impact for a return on investment of $12 for every dollar spent on oversight. The OIG hotline received and triaged 15,617 contacts in this reporting period to help identify wrongdoing and address concerns with VA activities. OIG special agents opened 178 investigations and closed 183, with efforts leading to 112 arrests. Collectively, the OIG's work over this reporting period also resulted in 459 administrative sanctions and corrective actions.

Conducting oversight of VA is challenging and complex, but the VA OIG is committed to helping ensure that veterans and their families are getting the benefits, care, and services they are eligible to receive, while making the best use of taxpayer dollars. To meet that challenge, we have expanded our reach in criminal and administrative investigations as well as proactive data analytics, and have invested in systems and processes to make our work more effective and efficient. We have also enhanced vital healthcare facility cyclical inspections that focus on patient safety and impediments to high-quality care. The OIG has further launched a new cyclical inspection of inpatient mental health services. Recent massive VA initiatives such as the PACT Act (expanding care and benefits for toxic exposure during military service), community healthcare expansion, and systems modernization efforts make our oversight work that much more consequential. These modernization efforts include revamping financial, supply chain management, and patient health records systems. For the electronic health records

A Message from the Inspector General

modernization, our office has released 18 reports to date that have stimulated corrective actions and contributed to the reset of the new system's implementation.

OIG leaders and staff greatly appreciate VA leaders' stated commitment to creating a culture of accountability and the many VA personnel who have engaged candidly and cooperatively with us. Finally, I thank members of Congress, veterans service organizations, and the veteran community for their steadfast support that is so vital to our work.

MICHAEL J. MISSAL

Contents

My VA OIG Story is a video series available on the OIG's **YouTube channel** (@VetAffairsOIG) that focuses on the OIG's most valuable resource: its employees. The OIG employs more than 1,100 personnel across the country including auditors, lawyers, doctors, nurses, special agents, and many other professionals from a broad array of fields. Each are dedicated to serving veterans, their families, and caregivers as well as improving the efficiency, effectiveness, and integrity of VA programs and operations and have a unique story to tell. View the stories pictured below on the VA OIG's **playlist**.

Organization Profile

The Department of Veterans Affairs

The VA OIG oversees VA's three administrations. The Veterans Health Administration (VHA) provides healthcare services, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration provides interment and memorial benefits.

The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to their country.

VA is the second-largest federal employer. For fiscal year (FY) 2024, VA is operating under a $331.1 billion budget with approximately 450,000 employees serving an estimated 18.3 million veterans. VA maintains facilities in every state, the District of Columbia, American Samoa, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the US Virgin Islands. It also operates the nation's largest integrated healthcare system. For more information, visit **VA's website**.

The Office of Inspector General

MISSION

The mission of the VA OIG is to serve veterans and the public by conducting meaningful independent oversight of VA.

HISTORY AND STATUTORY AUTHORITY

The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (the IG Act), as amended.[1] This act states that the inspector general is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of—and to prevent and detect criminal activity, waste, abuse, and mismanagement in—VA programs and operations; and (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The inspector general has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements with the Department. In addition, the Veterans Benefits and

1 Inspector General Act of 1978, 5 U.S.C. §§ 401–424, as amended by Pub. L. No. 117-263 § 5273 (2022). The amendments in Pub. L. No. 117-263 have not yet been codified but are to be incorporated into current § 405(b) pursuant to Pub. L. No. 117-286, § 5(b), 136 Stat. 4196, 4360 (2022).

Organization Profile

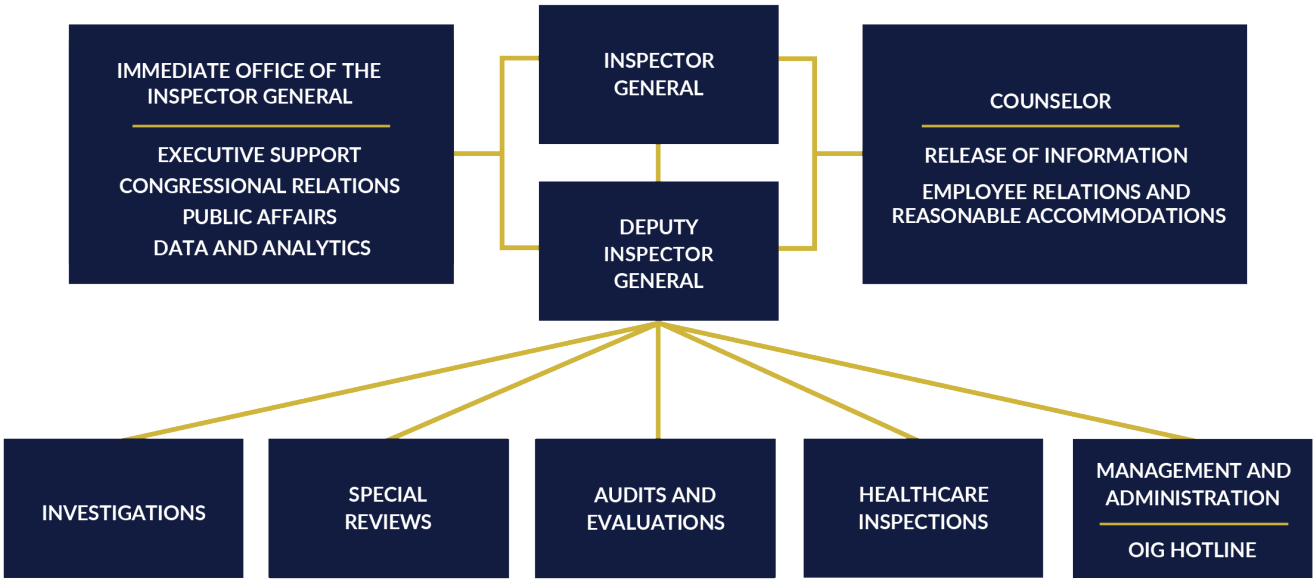
Services Act of 1988 charged the OIG with overseeing the quality of VA health care.[2] Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has more than 1,100 staff organized into five primary directorates: the Offices of Investigations, Special Reviews, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline). The OIG also has offices for the counselor to the inspector general, data and analytics, congressional relations, and public affairs, as well as staff dedicated to executive support. The FY 2024 funding from ongoing appropriations provided $296 million for OIG operations—a $23 million increase from the previous year.

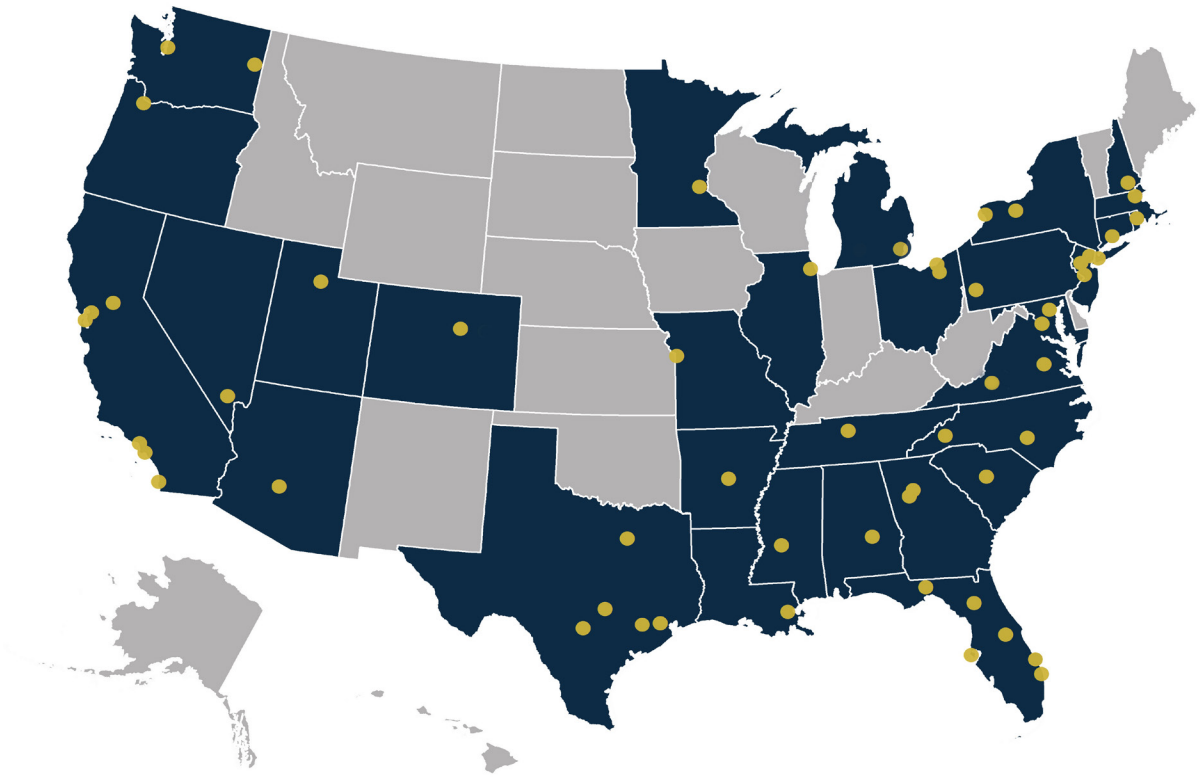
In addition to its Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff are dedicated to performing their duties fairly, objectively, and with the highest professional integrity. For more information, visit the **VA OIG's website**.

OIG ORGANIZATIONAL CHART



2 Veterans Benefits and Services Act of 1988, Pub. L. No. 100-322, 102 Stat. 487 (1988).

OIG FIELD OFFICES MAP



- Asheville, NC
- Atlanta, GA
- Aurora, CO
- Austin, TX
- Baltimore, MD
- Bay Pines, FL
- Bedford, MA
- Buffalo, NY
- Canandaigua, NY
- Cleveland, OH
- Columbia, SC
- Dallas, TX
- Decatur, GA
- Detroit, MI
- Fayetteville, NC
- Gainesville, FL
- Hines, IL
- Houston, TX
- Independence, OH
- Jackson, MS
- Kansas City, MO
- Katy, TX
- Las Vegas, NV
- Long Beach, CA
- Los Angeles, CA
- Lyons, NJ
- Manchester, NH
- Martinez, CA
- Minneapolis, MN
- Miramar, FL
- Montgomery, AL
- Nashville, TN
- New Orleans, LA
- New York, NY
- Newark, NJ
- North Little Rock, AR
- Oakland, CA
- Orange, CT
- Orlando, FL
- Palm Beach Gardens, FL
- Phoenix, AZ
- Pittsburgh, PA
- Portland, OR
- Providence, RI
- Richmond, VA
- Sacramento, CA
- Salem, VA
- Salt Lake City, UT
- San Antonio, TX
- San Diego, CA
- Seattle, WA
- Spokane, WA
- Tallahassee, FL
- Trenton, NJ
- Washington, DC

Offices of the Inspector General

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The immediate office of the inspector general coordinates all executive correspondence, congressional relations, stakeholder engagement, and media inquiries. Staff ensure that information is accurately and promptly released and that requests from VA, veterans, legislators, and reporters are appropriately addressed. The office also coordinates strategic planning and data services that include modeling (advanced analytics, information integration, and data visualization). The inspector general and deputy inspector general provide leadership and set the direction for a nationwide staff of auditors, investigators, inspectors, attorneys, healthcare professionals, and support personnel who conduct independent oversight of the second-largest agency in the federal government. In addition, design, report production, and dissemination functions are within the immediate office. Report follow-up staff also make certain that corrective actions taken by VA in response to OIG recommendations are effectively monitored and resolved.

THE OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL

The counselor's office provides independent legal advice to OIG leaders and is involved in all aspects of office operations. OIG attorneys provide legal support for investigations, audits, and inspections; work with OIG investigators in developing *qui tam* and False Claims Act matters; represent the OIG in employment litigation and personnel matters; and inform legislative proposals and congressional briefings. The counselor's office also oversees the work of the Release of Information Office and staff responsible for handling employee relations matters and reasonable accommodation requests.

THE OFFICE OF INVESTIGATIONS

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The office is staffed by special agents with full law enforcement authority, forensic accountants, and other professionals. Staff use data analytics, cybertools, covert operations, and other strategies to detect and address conduct that poses a threat to or has harmed veterans, other beneficiaries, or VA personnel, operations, and property. Through criminal prosecutions and civil monetary recoveries, the OIG's investigations promote integrity, patient safety, efficiency, and accountability within VA.

THE OFFICE OF SPECIAL REVIEWS

Special Reviews staff conduct administrative investigations and increase the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of another OIG directorate or office. Staffed with professionals possessing a broad array of expertise, this office undertakes projects in response to referrals from VA employees, the OIG hotline, Congress, the Office of Special Counsel, veterans service organizations, and other sources. It also works collaboratively with the other OIG directorates to review topics of interest that span multiple offices or federal agencies.

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations provides independent oversight of VA's activities to improve the integrity of its programs and operations. Staff are involved in evaluating such diverse areas as medical supply and equipment inventory and financial systems, the administration of benefits, resource

utilization, acquisitions, construction, and information security. This work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The office also reviews VA's contracts with outside organizations, providing preaward and postaward reviews of Federal Supply Schedule, construction, and healthcare provider contracts. Preaward reviews assist VA contracting officers with negotiating fair and reasonable prices, while postaward reviews assess compliance with contract terms and conditions and help recover overcharges.

THE OFFICE OF HEALTHCARE INSPECTIONS

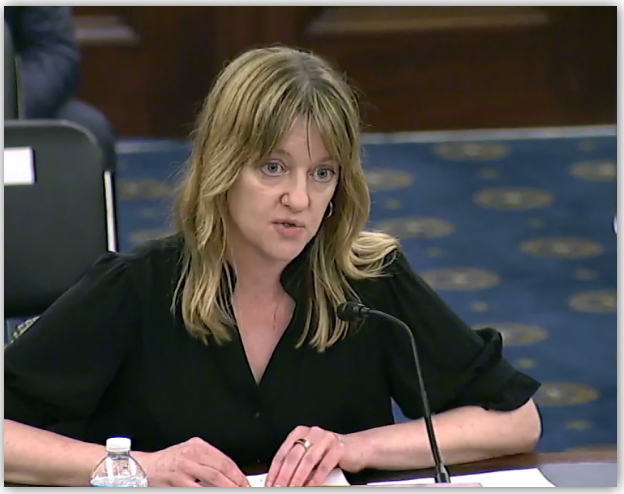
Healthcare Inspections personnel assess VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. Field staff participate in Comprehensive Healthcare Inspection Program reviews focusing on leadership, quality management, and adherence to requirements and standards for providing patient care. Facility results are aggregated annually into summary reports that identify national trends. This office also conducts statistically supported national reviews of topical issues and provides consultations to criminal investigators and audit staff as needed.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

The Office of Management and Administration provides comprehensive support services to the OIG. Staff promote organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, information technology (IT), and other critical services to the organization. The office also oversees the OIG hotline, which receives, screens, and refers all allegations and complaints for additional action. Staff selectively accept concerns after a review of the complaint, prioritizing those that pose the most potential risk to veterans and VA programs and operations, or those for which the OIG may be the only avenue of redress.

Listen to a *Veteran Oversight Now* **podcast** in which Inspector General Michael J. Missal shares his thoughts on changes to federal oversight since the passage of the Inspector General Act in 1978. (Season 2, Episode 9).

Shawn Steele, Director of the Healthcare Infrastructure Division for the Office of Audits and Evaluations, testifies before the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations on *Background Checks: Are VA's HR Failures Risking Drug Abuse and Veteran Harm?* on December 6, 2023.



Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for the Office of Healthcare Inspections, testifies before the Senate Veterans' Affairs Committee on *Vet Centers: Supporting the Mental Health Needs of Servicemembers, Veterans, and Their Families* on January 31, 2024.

Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testifies before the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs on *Is VA Illegally Spending Taxpayer Dollars in its Compensation and Pension Programs?* on February 14, 2024.

Deputy Inspector General David Case testifies before the House Veterans' Affairs Committee's Subcommittee on Technology Modernization on *EHR Modernization Deep Dive: Can the Oracle Pharmacy Software be Made Safe and Effective?* on February 15, 2024.

Highlighted Activities and Findings

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period October 1, 2023–March 31, 2024. Highlighted below are some of the priorities set, activities conducted, and oversight report findings issued during this six months by the VA OIG's offices. This information is supplemented by tables that identify OIG investigations and publications completed this reporting period, open (unimplemented) recommendations to VA with their monetary impact, and VA management's nonconcurrence with specific report recommendations. This *Semiannual Report to Congress* reflects changes made under the National Defense Authorization Act for Fiscal Year 2023 to simplify the reporting requirements in the IG Act, including that an OIG may provide hyperlinks directing readers to previously published information that satisfies reporting requirements in lieu of restating it in this report. Accordingly, selected oversight work is highlighted and all work products publicly released during this reporting period can be found by visiting the **VA OIG website**. The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure under federal law.

The Immediate Office of the Inspector General

This office is staffed by the inspector general, the deputy inspector general, and executive support personnel, including employees who prepare reports for public distribution and follow up on recommendations. The immediate office of the inspector general also includes personnel focused on special projects, congressional relations, data and analytics, and public affairs.

CONGRESSIONAL RELATIONS

Congressional relations staff actively engages with Congress to promptly inform members and their staff of critical issues affecting VA programs and operations. During this reporting period, the OIG participated in four congressional hearings on VA's electronic health record (EHR) modernization, personnel suitability, vet centers, and compensation and pension programs. These hearings highlighted recent and ongoing OIG oversight work. For example, during a hearing before the House Veterans' Affairs Committee's Subcommittee on Technology Modernization, Deputy Inspector General David Case's testimony on VA's EHR modernization efforts focused on three reports that at the time were under review by the Department dealing with several areas related to the program. One inspection report focused on pharmacy-related patient safety issues affecting the health care delivered at the VA Central Ohio Healthcare System and other VHA medical facilities. He emphasized that about 250,000 veterans with medication orders and/or who had medication allergies documented in the new EHR had not been notified of the potential risk for a medication- or allergy-related patient safety event if they received care at a legacy EHR site. The other two reports examined systemic deficiencies in the new EHR's appointment scheduling package. Specifically, one report spotlighted the OIG's concern that VHA is requiring mental health staff at new EHR sites to make fewer attempts to contact no-show patients than required at sites using the legacy system. Left uncorrected, these pose even greater risk of impacting

veterans' prompt access to care and a different standard of care between sites with the new EHR and the legacy system.

The OIG conducted 66 briefings on oversight reports with members and their staffs. Some of the topics addressed included the following:

- VA's inadequate oversight of its community healthcare providers' opioid prescribing practices
- VA's insufficient quality assurance related to contract medical exams
- VA's high rate of noncompliance with requirements for vetting contractor employees
- Inconsistent application of rating updates for veterans' hip and knee replacement benefits
- VA's oversight to improve accessibility to websites and IT systems for individuals with disabilities
- Supply chain management deficiencies
- Opportunities for improvements to vet centers
- Enhancements needed to VA policies on emergent care for patients with acute sexual assault indicators

Following the briefings, the OIG team keeps congressional offices informed of VA's progress in implementing OIG recommendations. The team also coordinates responses to requests for technical assistance from congressional offices and committees during legislative drafting and after introduction of a bill to clarify anticipated oversight efforts. For example, OIG staff reviewed legislation related to veterans' education programs and made suggestions to tighten program requirements in order to lessen the risk of fraud.

During this reporting period, the congressional relations team fielded 71 inquiries from House and Senate offices related to constituent matters for review or referral. Congressional relations staff also assist with coordinating matters with other VA oversight offices, federal agencies, and those in the inspector general community, acting as liaisons to the Government Accountability Office and the Pandemic Response Accountability Committee to align areas of oversight and to leverage one another's work. They serve on committees for the Council of the Inspectors General on Integrity and Efficiency and help research practices and policy affecting OIGs. Staff also ensure that all OIG directorates are aware of external agencies' efforts and facilitate information-sharing sessions to shape more impactful audits, reviews, inspections, and investigations.

DATA AND ANALYTICS

The OIG uses data-driven approaches to guide its work and identify the areas of greatest risk to veterans and their families, VA programs, and the misuse of taxpayer dollars. The Office of Data and Analytics (ODA) uses advanced analytics, data visualization, and comprehensive data services to support proactive oversight of VA programs and operations. The office, in collaboration with directorate teams

across the OIG, created and refined user-friendly, self-service applications and dashboards to empower all staff to enhance their work using just-in-time information.

During this reporting period, ODA continued work on 112 projects, created nine new internal data-monitoring tools and two content search tools, and made enhancements to several other tools. ODA work addressed a broad range of subjects, including financial management, staffing levels, personnel awards and incentives, veterans' access to VHA health care, community care referrals and usage, electronic health record modernization, benefit claims processing, PACT Act implementation, and contracts and procurements. ODA also focused on advancing oversight work on VA's suicide prevention efforts, homelessness programs, vet center services, and the fiduciary program.

In collaboration with a directorate, ODA also developed a comprehensive data consolidation platform to aggregate myriad data sources into a unified search interface. Leveraging advanced federated search technologies, the tool enables OIG personnel to execute seamless, cross-domain searches quickly and with minimal effort.

This office fulfilled 236 internal data requests and 497 access requests to VA data systems during this period. The responses supported OIG oversight of VA's broad range of healthcare services and benefits programs involving disabilities, pensions, education, housing assistance, and veterans' burials. In addition, ODA conducted formal trainings for OIG staff and partnered with directorate teams to develop facility-level information to help guide proactive healthcare and vet center inspections. The ongoing ODA training series builds OIG staff expertise and supports continuing professional education tailored to oversight goals.

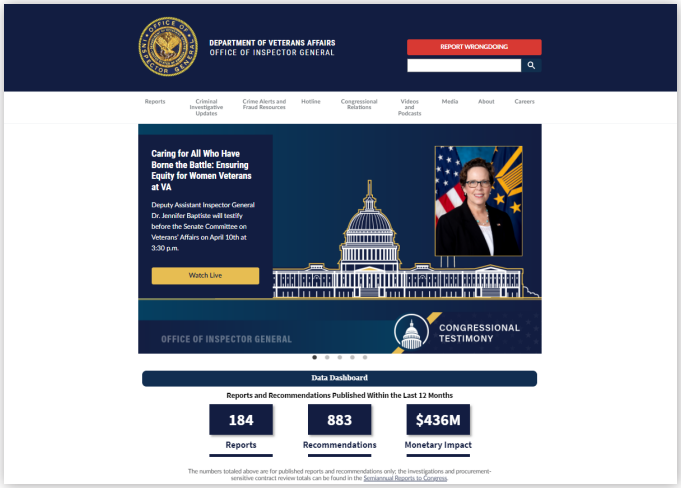
PUBLIC AFFAIRS

The OIG is committed to maintaining transparency and to providing accurate and timely information to veterans and their families, VA leaders and staff, the media, veterans service organizations, Congress, and the public. To that end, public affairs staff disseminated report information, news releases, podcasts, and other communications products to keep stakeholders informed of the OIG's oversight work. Staff also worked with US Attorneys' public affairs offices and other law enforcement partners to release public statements and respond to requests for information on criminal investigations. Personnel within this office also have responsibility for following up on the implementation of OIG report recommendations. In this six-month reporting period, those efforts included sending 491 requests for status updates to various offices within VA tasked with taking action. These efforts facilitated the closing of 359 recommendations during this reporting period.

The public affairs team expanded its presence on LinkedIn and X (formerly Twitter) by roughly 14,500 followers, totaling more than 99,300. Staff published 244 updates on reports, hiring activities, and other news; posted 179 tweets; and released 148 email bulletins through GovDelivery. The number of

Highlighted Activities and Findings

OIG bulletin subscribers increased by about 9,000 since the previous reporting period, bringing the total to nearly 163,000.



Public affairs staff also spearheaded the redesign of the OIG's public-facing website—**www.vaoig.gov**—which is the primary source for all content produced by the organization. The new website enhances users' online viewing and reflects feedback from veterans and other stakeholders who have shifted from primarily big screen usage to more extensive reliance on mobile devices and a preference for multimedia content over text-heavy webpages. Launched in October, the new site features many functional improvements, including a data dashboard that provides up-to-date 12-month snapshots of important metrics such as the OIG's monetary impact, number of reports and recommendations issued, as well as the "age" of open recommendations (expressed as the percentage of OIG recommendations open less than a year, between one and five years, and more than five years). The website's library archives thousands of OIG publications—some dating as far back as 1997—in a user-friendly, searchable system that can filter reports by topic, relevant VA office or administration, district or state, and several other options. The public affairs team has also employed more effective strategies to improve the website's visibility on internet search engines, enabling the OIG to reach more veterans and their families with critical resources and information.

The team produced three *Veteran Oversight Now* podcast episodes this reporting period to supplement and provide context to its oversight reports. The first presented an interview with the OIG's hotline director and focused on allegations of delays in the receipt of patients' colorectal cancer screening tests at the Phoenix VA Health Care System in Arizona. A second discussed how multiple OIG reports detail chronic leadership failures at the Indianapolis, Indiana, VA medical center. The final podcast episode featured Inspector General Missal, who shared his thoughts on changes to federal oversight since the passage of the IG Act in 1978.

The OIG receives extensive local and national media coverage and is highlighted in close to 70 Department of Justice (DOJ) press releases in just this reporting period for its criminal investigations. Among the broadcast and print media outlets that prominently featured the OIG's work are the *Washington Post*, CBS News, Fox News, ProPublica, The Hill, Bloomberg Law, *Washington Examiner*, the *Guardian*, Military.com, *Newsweek, Politico, Military Times, Miami Herald, The Denver Post, Stars and Stripes*, and Federal News Network. The coverage highlighted OIG findings on such deficiencies as VA's personnel suitability program; the new electronic health record system; and improvements needed in VA emergency care for victims of sexual assault.

The Office of the Counselor to the Inspector General

During this reporting period, the counselor's office continued to provide legal support to every division of the OIG. In addition to representing the agency in actions before administrative bodies, including the US Equal Employment Opportunity Commission (EEOC) and Merit Systems Protection Board (MSPB), the office also assisted the DOJ with prosecuting criminal cases and defending civil actions in federal district courts. Attorneys and specialists from the counselor's office also provided training to OIG managers on employee performance and discipline and to newly hired OIG employees on inspector general authorities, standards of conduct, and the EEOC complaint process. The office also provided training to the entire workforce on restrictions on federal employees' political activities under the Hatch Act.

The Employee Relations and Reasonable Accommodation Division processed 155 actions related to employee discipline, performance, and other workforce issues, and responded to nearly 850 inquiries concerning reasonable accommodation and leave administration. The division played a key role in assisting OIG officials with preparing for any potential future government shutdowns and ensuring continuity of operations. Division personnel also created a performance appraisal tip sheet for managers to provide guidance on accurately evaluating the performance of non-Senior Executive Service employees. Additionally, personnel conducted a live course on "Performance Management: Progress Reviews" during an OIG mandatory management training to equip managers with the necessary skills and techniques for conducting effective reviews. The division's employee relations team also spearheaded the processing of more than a dozen fact-findings in conjunction with the Administrative Law Division to assist management officials in addressing workplace concerns.

The Administrative Law Division, in addition to assisting with the fact-finding inquiries, represented the OIG in four equal employment opportunity complaints and four appeals before the MSPB. For the single case reaching the decision stage for this reporting period, the team received a favorable result for the OIG in an MSPB appeal filed by an employee who was removed during the probationary period. The division also conducted legal reviews of various OIG policies and directives, assisted with OIG's oversight work, and provided live trainings and ethics briefings for new employees and supervisors.

Attorneys in the Oversight and Procurement Division have provided high-quality and impactful legal advice to OIG directorates in support of several oversight projects. They accompanied audit teams on site visits, collaborated with the Office of Special Reviews on contractor whistleblower retaliation matters, as well as provided significant advice to the Office of Healthcare Inspections on a national report regarding VA's provision of emergency care to patients who presenting with acute sexual assault. The work on sexual assault responses prompted 33 senators to write a letter to the Secretary demanding information and prompt action in response to concerns the OIG identified. In support of the Office of Investigations, attorneys in the office reviewed subpoenas and provided input on trainings and legal issues affecting criminal and civil investigations. Attorney advisors have also worked closely with the Office of

Management and Administration on contracting matters, including providing legal sufficiency reviews and advice on OIG procurements.

The Release of Information Office (ROI) responded to more than 465 record requests and appeals during this reporting period. Staff also provided ongoing support to US Attorney's offices in several Freedom of Information Act cases and reviewed all reports published by the OIG during the review period to ensure compliance with the Privacy Act and statutory information release restrictions unique to VA. ROI attorneys participated in multiagency working groups to understand and help implement the new National Law Enforcement Accountability Database requirements within the OIG. The division developed a process to implement new requirements in section 5274 of the National Defense Authorization Act for Fiscal Year 2023, which amends section 405(g) of the IG Act, requiring offices of inspectors general to notify nongovernmental organizations or business entities after they are specifically identified in a published audit, evaluation, inspection, or other noninvestigative report. During the six-month SAR reporting period, the OIG received its first response from such a notice and posted it with the related report on the public-facing website, as required. The office also responded under VA's "Touhy regulations" to numerous subpoenas for the testimony of OIG personnel and coordinated with US Attorney Offices as needed.

The Office of Investigations

112
Arrests

78
Convictions

$1.2B
Monetary Benefits

Office of Investigations (OI) staff investigate potential criminal activity and civil violations of law, including fraud related to VA benefits, construction, education, procurement, and health care, as well as drug offenses, crimes of violence, threats against VA employees or facilities, and cyberthreats to VA information systems. During this six-month reporting period, investigative efforts resulted in 112 arrests, 78 convictions, and more than $1.2 billion in monetary benefits for VA.

OI continues to prioritize high-impact investigations. Its personnel coordinate with other OIG directorates, external law enforcement partners, and the DOJ to help ensure that veterans, VA employees, and VA assets are protected and wrongdoers are held accountable. In addition, OI provides expert advice to Congress on VA-related anticrime measures. For example, OI personnel worked with the OIG's congressional relations staff to propose legislative changes to deter fraud related to both education and compensation benefits. Through its proactive and reactive investigative priorities, OI persisted in identifying weaknesses in VA disability benefits programs that could be mitigated with legislative or regulatory changes from policymakers. Fraud schemes that exploit these programs have been the focus of coordinated nationwide law enforcement actions that highlight their wide reach and extraordinary impact on VA's operations.

Two fraud alerts were issued by OI during this reporting period. The first notified VBA employees of the need to identify and report possible public disability benefits questionnaire (DBQ) fraud schemes. Public DBQs are benefit forms that veterans must complete and submit to help VA evaluate their disability benefit claims. The fraud alert encourages VBA staff to report when veterans share that they are being charged high fees from unaccredited individuals for assistance with completing DBQs or an initial claim filing, or when public DBQs raise questions of authenticity or other red flags. The second fraud alert pertained to the theft of funds by fiduciaries who have been appointed to manage the financial affairs of veterans and other beneficiaries unable to do so for themselves. It identified several red flags for this type of theft, including fiduciaries lacking documentation to support expenses, being unresponsive to VA requests, and restricting VA's access to beneficiaries during field exams. These and other OI efforts enhance the detection of high-dollar fraud in a number of risk areas and help prevent harm to veterans, their families, and caregivers.

During the reporting period, OI's staff conducted numerous successful investigations resulting in arrests, indictments, and sentencing. The selected investigations summarized below illustrate OI's emphasis on a broad range of cases that have led to monetary recoveries for VA that can be reinvested in its programs, services, and benefits; address fraud, waste, and abuse by bad

actors and VA employees in positions of trust; and help ensure benefits and services meant for veterans and other eligible beneficiaries are being received.

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

VBA implements a number of programs for eligible veterans and family members, including monetary benefits, education assistance, insurance, and VA-guaranteed home loans. OIG investigations routinely uncover large amounts of benefit payments made to ineligible individuals. Education investigations target fraudsters that do not deliver promised services to eligible veterans, service members, and their qualified family members. With respect to home loans, agents focus on loan origination fraud, equity skimming, and criminal conduct related to the management of foreclosed loans or properties. Personnel also investigate allegations of crimes committed by VA-appointed fiduciaries and caregivers. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period. Additional cases are listed in **table 7.**

FORMER NAVY DOCTOR SENTENCED FOR DISABILITY INSURANCE FRAUD

A multiagency investigation revealed that a former Navy doctor conspired with others to submit fraudulent claims through the Traumatic Servicemembers Group Life Insurance (TSGLI) program, which provides short-term financial support to help service members recover from a severe injury. The coconspirators submitted numerous TSGLI benefit claims that included fraudulent reports of catastrophic injuries and exaggerated the loss of claimants' activities of daily living. The claims were made to generate payouts of $25,000 to $100,000 per claim to individuals who then gave kickbacks to the coconspirators who recruited them. VA supervises the administration of the TSGLI program. In total, 10 individuals were convicted in connection with this scheme. The loss to the TSGLI program is approximately $2 million. In addition to being sentenced in the Southern District of California to 12 months and one day in prison and 36 months of probation, the former Navy doctor was ordered to forfeit $180,000 after previously pleading guilty to conspiracy to commit wire fraud. The VA OIG, Naval Criminal Investigative Service, and FBI conducted the investigation.

VETERAN PLEADED GUILTY TO MAKING FALSE STATEMENTS ABOUT HIS CLAIMED DISABILITY

According to a VA OIG investigation, a veteran lied to VA about being unable to use both his feet, which resulted in his receipt of VA compensation for almost two decades and vehicle adaption benefits to which he was not entitled. The veteran pleaded guilty in the District of New Hampshire for making false statements. The loss to VA is approximately $662,000.

VA Staff Can Help Stop Public DBQ Fraud

The VA OIG seeks VBA employees' help in preventing public DBQ fraud. Report when veterans are charged high fees for help with completing DBQs or filing the initial claim, or when public DBQs raise red flags.

View the **full fraud alert** or learn more about fraud indicators on the **VA OIG website.**

SCHOOL OWNER SENTENCED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

Another VA OIG investigation revealed that the owner of a non-college-degree school defrauded the VA education benefits program by making various misrepresentations to VA and the Louisiana Department of Veterans Affairs. The school owner was aware that the funds were intended to train veteran students but used them instead to train and provide service dogs. In some cases, the defendant obtained VA payments and provided no services whatsoever.
The total loss to VA is approximately $384,000. After pleading guilty to theft of government funds, the defendant was sentenced in the Western District of Louisiana to 12 months of home confinement, 60 months of supervised release, and over $384,000 in restitution.

FORMER FIDUCIARY SENTENCED FOR MISAPPROPRIATING FUNDS MEANT FOR VETERAN UNCLE

A former VA-appointed fiduciary spent over $115,000 in VA compensation benefits that were intended for her veteran uncle. The stolen funds were used as a down payment for a home and to pay for subsequent home improvement projects. She was sentenced in the Eastern District of Louisiana to 18 months in prison and 36 months of supervised release after pleading guilty to misappropriation by a veteran's fiduciary. Restitution will be determined at a future hearing. This investigation was completed by the VA OIG and FBI.

CRIME ALERT

Protect Vulnerable Veterans from Fiduciary Theft

The VA OIG continues to investigate theft of funds by individuals who have been appointed to help veterans and other beneficiaries unable to manage their financial affairs.

View the **full fraud alert** or learn more about fraud indicators on the **VA OIG website.**

ONE OF THREE INDIVIDUALS SENTENCED FOR DEFRAUDING VA BY POSING AS THE SPOUSE OF MULTIPLE DECEASED VETERANS

A VA OIG and Michigan Attorney General investigation found that three individuals used aliases to obtain or create fraudulent documents, including vital records such as birth certificates, to make it appear as if they were the surviving spouses of deceased veterans. These documents were used to fraudulently obtain VA Dependency and Indemnity Compensation benefits, VA Survivors Pension benefits, and unclaimed funds from Michigan. One of the defendants was sentenced in the Third Judicial Circuit Court of the State of Michigan to serve between 78 months and 20 years of incarceration and ordered to pay restitution of $470,000 after previously pleading no contest to conducting a criminal enterprise and false pretenses. Of the restitution amount, VA is due $430,000.

SELECTED VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. The selected case summaries that follow illustrate the type of VHA investigations conducted during this period. Additional cases are listed in **table 7.**

Highlighted Activities and Findings

MANUFACTURER AGREED TO NEARLY $2 BILLION GLOBAL RESOLUTION OF CRIMINAL AND CIVIL INVESTIGATIONS INTO SALES AND MARKETING OF BRANDED OPIOID DRUG

The DOJ announced that an opioid manufacturer entered into a global resolution under which the company agreed to pay a criminal fine of $1.086 billion, a civil settlement of $475.6 million, and the criminal forfeiture of $450 million. The manufacturer also agreed to plead guilty to a misdemeanor charge of violating the Federal Food, Drug, and Cosmetic Act by introducing misbranded drugs into interstate commerce. A multiagency investigation resolved allegations that the manufacturer's sales representatives marketed their opioid drug to prescribers by touting the medication's purported abuse deterrence, tamper resistance, and crush resistance despite a lack of clinical data supporting those claims. In an attempt to increase revenue, the manufacturer allegedly partnered with a consulting company to devise a marketing scheme that targeted healthcare providers that the company knew were prescribing their opioid for nonmedically accepted indications. The loss to federal healthcare programs is approximately $208.5 million. Of this amount, the loss to VA is approximately $8.5 million. This investigation was conducted by the VA OIG, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), Food and Drug Administration Office of Criminal Investigations, Amtrak OIG, and FBI.

TWO FORMER VA REGISTERED NURSES SENTENCED FOR MAKING FALSE STATEMENTS REGARDING PATIENT'S DEATH

According to a VA OIG investigation, two former registered nurses at the Oklahoma City VA Medical Center made false statements to investigators related to the suspicious death of an inpatient veteran. Specifically, they stated that they did not pause medication being administered to the veteran before his death when they both knew that they did. Both nurses pleaded guilty in the Western District of Oklahoma to false statements and received respective sentences of six months and three months in prison, with each also receiving one year of supervised release.

MEDICAL MARKETER FOUND GUILTY FOR $55 MILLION PRESCRIPTION DRUG FRAUD CONSPIRACY

A multiagency investigation resulted in charges alleging that numerous defendants participated in a scheme to defraud federal healthcare programs by billing for nonreimbursable medications in compounded prescriptions. Although intended to be tailored to individual patient needs, these medications were designed to maximize reimbursements regardless of medical necessity. Compounding pharmacy owners and others paid illegal kickbacks to medical marketers that recruited area doctors to write these expensive prescriptions by offering "investment opportunities" so that the doctors could profit from the scheme. The total loss to the government is approximately $55 million. Of this amount, the loss to VA is approximately $3 million. A medical marketer for several compounding pharmacies was found guilty by a federal jury in the Northern District of Texas on charges of receiving unlawful kickbacks, conspiracy to defraud the United States, and money laundering. This investigation was conducted by the VA OIG, Department of Labor (DOL) OIG, FBI, DCIS, and HHS OIG.

DEFENDANT SENTENCED FOR SCHEME INVOLVING STOLEN DIABETIC TEST STRIPS

A former pharmacy technician at the Battle Creek VA Medical Center in Michigan used her position to steal more than $400,000 in diabetic test strips from the facility and then sold them to individuals not affiliated with VA. She was aided by several codefendants. Following an investigation by the VA OIG, VA Police Service, and the Food and Drug Administration Office of Criminal Investigations, one of her codefendants was sentenced in the Western District of Michigan to 78 months of incarceration and

restitution of over $427,000. The codefendant also agreed to pay more than $1.2 million to resolve the government's civil claims arising from his misconduct. The former pharmacy technician and another codefendant were previously sentenced in connection with this scheme.

FORMER VA PHARMACY TECHNICIAN SENTENCED FOR DRUG DIVERSION SCHEME

A pharmacy technician who worked at the VA medical center in Kerrville, Texas, stole more than 40 packages containing controlled substances intended for veterans from mailboxes in and around Kerrville and sold the substances to accomplices for further distribution. The former pharmacy technician was sentenced in the Western District of Texas to 42 months of incarceration, 36 months of supervised release, and restitution of more than $2,000. The investigation was conducted by the VA OIG, Drug Enforcement Administration, Kerr County Sheriff's Office, and the US Postal Inspection Service.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types and examples listed above, including allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement practices. OI also investigates information management crimes, such as theft of IT equipment and data, network intrusions, and child pornography, as well as threats and assaults involving VA employees and facilities. The case summaries that follow provide a sampling of these investigations conducted during the reporting period, with additional cases also listed in **table 7.**

SURGICAL SALES REPRESENTATIVES PLEADED GUILTY FOR ROLES IN MULTIMILLION-DOLLAR BRIBERY SCHEME

Two surgical sales representatives admitted to defrauding VA with the help of two now former VA employees at the James H. Quillen VA Medical Center in Mountain Home, Tennessee. The sales representatives created and used two shell companies to submit invoices to VA for orthopedic surgeries, which the VA employees paid for using a purchase card. The billings for these surgeries, including a vast array of components, instruments, and implants, were approximately seven to 10 times higher than historical billings for similar surgeries. The sales representatives routinely provided the VA employees with envelopes of cash, which totaled more than $80,000. The loss to VA is approximately $3.7 million. Both sales representatives pleaded guilty in the Eastern District of Tennessee to conspiracy to commit bribery and "honest services" wire fraud.[3] The two former employees were previously indicted in the Eastern District of Tennessee on charges of bribery, money laundering, honest services fraud, and wire fraud. This investigation was conducted by the VA OIG, General Services Administration OIG, and IRS Criminal Investigation.

FORMER VA CONTRACTING OFFICER AND TRANSPORTATION COMPANY OWNER PLEADED GUILTY FOR ROLES IN BRIBERY SCHEME

According to an investigation by the VA OIG and FBI, a transportation company owner paid a bribe of $100,000 to a former South Texas Veterans Healthcare System contracting officer in exchange for the award of a set-aside contract to a business that the transportation company owner controlled. The

3 This is defined as a scheme or artifice to deprive another of the intangible right of honest services.

former VA contracting officer and the owner pleaded guilty in the Western District of Texas to conspiracy to commit bribery.

PLUMBING AND HEATING COMPANY TO PAY $1.3 MILLION TO RESOLVE CIVIL FRAUD ALLEGATIONS

A VA OIG and General Services Administration OIG investigation resolved allegations that a plumbing and heating company, which was certified as a service-disabled veteran-owned small business (SDVOSB), violated the False Claims Act by not properly subcontracting with similarly situated SDVOSBs on at least eight contracts across seven VA medical centers. The company entered into a civil settlement with the US Attorney's Office for the Western District of Washington under which it agreed to pay $1.3 million to resolve these allegations.

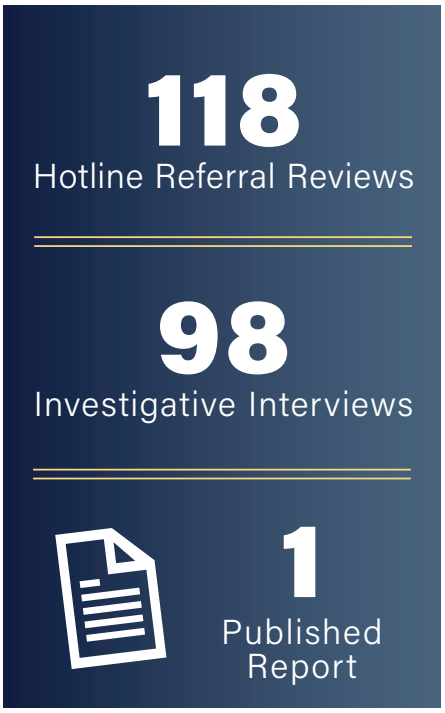
MULTIPLE DEFENDANTS SENTENCED IN CONNECTION WITH WORKERS' COMPENSATION FRAUD SCHEME

From 2011 until 2017, the former owner of a medical supply and billing company and the company's former chief executive officer conspired with others to defraud private and government healthcare benefit programs—including the DOL's Office of Workers' Compensation Program, which covers VA and other federal employees—by submitting claims for topical medications supplied by the company. The company billed insurers at markups of between 15 and 20 times what the medications actually cost, and then paid the prescribing healthcare providers unlawful kickbacks based on the amounts collected. Both the former owner and former chief executive officer from the medical supply and billing company were sentenced in the Western District of Arkansas after previously pleading guilty to conspiracy to commit wire fraud and illegal remunerations. The former owner was sentenced to 48 months of incarceration, three years of supervised release, and a fine of $25,000. The former chief executive officer was sentenced to 32 months of incarceration and three years of supervised release. A third defendant, a healthcare provider, was previously sentenced to 48 months in prison. These three defendants were ordered to jointly pay restitution of over $3.5 million. A fourth defendant, another healthcare provider, was sentenced to 36 months of probation and ordered to pay restitution of more than $845,000. Neither of these healthcare providers had the legal authority to disburse medications in their state. The total loss to DOL is over $3.9 million. VA suffered a loss of more than $487,000 in connection with workers' compensation claims filed by VA employees. This investigation was completed by the VA OIG, US Postal Service OIG, DCIS, and DOL OIG.

VETERAN SENTENCED FOR MAKING THREATS AGAINST A VA EMPLOYEE AND THE LOMA LINDA VA MEDICAL CENTER

A veteran used a software application that cloaks phone numbers to threaten to kill a VA employee and their family. The veteran subsequently made threats to destroy the Loma Linda VA Medical Center in California with an explosive device. The defendant was sentenced in the Central District of California to 32 months in prison and 36 months of supervised release after pleading guilty to threatening a federal employee. The VA OIG and FBI conducted this investigation.

The Office of Special Reviews



The Office of Special Reviews (OSR) provides the OIG with the flexibility to promptly examine issues not squarely within the scope of another directorate. Its multidisciplinary staff of attorneys, investigators, and analysts evaluates allegations of misconduct or gross mismanagement that implicate senior VA officials or that significantly affect VA programs and offices. The office's work also includes oversight projects that focus on issues of ethics, gross waste of funds, and the effectiveness of VA programs and operations.

During this reporting period, OSR devoted significant resources to a high-priority investigation of the facts and circumstances relating to VA's payment of more than $10 million for critical skills incentives to certain senior executives that VA later determined had been erroneously made. That report is expected to be released in the next SAR reporting period. Staff also vetted an increasing number of allegations of potential whistleblower retaliation against employees of VA contractors, grantees, subcontractors, and subgrantees. OSR investigates allegations of whistleblower reprisal made by employees of VA contractors or grantees pursuant to 41 U.S.C. § 4712. Federal law prohibits inspectors general from disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not publicly released. To promote transparency of its activities to the greatest extent permitted by law, the OIG does release statistical information about these cases. During this reporting period, OSR staff allocated significant resources to assessing 16 such cases. OSR has been taking numerous steps to address this increasing workload, including evaluating processes for greater efficiency and the sufficiency of staffing. In addition, the office published the following report during this SAR period.

LOGISTICS MANAGERS IMPROPERLY ALLOWED EMPLOYEES TO AUCTION OFF GOVERNMENT PROPERTY

In March 2023, while conducting an audit of the Denver Logistics Center (DLC), the OIG found an employee recreation group was auctioning items that VA purchasers had requested through free offers associated with supply orders that met a minimum-dollar threshold. DLC staff auction winners took the items for personal use, and the proceeds were used to fund staff social events. The OIG initiated this administrative investigation to examine possible misconduct by VA senior leaders responsible for maintaining ethical procurement practices.

DLC purchasing agents claimed free items, such as Yeti coolers, for 32 purchases from February 2021 through May 2023. The employee recreation group then sold the items to staff through silent auctions. Under federal law, the items were government property because they were part of a purchase made by VA. Federal ethics regulations state, "employee[s] ha[ve] a duty to protect and conserve Government property and shall not use such property, or allow its use, for other than authorized purposes." DLC

leaders and staff had taken related VA ethics and purchase card training, which explained management of government property, ethical restraints on receiving free incentives, and purchase card prohibitions; however, no one at the DLC appeared to have questioned the propriety of the auctions.

The OIG found the purchases associated with the free items constituted waste. Contrary to VA policy, which requires every effort be made to use government-wide or agency contracts, the DLC purchased these items without considering a preestablished government contract. The DLC director halted the auctions and the acceptance of free merchandise in June 2023. VA concurred with the OIG's six recommendations that include a full accounting of losses and recoveries, enhanced guidance and training, and taking other needed administrative actions. VA was also alerted to 168 other facilities that appeared to be receiving free incentives for further examination.

The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) released 20 publications summarizing results from its oversight work, including four VA management advisory memoranda. Overall, its published reports resulted in 85 recommendations with a potential monetary impact for VA of more than $110 million for the reporting period. OAE teams also conducted 37 preaward and postaward contract audits and reviews to help VA obtain fair and reasonable pricing on products and services as well as ensure that contractors comply with the terms of their contracts. OAE identified potential cost savings of over $100 million and recovered more than $7.2 million in overcharges from preaward and postaward contract audits and reviews.

OAE's oversight of VBA's broad range of benefit programs continues to receive considerable public attention—driven by outreach to the veteran community as well as frequent media coverage and congressional testimony. Notable recent oversight includes an audit that identified a significant risk of fraud against VA and veterans related to the completion of public disability benefits questionnaires used to support benefit claims (discussed in the Featured Reports section below). Audit staff worked with criminal investigators to issue a fraud alert to VBA personnel to make them aware of indicators of scams that should be reported.

Additional audit reports examined the causes of ongoing improper payments made by VBA. During this reporting period, the deputy assistant inspector general for audits and evaluations testified before the House Veterans Affairs' Subcommittee on Disability Assistance and Memorial Affairs to highlight that incorrect payments—both over- and underpayments—are often caused by VBA's lack of effective internal controls, inadequate technology systems, or human error resulting from complicated and unclear policies and guidance.[4] For example, VBA recently modernized its rating schedule for disabilities related to the recovery period for hip and knee replacements. VBA uses this schedule to determine monthly compensation to eligible veterans, but the audit team found that claims processors did not always decide the correct number of months for convalescence periods or make certain that benefits were accurate due to VBA's insufficient monitoring of decisions, and limitations with the processing system. Further, VBA could have enhanced training material to ensure comprehension. OAE estimated that for 38 percent of claims, VBA rating specialists did not assign the correct number of months when granting periods of

4 Hearing on "*Is VA Illegally Spending Taxpayer Dollars in Its Compensation and Pension Programs?*" before the Subcommittee on Disability Assistance and Memorial Affairs, House Committee on Veterans' Affairs, 118th Cong. (February 14, 2024) (statement of Brent Arronte, Deputy Assistant Inspector General, Office of Audits and Evaluations, VA Office of Inspector General).

convalescence, resulting in about $3.3 million in either overpayments or underpayments for hip and knee replacements.[5]

OAE also continued to identify significant deficiencies in VA's personnel suitability program. Applicants for VA positions must undergo background investigations as a condition of their employment to help ensure the safety of veterans they will encounter if hired, their family members, other VA employees, and visitors to its medical centers and other facilities. In addition to checking that an individual is suited for the position, this vetting also helps secure sensitive information and VA resources. In December, the director of OAE's Healthcare Infrastructure Division testified before the House Veterans' Affairs Subcommittee on Oversight and Investigations, discussing VA's lack of oversight, effective data, and information technology systems to ensure that required background investigations were conducted and adjudicated within required timelines for staff at medical facilities nationwide.[6] Delays increase the risk of putting individuals who have been hired while their vetting is still ongoing in positions where they can serve veterans and, depending on the job, have access to drugs, expensive equipment and supplies, and sensitive information or systems. The director's testimony emphasized the results of a prior audit report that found a small number of investigations were not initiated at all, about 7 percent were not begun within 14 days of an employee's start date as required (on average 100 days), and about 23 percent were not adjudicated within the required 90-day period (on average over 200 days).[7] Prompted by these and other findings, Senator Jerry Moran recently directed VA to develop and submit a comprehensive plan, including any legislative needs, to make certain that VA's workforce will be screened and held to the highest professional standards. During this reporting period, OAE published a related audit report that focused on the vetting of contractor employees and found multiple instances of noncompliance that put veterans at risk. The findings of this audit are detailed below.

Two financial efficiency inspection reports were also released within the last six months, which identified $32 million in potential savings. These inspections assessed the oversight and stewardship of funds to improve financial operations. Overall, VA's financial statements for FYs 2022 and 2023 received an "unmodified opinion" (clean report), meaning the auditor found them to be presented fairly, in all material respects, in accordance with generally accepted accounting principles. However, the auditor identified three material weaknesses related to (1) controls over significant accounting estimates, (2) financial systems and reporting, and (3) information technology security controls. The information technology security controls material weakness has been reported for more than 10 years. All other material weaknesses and significant deficiencies have been reported in some form since at least FY 2016.

Finally, OAE released two reports this period that addressed the aging infrastructure of VA facilities. In addition to examining VHA's efforts to prevent and control *Legionella* at its medical centers, which is discussed below, audit staff assessed whether VA used more than $1 billion appropriated by Congress to repair buildings with identified seismic deficiencies in zones prone to earthquakes. This project showed that VA cannot effectively prioritize seismic funding without accurately identifying the seismic risk of its

5 VA OIG, *Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*, Report No. 23-00153-41, February 21, 2024.

6 Hearing on "*Background Checks: Are VA's HR Failures Risking Drug Abuse and Veteran Harm?*" before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, 118th Cong. (December 6, 2023) (statement of Shawn Steele, Director, Healthcare Infrastructure Division, Office of Audits and Evaluations, VA Office of Inspector General).

7 VA OIG, *VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement*, Report No. 21-03718-189, September 21, 2023.

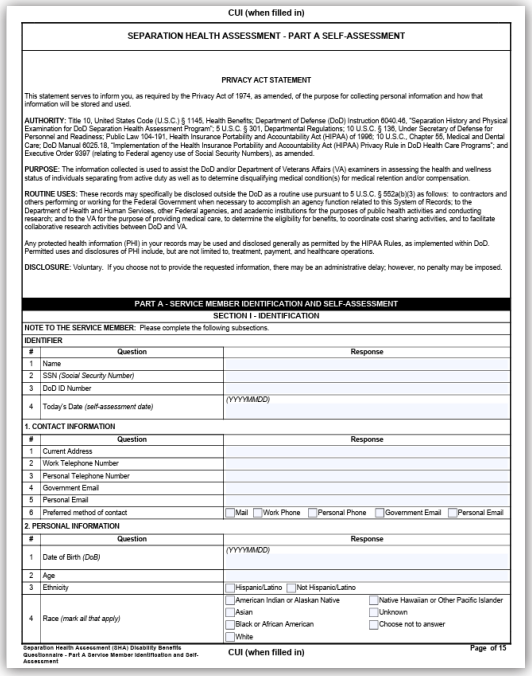
critical and essential buildings. VA's ineffective prioritization increases the risks to veteran and employee safety and impedes the ability to continue to provide lifesaving care during or following an earthquake.[8]

The following publications are examples of the work OAE staff conduct to assist VA in improving the services it offers veterans. All published OAE reports and other products are listed in **table 8** and on the **VA OIG website**.

FEATURED REPORTS

WITHOUT EFFECTIVE CONTROLS, PUBLIC DISABILITY BENEFITS QUESTIONNAIRES CONTINUE TO POSE A SIGNIFICANT RISK OF FRAUD TO VA

The OIG conducted this review as required by the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020. In this second report to Congress, the OIG sought to determine whether VBA continues to use updated public disability benefits questionnaires and provides sufficient oversight, given the significant risk of fraud associated with their misuse. Publicly available questionnaires are completed by veterans' non-VA medical providers, whereas internal questionnaires are completed by VA medical providers. The OIG team found VBA generally accepted and used public questionnaires when determining entitlement to benefits. However, VBA does not have effective controls to mitigate the risk of using fraudulent forms to decide benefits. The team estimated from a statistical sample that of the 31,900 claims completed during the review period (January 1 to December 31, 2022), approximately 22,000 claims (69 percent) had one or more fraud risk indicators. Though these are only possible instances of fraud, the team's projections suggest that the risk to VA during the year reviewed could be approximately $390 million. VBA concurred with the OIG's five recommendations to address the problems.



CUI (when filled in)

SEPARATION HEALTH ASSESSMENT - PART A SELF-ASSESSMENT

PRIVACY ACT STATEMENT

This statement serves to inform you, as required by the Privacy Act of 1974, as amended, of the purpose for collecting personal information and how that information will be stored and used.

AUTHORITY: Title 10, United States Code (U.S.C.) § 1145, Health Benefits; Department of Defense (DoD) Instruction 6040.46, "Separation History and Physical Examination for DoD Separation Health Assessment Program"; 5 U.S.C. § 301, Departmental Regulations; 10 U.S.C. § 136, Under Secretary of Defense for Personnel and Readiness; Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996; 10 U.S.C., Chapter 55, Medical and Dental Care; DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs"; and Executive Order 9397 (relating to Federal agency use of Social Security Numbers), as amended.

PURPOSE: The information collected is used to assist the DoD and/or Department of Veterans Affairs (VA) examiners in assessing the health and wellness status of individuals separating from active duty as well as to determine disqualifying medical condition(s) for medical retention and/or compensation.

ROUTINE USES: These records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. § 552a(b)(3) as follows: to contractors and others performing or working for the Federal Government when necessary to accomplish an agency function related to this System of Records; to the Department of Health and Human Services, other Federal agencies, and academic institutions for the purposes of public health activities and conducting research; and to the VA for the purpose of providing medical care, to determine the eligibility for benefits, to coordinate cost sharing activities, and to facilitate collaborative research activities between DoD and VA.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay; however, no penalty may be imposed.

PART A - SERVICE MEMBER IDENTIFICATION AND SELF-ASSESSMENT

SECTION I - IDENTIFICATION

NOTE TO THE SERVICE MEMBER: Please complete the following subsections.

IDENTIFIER

#	Question	Response
1	Name	
2	SSN (*Social Security Number*)	
3	DoD ID Number	
4	Today's Date (*self-assessment date*)	(YYYYMMDD)

1. CONTACT INFORMATION

#	Question	Response
1	Current Address	
2	Work Telephone Number	
3	Personal Telephone Number	
4	Government Email	
5	Personal Email	
6	Preferred method of contact	☐ Mail ☐ Work Phone ☐ Personal Phone ☐ Government Email ☐ Personal Email

2. PERSONAL INFORMATION

#	Question	Response
1	Date of Birth (*DoB*)	(YYYYMMDD)
2	Age	
3	Ethnicity	☐ Hispanic/Latino ☐ Not Hispanic/Latino
4	Race (*mark all that apply*)	☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown ☐ Black or African American ☐ Choose not to answer ☐ White

Separation Health Assessment (SHA) Disability Benefits Questionnaire - Part A Service Member Identification and Self-Assessment

CUI (when filled in)

Page of 15

NONCOMPLIANCE WITH CONTRACTOR EMPLOYEE VETTING REQUIREMENTS EXPOSES VA TO RISK

This audit assessed VA's compliance with executive orders, federal regulations, and VA requirements for vetting employees of contractors to work on behalf of VA. The team found VA officials had a high rate of noncompliance:

- 94 percent of contract files reviewed did not include position designations establishing the investigative requirements for the contract

8 VA OIG, *VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds*, Report No. 22-00410-197, December 14, 2023.

- 90 percent of contract files did not include language to communicate vetting requirements to the contractor
- 75 percent of employees on the contracts reviewed did not have a fingerprint check
- 79 percent of employees did not have a formal background investigation

To avoid hiring contractor employees who could put VA employees, veterans, information, and information systems at increased risk, the OIG made recommendations to improve vetting by updating and clarifying guidance and conducting compliance inspections.

VHA SHOULD CONTINUE TO IMPROVE WATER SAFETY AND OVERSIGHT OF PREVENTION PRACTICES TO MINIMIZE THE EFFECTS OF *LEGIONELLA*

VHA Directive 1061 establishes standards to prevent and control healthcare-associated *Legionella* disease at VHA-owned buildings where patients, residents, visitors, or staff stay overnight. The OIG audited whether VHA complies with the directive and effectively prevents and controls *Legionella* bacteria in potable water distribution systems. The OIG determined the four VA medical facilities reviewed—in Salem, Virginia; Brooklyn, New York; Pittsburgh, Pennsylvania; and Dublin, Georgia—did not fully comply with VHA requirements on components of their *Legionella* disease prevention plans, water safety testing validation collection, remediation actions, and reporting practices. VHA leaders also did not receive complete water safety test results needed for effective oversight. In addition, VA medical facility leaders responsible for notifying its clinical staff of *Legionella* conditions did not communicate positive test results to ensure awareness of elevated diagnostic levels. The OIG made eight recommendations to improve oversight of water sampling, fix identified problems, and ensure VHA Directive 1061 is followed.

SIGNIFICANT DEFICIENCIES FOUND IN VA'S DENVER LOGISTICS CENTER INVENTORY MANAGEMENT OPERATIONS AND SYSTEMS

VA's DLC manages millions of dollars of supplies for VHA facilities and patients. VA policy holds staff who use, supervise, or control VA-owned goods accountable for those goods from acquisition to disposition. The OIG audit examined whether the DLC maintained accurate inventories of VA-owned goods and found significant deficiencies in inventory management operations. The audit also revealed the DLC's inventory management system software has access and security vulnerabilities and lacked transparency. The DLC has largely operated under minimal oversight that the OIG found to be ineffective at ensuring VA policies were followed and VA-owned goods protected. The independent nature of DLC operations coupled with the deficiencies identified in this audit impede the DLC from effectively fulfilling its mission and create a heightened risk of fraud, waste, and abuse. VA concurred with the OIG's 19 recommendations to improve DLC operations, oversight, and information system deficiencies.

VA SHOULD ENHANCE ITS OVERSIGHT TO IMPROVE THE ACCESSIBILITY OF WEBSITES AND INFORMATION TECHNOLOGY SYSTEMS FOR INDIVIDUALS WITH DISABILITIES

VA is required by law to make information on its websites, related resources, and data systems accessible to people with disabilities. The OIG conducted this audit to address concerns from Congress and a veterans service organization about the accessibility of VA websites and information technology systems. The OIG found areas for which VA's efforts and monitoring of Section 508 requirements could be improved to ensure websites and information technology systems are equally accessible to all. Specifically, web managers did not routinely maintain the Web Registry, VA's official repository of

websites, as required, and websites were not consistently scanned for compliance until recently. Further, VA officials did not always keep administrations and staff offices apprised of requirements and related procedures, resulting in noncompliant VA information technology systems and an inaccurate VA Systems Inventory, which designates systems as Section 508 compliant, noncompliant, or unassessed. Finally, three directives were not recertified within the required timeline. The OIG made six recommendations to address these shortcomings and safeguard accessibility.

SCHEDULING CHALLENGES WITHIN THE NEW ELECTRONIC HEALTH RECORD MAY AFFECT FUTURE SITES

The new EHR includes a scheduling system intended to enhance scheduling efficiency and user experience. The VA OIG issued this management advisory memorandum to address the concern that EHR scheduling system challenges experienced at smaller VA medical facilities could be exacerbated at larger, more complex medical centers. This memo was meant to assist VHA in determining whether additional actions are warranted prior to or during future deployments. Scheduling challenges include the need for additional staffing and overtime, displaced appointment queue functionality, problems related to healthcare providers and schedulers sharing information, inaccurate patient information, difficulties changing appointment type, and the inability to automatically mail appointment reminder letters. These issues create inconsistent work-arounds and additional effort, increasing the risk for scheduling errors. Consequently, at future go-live facilities, assessing staffing levels and overtime usage before deployment and preparing staff with approved workflow best practices may help to reduce employee resistance and facilitate successful adoption of the system.

VA SHOULD VALIDATE CONTRACTOR ENERGY BASELINE AND SAVINGS ESTIMATES AND ENSURE PAYMENTS ARE LEGALLY COMPLIANT

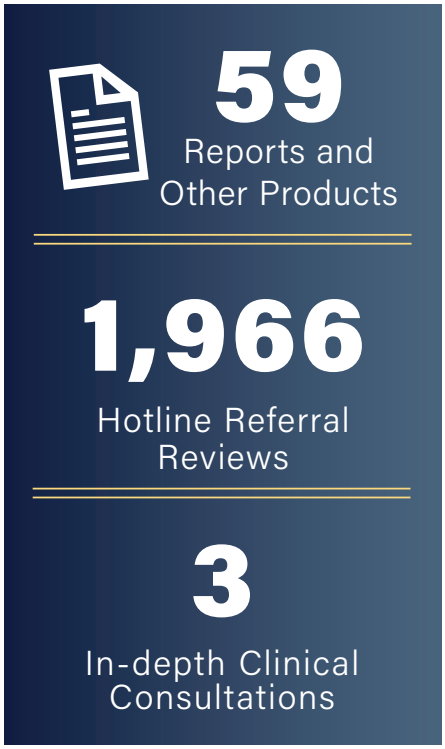
Energy savings performance contracts allow government agencies to implement conservation measures without paying direct capital costs up front. Energy service companies finance the capital costs of these upgrades and are compensated through the energy cost savings received. For VA, the measures help reduce energy or water usage at medical facilities—for example, by installing low-energy lighting and low-flow bathroom fixtures. Estimates of cost savings come from the contractor. Before awarding the work, VA must validate that the estimates are reasonable. If they are overstated, VA may be locked into a payment schedule that exceeds its actual energy savings. The OIG found VA did not independently review contractors' estimated savings calculations at four of 13 medical facilities using energy savings performance contracts due to a lack of effective policies and quality control procedures. The OIG made four recommendations to address these weaknesses.

Highlighted Activities and Findings

VETERAN READINESS AND EMPLOYMENT STAFF IMPROPERLY SENT PARTICIPANTS TO VETERAN EMPLOYMENT THROUGH TECHNOLOGY EDUCATION COURSES

The Veteran Readiness and Employment (VR&E) Service and Veteran Employment Through Technology Education Courses (VET TEC) programs support veterans seeking education or training for employment. However, requirements differ between the two programs, and a waiver is required for VR&E participants to attend VET TEC programs. The OIG conducted this review to assess the allegation that a VET TEC training provider was knowingly enrolling VR&E participants with improper authorizations. Upon review, the allegation was substantiated; 33 of 42 VR&E participants were improperly enrolled to attend VET TEC courses. The OIG considers the $387,000 spent on those courses as improper payments. VR&E staff were not adequately informed about VET TEC and were generally unaware the program could not be used by VR&E participants. VR&E controls also did not prevent participants from being authorized and enrolled in unapproved courses. The OIG made two recommendations to the undersecretary for benefits.

The Office of Healthcare Inspections



OHI remains dedicated to focusing on projects that capitalize on its staff's vast clinical expertise and insight into the unique experiences of our nation's veterans. Through a variety of oversight reports, OHI provides stakeholders with a truly comprehensive understanding of the quality of health care delivered to veterans. These include cyclical healthcare inspections, national-level projects, and other significant efforts. During this reporting period, inspection teams maintained their scrutiny of how leaders' actions affect healthcare delivery. OHI reports have repeatedly provided evidence that frontline personnel's adherence to high quality and patient safety practices are dependent on engaged and proactive leaders.

The office published several reports this period that highlighted failures by those in leadership positions to ensure that basic standards and safeguards are achieved as required. These included leaders failing to report perceived dangerous clinical practices to state licensing boards, to initiate or adequately conduct required quality reviews, and to adhere to hiring policies that prevent unqualified or incompetent healthcare providers from practicing. The report findings demonstrate that VHA's internal oversight structure is broken. When executive leaders themselves bypass basic tenets of safe healthcare practices—as illustrated in the Montana VA Health Care System summary below, in which the former chief of staff provided care to patients for which he was not privileged to provide—efforts to achieve a safe and just culture are significantly undermined.

OHI continues to monitor the progress and performance of VA's largest healthcare initiatives: the implementation of the new electronic medical record system and the provision of care in the community. Persistent challenges in improving the usability of the Oracle-Cerner electronic health record system and its impact on patient safety have been identified in recent reports and influenced VA's decision to delay deployment at all other facilities, with the exception of a March 2024 rollout of the new system at a joint VA-DoD facility in North Chicago, Illinois. The findings have also helped VA identify and redress other issues that can negatively affect how facilities using the new system provide timely access to quality veteran care. As to community care, OHI has repeatedly reported on VHA staff's confusion about and lack of adherence to policies that relate to managing and coordinating services for veterans referred to community providers for needed care. As VHA continues to experience impediments to meeting its recruiting and retention of clinical and support staff, oversight of the administrative and clinical functions associated with community care coordination is critical.

One of OHI's most recognized programs, the Comprehensive Healthcare Inspection Program (CHIP), is being reimagined as the Healthcare Facility Inspections program to be of even greater value to medical facility staff and leaders, as well as other stakeholders. As the final FY 2023 CHIP reports are being published, staff have begun site visits for the new healthcare inspections at VA facilities in preparation for the debut of these revamped reports. These inspections are designed to better assess the culture

of a facility and its influence on the delivery of health care. The upcoming reports are meant to be used as a tool for leaders across the system to proactively address OIG-identified deficiencies and findings.

The office published 59 oversight reports and other products during the six-month reporting period, including four national healthcare reviews; one Care in the Community summary report, 39 CHIP facility, Veterans Integrated Service Network (VISN)-level, and summary reports; 14 reports responsive to OIG hotline complaints; and one management advisory memorandum.[9] The memorandum focused on concerns with facilities not consistently conducting institutional disclosures of adverse events to patients or their personal representatives.

The selection of publications highlighted below reflect the extensive array of findings and recommendations that can have a significant impact on VA programs and processes and ultimately veterans' timely access to quality care that is delivered with compassion and respect. All OHI reports and other products are listed in **table 8** and on the **VA OIG website**.

NATIONAL HEALTHCARE REVIEWS

The five national healthcare reviews published during this reporting period explore issues such as acute sexual assault (nonconsensual sexual contact warranting medical treatment or forensic collection) and alcohol withdrawal. Selected reports are summarized below.

GREATER COMPLIANCE WITH POLICIES NEEDED RELATED TO THE MANAGEMENT OF EMERGENT CARE FOR PATIENTS PRESENTING WITH ACUTE SEXUAL ASSAULT

This review focused on VHA's policy on the management of emergent care for individuals presenting with acute sexual assault. Sexual assault has medical, psychological, and legal consequences. VHA needs to provide emergency care for acute sexual assault at a relatively low frequency compared with other types of emergency care, which makes it challenging to maintain staff's procedural knowledge. The OIG found deficiencies in facilities' staff adherence to requirements to ensure provision of (1) prophylaxis for sexually transmitted infection and pregnancy, (2) psychological counseling, and (3) informed consent. VHA policy establishes requirements for providing safe, quality care. Facility and community resources, as well as jurisdictional requirements, on reporting and evidence collection vary across facilities. Given this variability, many facilities can improve guidance to ensure proper implementation of VHA policy while providing frontline staff with tailored local procedures and accessible resources. The under secretary for health concurred with the OIG's eight recommendations to address deficiencies with practices and improve guidance.

9 The Office of Healthcare Inspections also provided significant support to the Department of State OIG for its *Inspection of the Bureau of Medical Services*, published in December 2023, by detailing two medical professionals for the duration of the inspection.

VETERANS HEALTH ADMINISTRATION NEEDS MORE WRITTEN GUIDANCE TO BETTER MANAGE INPATIENT MANAGEMENT OF ALCOHOL WITHDRAWAL

OHI evaluated national and healthcare system guidance issued by VHA to assess if it addressed inpatient management of alcohol withdrawal. Determining a patient's severity of alcohol withdrawal is critical in facilitating treatment decisions that may prevent the progression of symptoms that could be fatal. Current VHA guidance does not specifically address inpatient management of alcohol withdrawal, which does not fall under any single VHA national program office. The OIG found healthcare systems lacked written guidance related to assessing alcohol withdrawal severity; determining the appropriate level of care; evaluating co-occurring conditions; consulting with substance use disorder experts; and administering pharmacotherapy interventions. The under secretary for health concurred with the OIG's three recommendations to identify a national program office for the oversight of alcohol withdrawal management in inpatient settings; to develop written guidance that includes expectations for determining alcohol withdrawal severity, level of care, and when transfer of care is indicated; and to implement related training for inpatient staff.

HEALTHCARE INSPECTIONS

These for-cause inspections (including those previously referred to as "hotline" inspections) assess allegations pertaining to VA medical care that are made by patients or their families, VA employees, members of Congress, and other stakeholders. Of the 14 healthcare inspections published during the first half of FY 2024, the three summaries below highlight failures in VHA oversight, systems, and processes. Specifically, they focus on the lack of oversight over a facility leader providing care without privileges, scheduling errors in the new electronic health record system that may have contributed to a patient death, and deficiencies in the community care network credentialing process.

CHIEF OF STAFF'S PROVISION OF CARE WITHOUT PRIVILEGES, QUALITY OF CARE DEFICIENCIES, AND LEADERS' FAILURES AT THE MONTANA VA HEALTH CARE SYSTEM IN HELENA

An OHI inspection team assessed allegations that the healthcare system's chief of staff provided pregnancy care without privileges and used deficient care. The inspection also evaluated facility leaders' responses to these identified concerns. The team found that not only did the chief of staff practice without privileges when providing pregnancy care during a patient's second and third trimesters, he also failed to follow evidence-based clinical standards when evaluating the patient for potentially severe pregnancy-related conditions, placing the patient and her fetus at risk. The chief of staff prescribed an inadequate antibiotic and delayed consultation in his postoperative treatment for another patient. He also failed to perform expected preoperative testing for surgical procedures in 32 of 35 cases reviewed. The OIG found deficiencies in leaders' oversight of the chief of staff, including failures to complete required ongoing professional practice evaluations, to follow privileging processes, and to report deficiencies in the chief of staff's care to the state licensing board. VA concurred with the OIG's 10 recommendations related to correcting these deficiencies, ensuring alignment with VHA and facility privileging policies, and reviewing care deficiencies to identify follow-up needs.

SCHEDULING ERROR OF THE NEW ELECTRONIC HEALTH RECORD AND INADEQUATE MENTAL HEALTH CARE AT THE VA CENTRAL OHIO HEALTHCARE SYSTEM IN COLUMBUS CONTRIBUTED TO A PATIENT DEATH

OHI found that an error in the new electronic health record resulted in VA Central Ohio Healthcare System staff's failure to complete minimum scheduling efforts following a missed appointment for a patient who later died by drug overdose. The team determined that for sites using the new electronic health record, VHA required fewer patient contact attempts following missed mental health appointments. A nurse practitioner and psychologist did not comprehensively evaluate and address the patient's mental health needs. A supervisory psychologist did not identify concerns about the patient's mental health and ensure follow-up. Staff failed to send the patient "caring communications" after a "high risk for suicide" patient record flag was deactivated. Facility leaders did not communicate a root cause analysis with a "lesson learned" to staff. The OIG made one recommendation to the deputy secretary to monitor new electronic health record scheduling functionality, two recommendations to the under secretary for health to evaluate minimum scheduling effort requirements and establish lessons learned guidance, and three recommendations to the facility director to review the patient's care and staff's compliance with caring communications protocols.

DEFICIENCIES IN THE COMMUNITY CARE NETWORK CREDENTIALING PROCESS OF A FORMER VA SURGEON AND VETERANS HEALTH ADMINISTRATION OVERSIGHT FAILURES

During a review of a former VA surgeon's eligibility to participate in VA's Community Care Network, the OIG identified multiple failures by the VA Office of Integrated Veteran Care and a third-party administrator that undermined credentialing and oversight processes. The third-party administrator, which is responsible for ensuring all licensed non-VA providers are credentialed, failed to address concerns and inconsistencies in the surgeon's credentialing file. Furthermore, due to a misapplication of privacy rules, the third-party administrator did not release information to VA regarding the surgeon's voluntary relinquishment of their Florida medical license. VA concurred with the OIG's eight recommendations related to reviewing the surgeon's Community Care Network eligibility, contracts, and care provided, as well as the third-party administrator's credentialing decisions for providers.

PROACTIVE, CYCLICAL INSPECTION PROGRAMS

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM

CHIP reviews are an important element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. All CHIP reports are based on inspections that are routinely and proactively performed approximately every three years for each VA medical facility to help consistently examine key conditions and activities. CHIP inspections evaluate specific areas of focus on a rotating basis each year. For the 34 facility-level, four VISN-level, and one summary CHIP reports published during this reporting period, the areas of focus were (1) leadership and organizational risks; (2) quality, safety, and value; (3) medical staff privileging; (4) environment of care; and (5) mental health (suicide prevention initiatives).

CARE IN THE COMMUNITY HEALTHCARE INSPECTION PROGRAM

This program examines key clinical and administrative processes that are associated with providing quality VA and community (non-VA) care, specifically focusing on congestive heart failure management, home dialysis care, mammography services and communication of results, and diagnostic evaluations

following positive screenings for depression and alcohol misuse. OHI published one FY 2022 Care in the Community healthcare inspection summary during this reporting period.

VET CENTER INSPECTION PROGRAM

VCIP reports provide a focused evaluation of the quality of care delivered at vet centers. These centers are community-based clinics that offer critical interventions for psychological and psychosocial readjustment problems related to various types of military service and deployment stressors, such as combat-related trauma and military sexual trauma. Their services are meant to support a successful transition from military to civilian life and are open to eligible veterans, active-duty service members, National Guard members, reservists, and their families. Currently, the VCIP reports' areas of focus are (1) leadership and organizational risks; (2) quality reviews; (3) suicide prevention; (4) consultation, supervision, and training; and (5) environment of care. Several VCIP reports will publish later this year from the multiple site visits conducted in FY 2023.

Listen to a *Veteran Oversight Now* **podcast** in which a VA OIG healthcare inspection hotline director discusses delays in the receipt of patients' colorectal cancer screening tests due to an unpaid postage bill by the Phoenix VA Health Care System in Arizona. (Season 3, Episode 1).

Listen to a *Veteran Oversight Now* **podcast** in which a VA OIG healthcare inspection hotline director discusses how multiple OIG reports detail chronic leadership failures at the Indianapolis, Indiana, VA medical center. (Season 3, Episode 2).

The Office of Management and Administration

15,617
Hotline Contacts

358
Administrative Sanctions and Corrective Actions

43%
Percent of Allegations Substantiated

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations. OMA has been overseeing the execution of the OIG's largest budget to date in FY 2024 at $296 million. Furthermore, OMA's ongoing recruitment and retention efforts, conducted in partnership with all directorates, have contributed to the growth of the office to more than 1,100 employees.

The OIG's commitment to cultivate an environment that fosters diversity, equity, inclusion, and accessibility (DEIA) is carried out under OMA's leadership. This includes increasing the OIG's presence at job and career fairs to attract the highest-quality staff with a range of expertise, lived experience, and perspectives. Staff's administration of the DEIA program ensures continuous advancements in fostering employees' sense of belonging, driving positive cultural changes, and promoting DEIA values across the office.

Also, in collaboration with the General Services Administration and a consulting firm, OMA assessed the OIG's enterprise-wide real estate footprint to ensure its leased space makes efficient use of the budget and meets staff needs. To that end, OMA opened one office, relocated another, closed three locations, and initiated the redesign of another six sites.

Helping to advance organizational efficiency and effectiveness, personnel from OMA's information technology divisions initiated several projects and programs to modernize the OIG's infrastructure and address staff's evolving and complex technology needs. This includes further adoption and use of Microsoft Office 365, development of internal work product tracking and case management systems, increased information security scanning, as well as the research and planning of an upgraded call center software for the Hotline Division, which continued to receive and respond to a high volume of complaints regarding VA programs and services. During this six-month reporting period, hotline staff screened 15,617 contacts from complainants, as well as conducted a wide range of activities such as the following:

- Directed complaints to OIG offices and directorates to determine if cases should be opened or other dispositions taken
- Referred 582 cases to and required a written response from applicable VA offices for OIG review, as appropriate, after determining that allegations pertained to higher-risk topics but insufficient resources were available for OIG staff to complete a prompt independent review at that time
- Made 726 non-case referrals to appropriate VA offices, after determining that the allegations pertained to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated

- Closed 394 cases for which nearly 43 percent of allegations were substantiated, 358 administrative sanctions and corrective actions were taken, and more than $1.8 million in monetary benefits were achieved
- Responded to 592 requests for senior personnel record reviews from VA staff offices prior to promotions, new jobs, and awards
- Issued 469 semicustom complaint responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope

FEATURED HOTLINE CASES

Highlighted below are cases opened by the OIG's hotline that were not included in inspections, audits, investigations, or reviews by other directorates.

ALLEGATIONS OF RESIDENT ABUSE AND HOSTILE WORK ENVIRONMENT AT THE TUCSON VA MEDICAL CENTER'S COMMUNITY LIVING CENTER (CLC) WERE SUBSTANTIATED

Allegations were made to the hotline that residents of the Tucson VA Medical Center's CLC (a VA nursing home) were subjected to systemic verbal and physical abuse by VA staff and contractors, and a hostile work environment prevented some staff from reporting the abuse that could have helped to protect residents. The allegations and supporting evidence were sent to VISN 22—the Desert Pacific Healthcare Network—for review and response. The VISN's fact-finding team conducted staff interviews and reviewed existing records, witness statements, and VA police reports. The team substantiated that verbal abuse and unprofessional conduct occurred, that a hostile work environment did prevent some staff from raising concerns about residents, and that residents had been subjected to inappropriate restraint in the provision of personal care and activities of daily living care. The fact-finding team recommended 14 corrective actions, which the VISN 22 director provided to the medical center director to review, implement, and monitor. The corrective actions included establishing an orientation and continuing training program for CLC staff and retraining managers on responding to and addressing concerns of resident abuse, unprofessional conduct, and bullying in the workplace.

VA CENTRAL WESTERN MASSACHUSETTS HEALTH CARE SYSTEM REVISES LOCAL STANDARD OPERATING PROCEDURE FOR PHARMACY SERVICE IN RESPONSE TO DISCOVERING BAGS OF EXPIRED MEDICATION

The OIG hotline received an allegation that VHA Pharmacy Benefits Management failed to properly manage medication. Specifically, the allegation stated that medication that expired in 2022 was not appropriately updated in the designated pharmacy return program for monetary recoupment at the VA Central Western Massachusetts Health Care System, resulting in a financial loss to VA. The allegation was reviewed and partially substantiated by VISN 1 (the VA New England Healthcare System). In June 2023, investigators discovered tote bags of expired medications in the pharmacy that were awaiting entry into the designated pharmacy return program. While noncompliance with the inventory management section of VHA Directive 1108.07, General Pharmacy Service Requirements, was substantiated, there was a lack of supporting evidence that monetary loss resulted from this mismanagement. Two corrective actions were taken in response to OIG findings: (1) the chief of pharmacy provided proper inventory management training to facility staff and (2) a new section in the VA medical center's Pharmacy Service

standard operating procedure was created to specifically address the proper handling of expired medication returns.

VA EMPLOYEE'S MISHANDLING OF CLASSIFIED MATERIAL RESULTS IN SECURITY VIOLATION

Another complainant alleged that a VA Office of Emergency Management and Resiliency employee mishandled classified documents in a secure facility in August 2023. The matter was referred to the VA Office of Operations, Security, and Preparedness, which investigated and substantiated the allegation. They found that, at the time of the incident, the Office of Emergency Management and Resiliency was transitioning secure facility access controls from using a universal code to individually assigned Personal Identification Numbers (PINs). Personnel were instructed on how to gain access without an individually assigned PIN by using a combination lock during the transition. The security violation occurred when an employee printed a classified document from a secure workspace to the printer room. The employee attempted to recover the document but was unable to unlock the printer room, despite having received instruction on how to do so. The employee took no action to secure the document and left the facility. The classified document remained in the printer room overnight and was found the next morning by a coworker. This constituted a security violation because the printer room is not an authorized classified storage space. As a result, the employee was counseled and received retraining on the handling of classified material.

Statistical Performance

At a Glance: Selected Metrics for the Reporting Period

* Figure includes combined results from the Hotline Division and the Office of Investigations.

Table 1. Monetary Impact and Return on Investment

TYPE	THIS PERIOD
Better Use of Funds	$180,374,106
Dollar Recoveries	$5,823,139
Fines, Penalties, Restitution, and Civil Judgments[10]	$1,140,774,391
Fugitive Felon Program	$50,400,000
Savings and Cost Avoidance	$35,898,627
Questioned Costs	$37,679,787
Total Dollar Impact	**$1,450,950,050**
Cost of OIG Operations[11]	$117,644,541
Return on Investment[12]	**$12:1**

10 This category includes investigations conducted solely by the VA OIG and in partnership with other law enforcement agencies. The amount reported reflects the total monetary recovery to all government entities, nongovernment entities, and private individuals as a result of these investigations. Of the total amount reported for this period, VA received $173,463,744. This amount includes forfeited funds for which VA could submit a petition for remission.

11 The six-month operating cost for OHI ($30,355,459), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

12 The return on investment is calculated by dividing total dollar impact by cost of OIG operations.

Table 2. Reports and Other Products

REPORTS	THIS PERIOD
Administrative Investigations	1
Audits and Reviews	14
Care in the Community Inspections (National-Level)	1
Claim Reviews	0
Comprehensive Healthcare Inspection Program (National-Level)	1
Comprehensive Healthcare Inspection Program (VISN- and Facility-Level)	38
Financial Inspections	2
Healthcare Inspections	14
Information Security Inspections	0
Joint Reviews	0
National Healthcare Reviews	4
Postaward Contract Audits and Reviews*	10
Preaward Contract Audits and Reviews*	27
Special Reviews	0
Vet Center Inspections	0
Subtotal	**112†**
OTHER PRODUCTS	**THIS PERIOD**
Budget Request	1
Congressional Testimonies	4
Crime Alerts	2
Internal Investigation Summaries	0
Issue Statements	0
Major Management Challenges	1
Management Advisory Memoranda	5
Monthly Highlights	6
Peer Reviews Completed of Other OIGs	1
Podcasts	3
Press Releases	1
Whistleblower Reprisal Investigation Memoranda*	0
Subtotal	**24**
Total	**136**

* Denotes products prohibited from public release pursuant to federal law.
† The VA OIG also provided significant support to the Department of State OIG for its *Inspection of the Bureau of Medical Services*, published in December 2023, by detailing two Office of Healthcare Inspections medical professionals for the duration of the inspection.

Table 3. Selected Office of Investigations Activities

TYPE[13]	THIS PERIOD
Arrests[14]	112
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	35
Indictments	91
Indictments and Informations Resulting from Prior Referrals to Authorities	29
Criminal Complaints	22
Convictions	78
Pretrial Diversions and Deferred Prosecutions	7
Case Referrals to DOJ for Criminal Prosecution[15]	157
Case Referrals to State and Local Authorities for Criminal Prosecution[16]	25
Administrative Sanctions and Corrective Actions	101
Cases Opened	178
Cases Closed	183

13 Pursuant to 5 U.S.C § 405(b)(12) (as amended by Pub. L. No. 117-263), all investigative data reported and analyzed were collected via the OIG's case management system. Although 5 U.S.C. § 405(b)(11) requires federal inspectors general to list the total number of investigative reports issued during the reporting period, the VA OIG does not publish or issue investigative reports related to criminal investigations. Reports of noncriminal investigations are disclosed in **table 2**. Summaries of selected criminal cases are in the OIG's **Monthly Highlights**.

14 Total arrests include eight apprehensions of fugitive felons by VA OIG agents. This total does not include fugitive felon arrests made by other agencies with VA OIG assistance.

15 5 U.S.C. §405(b)(11) (as amended by Pub. L. No. 117-263) requires federal inspectors general to report the "total number of persons" referred to federal authorities for criminal prosecution. However, the VA OIG's case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

16 5 U.S.C. §405(b)(11) (as amended by Pub. L. No. 117-263) also requires federal inspectors general to report the "total number of persons" referred to state and local authorities for criminal prosecution. However, the VA OIG's case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

Table 4. Selected Office of Special Reviews Activities

TYPE	THIS PERIOD
Hotline Referral Reviews	118
Investigative Interviews	98
Reviews of Complaints Alleging Whistleblower Reprisal by VA Contractors or Grantees	4
Substantiated Instances of Contractor/Grantee Whistleblower Reprisal	0

Table 5. Selected Office of Healthcare Inspections Activities

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	2
Clinical Consultations to Other Federal Entities	1
Hotline Referrals Reviewed	1,966

Table 6. Selected Hotline Division Activities

TYPE	THIS PERIOD
Contacts	15,617
Cases Opened	582
Cases Closed	394
Administrative Sanctions and Corrective Actions	358
Substantiation of Allegations Percentage Rate	43%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	20
Individuals Provided Office of Special Counsel Contact Information	62
Individuals Provided Merit Systems Protection Board Contact Information	7
Individuals Provided Office of Resolution Management Contact Information	108

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

- Crimes and violations of rules/regulations
- Mismanagement or a gross waste of funds
- Abuse of authority
- Risks to patients, employees, and property

SUBMIT A COMPLAINT

ONLINE: www.vaoig.gov/hotline
FAX: 202.495.5861
MAIL: VA Inspector General Hotline (53H)
810 Vermont Ave, NW
Washington, DC 20420
PHONE: 800.488.8244

SCAN HERE FOR VA OIG HOTLINE

U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Investigations and Reports

The IG Act requires federal inspectors general to provide summaries of significant investigations closed during the reporting period, as well as specific information about the reports they publish and any associated monetary impact.[17] If, however, the office has previously published this information to its **website** or **oversight.gov,** the office may satisfy these reporting requirements by providing links to the relevant information.[18] The tables that follow identify OIG investigations and reports by type and date and include hyperlinks to their respective publications (when available).

Table 7 lists significant investigations with judicial action this period, with hyperlinks that direct readers to the full case summary as published in the VA OIG's **Monthly Highlights**. Although the IG Act only requires that federal inspectors general provide information regarding significant *closed* investigations, table 7 includes judicial actions from significant closed *and open* criminal investigations to provide a more accurate representation of the VA OIG's efforts this reporting period. When applicable, investigations in the table marked with an asterisk (*) indicate those with substantiated allegations of misconduct involving a senior government employee or official; however, the VA OIG has no investigations responsive to this reporting requirement this period.[19]

Table 7. Significant Criminal Investigations with Judicial Actions This Period

DATE	TITLE
VHA INVESTIGATIONS	
CHAMPVA AND OTHER HEALTHCARE FRAUD	
10/4/2023	**Compounding Pharmacy Owner Sentenced to Prison for Role in Fraud Scheme**
10/10/2023	**Medical Imaging Company and Chief Executive Officer Agreed to Pay $85.4 Million to Resolve False Claims Act Allegations**
10/31/2023	**Marketing Company Owner Pleaded Guilty to Role in Scheme Involving Durable Medical Equipment and Cancer Screening Tests**
11/2/2023	**Non-VA Physician Sentenced for Participating in Healthcare Fraud Conspiracy**
11/9/2023	**Former Inventory Management Specialist Sentenced for Purchase Card Fraud Scheme**
11/16/2023	**Three Codefendants Found Guilty in Connection with Multimillion Dollar Healthcare Fraud Scheme**

17 5 U.S.C. § 405(b)(2) and § 405(b)(3) (as amended by Pub. L. No. 117-263).

18 5 U.S.C. § 405(h) (as amended by Pub. L. No. 117-263).

19 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

Table 7. Significant Criminal Investigations with Judicial Actions This Period (Continued)

DATE	TITLE
CHAMPVA AND OTHER HEALTHCARE FRAUD (CONTINUED)	
12/5/2023	Diagnostic Company Agrees to Pay $14.7 Million to Resolve False Claims Act Allegations
12/20/2023	Veteran Charged with Defrauding VA's Foreign Medical Program
1/17/2024	Pharmacist Sentenced in Connection with Compounding Pharmacy Scheme
2/8/2024	Company Owner Pleaded Guilty to Healthcare Fraud Scheme Resulting in $89 Million Loss to Multiple Benefits Programs
2/13/2024	Health Services Company Owner Pleaded Guilty in Connection with Compounding Pharmacy Scheme
2/21/2024	Fourteen Indicted in Connection with Healthcare Fraud Scheme
2/27/2024	Two Health Service Company Owners Sentenced in Connection with Compounding Pharmacy Scheme
VBA INVESTIGATIONS	
EDUCATION BENEFITS FRAUD	
10/5/2023	Civil Complaint Filed Against Barber School and Owner for Defrauding GI Bill Program
11/29/2023	Technical School Employee Sentenced for Role in Education Benefits Fraud Scheme
12/18/2023	Technical School Employee Sentenced for Role in Education Benefits Fraud Scheme
1/30/2024	Barber and Cosmetology School Owner Indicted for Education Benefits Fraud
2/27/2024	Civil Complaint Filed Against For-Profit Schools for False Claims Involving the Post-9/11 GI Bill
THEFT OF GOVERNMENT FUNDS AND FIDUCIARY FRAUD	
10/5/2023	Defendant Sentenced for Stealing VA Benefits Intended for Her Deceased Great Aunt
10/10/2023	Another Former Fiduciary Sentenced for Misappropriating Veteran Inpatient's Funds
10/17/2023	Veteran Indicted for Exaggerating Disabilities to Obtain VA Benefits
10/31/2023	Defendants Sentenced for Theft of VA and Social Security Benefits Intended for Deceased Relative
11/3/2023	Former VA Employee Sentenced for Theft of Government Funds

Table 7. Significant Criminal Investigations with Judicial Actions This Period (Continued)

DATE	TITLE
THEFT OF GOVERNMENT FUNDS AND FIDUCIARY FRAUD (CONTINUED)	
11/29/2023	Deceased Veteran's Spouse Pleaded Guilty to Defrauding VA of Survivor Benefits for Nearly 30 Years
12/5/2023	Four Business Owners Sentenced for Defrauding VA of More than $6 Million
1/3/2024	Defendant Sentenced for Stealing 30 Years' Worth of VA Survivors' Benefits
1/30/2024	Veteran Pleaded Guilty in Connection with Benefits Fraud Scheme
2/14/2024	Individual Charged with Stealing the Identity of a Veteran for Over 20 Years to Fraudulently Obtain VA Benefits
3/11/2024	Veteran Convicted of Making False Statements in Recent Trial Pleaded Guilty to Theft of Government Funds
3/13/2024	Former VA Fiduciary Admitted to Stealing Benefits from Veteran
3/18/2024	Veteran's Sister Admits to Stealing His VA and Social Security Benefits
OTHER INVESTIGATIONS	
BRIBERY AND KICKBACKS	
11/1/2023	Former VBA Benefits Service Representative Indicted on Federal Extortion, Bribery, and Witness Tampering Charges
11/27/2023	Former VA Medical Center Supervisor Sentenced for Role in Bribery Scheme
SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD, WORKERS' COMPENSATION BENEFITS FRAUD, AND GRANT FRAUD	
12/7/2023	Former VA Nurse Practitioner Sentenced for Workers' Compensation Fraud Scheme
2/28/2024	Former Nonprofit Healthcare Employee Indicted for Fraudulently Obtaining VA Suicide Prevention Grant Funds
3/13/2024	Two Nonveterans Pleaded Guilty to $78 Million Rent-A-Vet Construction Fraud Scheme
FRAUD RELATED TO COVID-19	
10/18/2023	Medical Technology Company President Sentenced for Scheme Involving Fraudulent COVID-19 and Allergy Tests
1/30/2024	Defendant Pleaded Guilty to Fraudulently Obtaining Federal Pandemic Relief Loans
2/8/2024	Defendant Pleaded Guilty for Paycheck Protection Act and Economic Injury Disaster Loan Scheme

Table 7. Significant Criminal Investigations with Judicial Actions This Period (Continued)

DATE	TITLE
FRAUD RELATED TO COVID-19 (CONTINUED)	
3/8/2024	Owner of Defunct Business Charged with Fraudulently Obtaining Federal Pandemic Relief Loans
3/13/2024	Two Defendants Charged with Fraudulently Obtaining CARES Act Funds
3/18/2024	Former VA "Agent Cashier" Sentenced for Stealing from Patients and Engaging in Pandemic Assistance Fraud
SEX-RELATED OFFENSES, DRUG DISTRIBUTION, AND CRIMES AGAINST PERSONS	
10/11/2023	VA Employee Charged with Sending Sexually Explicit Content to a Minor
11/1/2023	Two Defendants Sentenced for Conspiring to Distribute Fentanyl at the Bedford, Massachusetts, VA Medical Center
2/9/2024	Veteran Inpatient Charged with Attempted Murder
3/19/2024	Veteran Inpatient Charged with First Degree Murder
THREATS AND ASSAULTS AGAINST VA EMPLOYEES	
1/3/2024	Veteran Charged with Making Threats against the West Haven VA Medical Center
1/4/2024	Another Veteran Charged with Making Threats against the Hines VA Hospital Staff and Local Law Enforcement Officers
1/10/2024	Nonveteran Charged with Making False Statements in Thousands of Phone Calls to VA's Veterans Crisis Line
2/26/2024	Veteran Sentenced for Starting a Fire at the Cleveland VA Medical Center
2/29/2024	Veteran Charged for Threatening to Blow Up Two VA Medical Centers

Table 8 lists VA OIG reports issued this period and indicates, if applicable, the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs) and the dollar value of recommendations that funds be put to better use. The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; are not supported by adequate documentation; or are expended for purposes that are unnecessary or unreasonable under governing authorities. Unsupported costs are a subset of questioned costs and are those determined by the OIG to lack adequate documentation at the time of the audit. Funds put to better use are those that could be used more efficiently if management took actions to implement an OIG recommendation.

Within table 8, reports marked with an asterisk (*) are precluded from public release pursuant to federal law.[20] Those marked with a dagger (†) indicate instances for which the VA OIG did not request or receive a VA management decision during the reporting period.[21] Reports marked with a double dagger (‡) indicate those with substantiated allegations of misconduct involving a senior government employee or official; however, the VA OIG has no investigations responsive to this reporting requirement this period.[22] A key to these symbols is included.

Table 8. Reports Issued This Period

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF AUDITS AND EVALUATIONS				
AUDITS AND REVIEWS				
10/3/2023	**VHA Should Continue to Improve Water Safety and Oversight of Prevention Practices to Minimize the Effects of Legionella**	22-03247-198	—	—
10/19/2023	**VBA Generally Helped Veterans Obtain Damaged or Destroyed Records**	22-03522-209	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

20 Preaward and postaward audits and reviews are submitted only to VA and are not publicly released. These reports contain nonpublic, confidential, and proprietary data relating to the contractors' business and include trade secret information protected from public release by 18 U.S.C. § 1905. Section 1905 provides for criminal penalties for any government employee or contractor who publicly discloses such protected information. Further, the reports are exempt, in whole or in part, from mandatory public disclosure under subparagraphs (b)(3), (b)(4), and (b)(5) of the Freedom of Information Act, 5 U.S.C. § 552. Portions of the reports that pertain to contractor proposals are also protected from disclosure by 41 U.S.C. § 4702. However, to improve transparency, the OIG does publish summaries of these reports. investigations of whistleblower reprisal allegations made by employees of VA contractors or grantees are protected from public release pursuant to 41 U.S.C. § 4712, which prohibits disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not published.

21 5 U.S.C. § 405(b)(5)(B) (as amended by Pub. L. No. 117-263).

22 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
11/16/2023	**Better Coordination Needed to Negotiate Consistent Prices for Prescription Eyeglasses**	21-02984-179	$6,500,000	—
12/12/2023	**Audit of VA's Financial Statements for Fiscal Years 2023 and 2022**	23-00940-18	—	—
12/13/2023	**The Office of Integrated Veteran Care Needs to Improve Community Dialysis Oversight and Develop a Strategy to Align Future Contracts with the MISSION Act**	21-03102-201	—	—
12/13/2023	**Significant Deficiencies Found in VA's Denver Logistics Center Inventory Management Operations and Systems**	22-02739-210	—	—
12/14/2023	**VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds**	22-00410-197	—	—
12/14/2023	**VA Should Validate Contractor Energy Baseline and Savings Estimates and Ensure Payments Are Legally Compliant**	22-02934-208	$68,000,000	—
1/4/2024	**Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA**	23-01690-31	—	—
1/17/2024	**VA Should Enhance Its Oversight to Improve the Accessibility of Websites and Information Technology Systems for Individuals with Disabilities**	22-03909-19	—	—
2/8/2024	**Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk**	21-03255-02	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
2/21/2024	**Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied**	23-00153-41	—	$3,300,000 *($3,300,000 unsupported costs)*
3/20/2024	**VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2024**	22-00879-93	—	—
3/28/2024	**Veteran Readiness and Employment Staff Improperly Sent Participants to Veteran Employment Through Technology Education Courses**	23-00967-64	—	$387,000 *($387,000 unsupported costs)*
FINANCIAL INSPECTIONS				
11/14/2023	**Financial Efficiency Inspection of the VA Augusta Health Care System in Georgia**	23-00821-01	$5,345,550	$6,685,919 *($4,400,000 unsupported costs)*
2/14/2024	**Financial Efficiency Inspection of the VA Memphis Healthcare System in Tennessee**	23-01198-47	$7,200	$20,064,000 *($16,200,000 unsupported costs)*
MANAGEMENT ADVISORY MEMORANDA				
1/9/2024	**End User Concerns with Integrated Financial and Acquisition Management System Training**	23-01287-20	—	—
1/11/2024	**VA's Allocation of Initial PACT Act Funding for the Toxic Exposures Fund**	23-02377-35	—	—
1/30/2024	**Veterans Are Receiving Concurrent Monthly Housing Allowance Payments while Participating in Certain VA Educational Programs**	23-03303-56	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MANAGEMENT ADVISORY MEMORANDA (CONTINUED)				
3/21/2024	**Scheduling Challenges Within the New Electronic Health Record May Affect Future Sites**	23-03295-80	—	—
POSTAWARD CONTRACT AUDITS AND REVIEWS*†				
10/24/2023	**Independent Audit Report of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract**	23-02959-11	—	$299,427
11/21/2023	**Review of Compliance with Sales Reporting and Industrial Funding Fee Requirements Submitted under a Federal Supply Schedule Contract**	21-02998-24	—	$98
11/21/2023	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 Submitted under a Federal Supply Schedule Contract**	22-02705-13	—	$1,425,754
12/6/2023	**Independent Audit Report of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract**	23-02820-36	—	$17,730
1/9/2024	**Independent Audit Report of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract**	23-03340-53	—	$210,742
1/31/2024	**Independent Audit Report on a Subcontractor Proposal for Request for Equitable Adjustment under a VA Contract**	23-02978-68	$348,727	—
2/6/2024	**Independent Audit Report on Subcontractor Proposal for Change Order Request under a VA Contract**	23-03055-76	$58,093	

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS AND REVIEWS* (CONTINUED)				
2/28/2024	**Independent Audit Report of Compliance with a Federal Supply Schedule Contract**	24-00473-79		$15,699
3/8/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 Submitted under a Federal Supply Schedule Contract**	23-00495-101	—	$120,732
3/22/2024	**Independent Audit Report of Compliance with VA Contracts**	23-02762-124	—	$5,152,686
PREAWARD CONTRACT AUDITS AND REVIEWS*†				
10/16/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02526-04	—	—
11/7/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03767-22	—	—
11/17/2023	**Independent Audit Report of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract**	23-02732-25	$1,343,575	—
11/17/2023	**Independent Audit Report of a Product Addition Proposal Submitted under a Federal Supply Schedule Contract**	23-01328-27	$1,694,610	—
11/17/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02534-29	$1,178,997	—
11/24/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03373-23	$935,737	—
11/24/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03254-26	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS*† (CONTINUED)				
12/6/2023	**Independent Audit Report of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract**	23-02731-33	—	—
12/13/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03505-34	—	—
12/14/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03342-39	$3,260,278	—
12/18/2023	**Independent Audit Report of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract**	23-02230-43	$218,651	—
12/28/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00384-40	$2,501,362	—
1/4/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03236-50	$5,067,554	—
1/17/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02527-38	—	—
1/26/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	23-02931-61	—	—
1/31/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03503-58	—	—
1/31/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	23-03339-67	$1,034,676	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS*† (CONTINUED)				
2/5/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00466-66	$1,256,428	—
2/7/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00451-71	$1,172,450	—
2/9/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	23-02902-77	—	—
2/28/204	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01818-89	$1,552,093	—
3/1/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00690-87	$21,316,009	—
3/12/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02719-103	$40,058,440	—
3/12/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00757-105	$2,665,584	—
3/14/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00574-115	$10,842,681	—
3/18/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03610-102	—	—
3/27/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-01120-104	$4,015,409	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF HEALTHCARE INSPECTIONS				
CARE IN THE COMMUNITY INSPECTIONS (NATIONAL-LEVEL)				
11/29/2023	**Care in the Community Summary Report for Fiscal Year 2022**	22-03772-28	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (NATIONAL-LEVEL)				
3/27/2024	**Comprehensive Healthcare Inspection Summary Report: Evaluation of Breast Cancer Surveillance in Veterans Health Administration Facilities**	23-01178-116	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL)				
10/24/2023	**Royal C. Johnson Veterans' Memorial Hospital in Sioux Falls, South Dakota**	23-00006-03	—	—
10/25/2023	**Veterans Health Care System of the Ozarks in Fayetteville, Arkansas**	22-00237-05	—	—
10/26/2023	**James E. Van Zandt VA Medical Center in Altoona, Pennsylvania**	23-00092-12	—	—
11/1/2023	**Mann-Grandstaff VA Medical Center in Spokane, Washington**	22-04135-06	—	—
11/1/2023	**Veterans Integrated Service Network 21: VA Sierra Pacific Network in Pleasant Hill, California**	22-00065-08	—	—
11/2/2023	**Iowa City VA Health Care System in Iowa**	22-02667-09	—	—
11/2/2023	**Veterans Integrated Service Network 16: South Central VA Health Care Network in Ridgeland, Mississippi**	22-00077-14	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL) (CONTINUED)				
11/7/2023	VA Pacific Islands Health Care System in Honolulu, Hawaii	22-00229-15	—	—
11/7/2023	Veterans Integrated Service Network 4: VA Healthcare in Pittsburgh, Pennsylvania	22-00072-16	—	—
11/15/2023	Overton Brooks VA Medical Center in Shreveport, Louisiana	22-00240-17	—	—
12/5/2023	VA Providence Healthcare System in Rhode Island	22-04037-32	—	—
12/19/2023	W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina	23-00004-37	—	—
1/3/2024	Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	22-03165-46	—	—
1/3/2024	Miami VA Healthcare System in Florida	23-00007-45	—	—
1/9/2024	Wilmington VA Medical Center in Delaware	23-00093-51	—	—
1/10/2024	Tomah VA Medical Center in Wisconsin	22-04132-48	—	—
1/23/2024	Veterans Integrated Service Network 22: VA Desert Pacific Healthcare Network in Long Beach, California	22-00057-54	—	—
1/25/2024	VA Caribbean Healthcare System in San Juan, Puerto Rico	23-00100-55	—	—
1/25/2024	Columbia VA Health Care System in South Carolina	23-00009-57	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL) (CONTINUED)				
2/1/2024	**Robert J. Dole VA Medical Center in Wichita, Kansas**	23-00014-65	—	—
2/7/2024	**Ralph H. Johnson VA Medical Center in Charleston, South Carolina**	23-00005-62	—	—
2/8/2024	**Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin**	22-04134-63	—	—
2/13/2024	**Samuel S. Stratton VA Medical Center in Albany, New York**	23-00011-73	—	—
2/20/2024	**Battle Creek VA Medical Center in Michigan**	22-04038-82	—	—
2/22/2024	**Alaska VA Healthcare System in Anchorage**	23-00017-81	—	—
2/22/2024	**James A. Haley Veterans' Hospital in Tampa, Florida**	23-00010-84	—	—
2/27/2024	**Minneapolis VA Health Care System in Minnesota**	23-00018-83	—	—
2/28/2024	**White River Junction VA Medical Center in Vermont**	23-00015-86	—	—
2/29/2024	**Aleda E. Lutz VA Medical Center in Saginaw, Michigan**	22-03166-88	—	—
3/6/2024	**Manchester VA Medical Center in New Hampshire**	22-03157-95	—	—
3/7/2024	**Charles George VA Medical Center in Asheville, North Carolina**	23-00023-96	—	—
3/12/2024	**Central Alabama Veterans Health Care System in Montgomery**	23-00106-94	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS				
3/19/2024	VA Pittsburgh Healthcare System in Pennsylvania	23-00095-107	—	—
3/19/2024	Beckley VA Medical Center in West Virginia	23-00117-108	—	—
3/25/2024	William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin	22-03167-110	—	—
3/26/2024	VA Ann Arbor Healthcare System in Michigan	22-03164-106	—	—
3/26/2024	VA Black Hills Health Care System in Fort Meade, South Dakota	23-00097-113	—	—
3/26/2024	Cheyenne VA Medical Center in Wyoming	23-00122-118	—	—
10/4/2023	Deficiencies in Facility Leaders' Response to Critical Surgical Events at the Michael E. DeBakey VA Medical Center in Houston, Texas	23-00080-227	—	—
10/31/2023	Deficiencies in Quality Management Processes and Delays in the Communication of Test Results and Follow-Up Care at the Phoenix VA Health Care System in Arizona	22-03599-07	—	—
11/14/2023	Delayed Receipt of Patients' Colorectal Cancer Screening Tests at the Phoenix VA Health Care System in Arizona	23-00383-21	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
1/4/2024	**Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures**	22-02294-42	—	—
1/10/2024	**Care Deficiencies and Leaders' Inadequate Reviews of a Patient Who Died at the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis, Tennessee**	23-00777-52	—	—
1/18/2024	**Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, And Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple**	22-04131-49	—	—
2/1/2024	**Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Medical Center in Oklahoma**	23-01325-59	—	—
2/6/2024	**Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena**	22-02975-70	—	—
2/15/2024	**Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas**	22-02113-75	—	—
3/6/2024	**Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia**	22-01315-90	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
3/12/2024	**Deficiencies in Quality of Care at VA Maine Healthcare System in Augusta**	23-00528-92	—	—
3/20/2024	**Inadequacies in Patient Safety Reporting Processes and Alleged Deficient Quality of Care Prior to a Patient's Foot Amputation at the Edward Hines, Jr. VA Hospital in Hines, Illinois**	23-01746-112	—	—
3/21/2024	**Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death**	23-00382-100	—	—
3/21/2024	**Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus**	23-01450-114	—	—
MANAGEMENT ADVISORY MEMORANDUM				
3/13/2024	**Institutional Disclosure Policy Requirements Should Be Clarified**	23-02386-91	—	—
NATIONAL HEALTHCARE REVIEWS				
10/31/2023	**Improvements Needed in Lung Cancer Screening Through Use of Community Care**	22-00416-10	—	—

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
12/12/2023	**Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault**	21-01445-30	—	—
1/4/2024	**Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal**	21-01488-44	—	—
3/14/2024	**Transition to VA Health Care and Utilization of Benefits for Veterans Who Reported Sexual Assault During Military Service**	22-01275-99	—	—
OFFICE OF SPECIAL REVIEWS				
ADMINISTRATIVE INVESTIGATION				
3/20/2024	**Logistics Managers Improperly Allowed Employees to Auction Off Government Property**	23-06147-111	—	—
Total			**$180,374,106**	**$37,679,787** *($24,287,000 unsupported costs)*

* Denotes products prohibited from public release pursuant to federal law.
† Denotes products for which the VA OIG did not request or receive a VA management decision.

Note: Dollar figures may not sum due to rounding.

Unimplemented Recommendations

The IG Act requires federal inspectors general to identify each recommendation made during a prior reporting period for which corrective action has not been completed by the Department, including any potential cost savings associated with the recommendation.[23] Table 9 identifies recommendations made prior to this reporting period that are open (unimplemented) as of March 31, 2024.

Visit the OIG's **Recommendation Dashboard** to track VA's progress in implementing OIG recommendations.

Table 9. Open Recommendations from Prior Reporting Periods

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/28/2018	**VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016**	18-00474-300	1	—
12/13/2018	**Inadequate Governance of the VA Police Program at Medical Facilities**	17-01007-01	1, 4	—
12/17/2019	**Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers**	17-03718-240	1, 7-8	—
4/27/2020	**Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington**	19-09447-136	1, 4	—

23 5 U.S.C. § 405(b)(2) (as amended by Pub. L. 117-263).

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
5/19/2020	Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina	19-08256-124	3	—
9/2/2020	Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources	18-03800-232	1	—
2/10/2021	Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi	20-01036-70	2	—
2/25/2021	Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement	19-07053-51	6, 11	—
3/3/2021	VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors	20-00421-63	1-2, 4-5	—
3/4/2021	Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing	19-06147-50	1-2, 4, 10	$3,700,000
5/25/2021	Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03178-116	5	—
6/10/2021	Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency	20-00541-133	1-4	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/15/2021	Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs	20-01487-142	1-2	$129,709,810
6/16/2021	Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System	19-07719-113	1, 6	$5,400,000
6/29/2021	Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk	20-00345-77	1-3, 5-10	—
7/1/2021	VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules	20-01646-139	1-7	$16,600,000
7/7/2021	Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03185-151	2-6	—
7/13/2021	Adaptive Sports Grants Management Needs Improvement	20-01807-173	3, 6-7	$247,000
8/5/2021	Improvements Still Needed in Processing Military Sexual Trauma Claims	20-00041-163	2	—
8/19/2021	Review of Veterans Health Administration Staffing Models	20-01508-214	1-3	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/9/2021	Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus	20-03465-243	1, 3-4	—
9/14/2021	Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds	21-00263-246	4	—
9/15/2021	Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont	21-00258-230	2	—
9/23/2021	Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors	20-01802-234	2	$20,000,000
9/27/2021	Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened	20-01910-244	1-3	—
9/27/2021	Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina	21-01304-275	5	—
9/29/2021	VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report	20-03407-253	1	—
9/30/2021	Comprehensive Healthcare Inspection of the Miami VA Healthcare System in Florida	21-00268-273	5	—
10/21/2021	Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance	19-06004-225	7	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
10/26/2021	Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico	21-00270-04	10	—
11/8/2021	Audit of VA's Compliance under the DATA Act of 2014	20-04237-09	1, 3-4, 9, 11	—
12/2/2021	VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements	20-00426-02	1	—
12/8/2021	VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services	20-01099-249	3	$341,700,000
12/8/2021	VHA Risks Overpaying Community Care Providers for Evaluation and Management Services	21-01807-251	1	$59,600,000
12/9/2021	Comprehensive Healthcare Inspection of the Fayetteville VA Coastal Health Care System in North Carolina	21-00277-41	3, 6	—
12/15/2021	Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains	19-09592-262	3	—
12/20/2021	MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data	20-03351-08	1	—
12/20/2021	Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers	21-01804-56	4, 6	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/13/2022	VA's Use of the Defense Logistics Agency's Electronic Catalog for Medical Items	20-00552-30	4-5	—
1/20/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020	21-01507-61	1-4, 6-7	—
2/17/2022	First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions	20-03086-70	2-3	—
2/17/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020	21-01506-76	3	—
3/17/2022	Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-00781-108	3	—
3/28/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020	21-01503-112	2-5	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
4/7/2022	Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities	20-00827-126	2, 4	—
4/25/2022	The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule	21-02889-134	1-5	—
5/24/2022	VHA Continues to Face Challenges with Billing Private Insurers for Community Care	21-00846-104	1-3	$805,200,000
5/26/2022	Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York	21-00299-162	8	—
6/1/2022	Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas	21-03305-139	5	—
6/1/2022	Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-03020-168	2	—
6/14/2022	Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore	21-00283-173	7-8	—
6/16/2022	Comprehensive Healthcare Inspection of the Washington DC VA Medical Center	21-00288-175	9	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/22/2022	Mission Accountability Support Tracker Lacked Sufficient Security Controls	21-03080-142	3	—
7/21/2022	Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure	21-02704-135	2-3	—
7/28/2022	VBA Improperly Created Debts When Reducing Veterans' Disability Levels	21-01351-151	1-2, 4	—
8/3/2022	The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring	21-02401-190	3	—
8/3/2022	VA Needs to Improve Governance of Identity, Credential, and Access Management Processes	22-00210-191	2-4	—
8/4/2022	Digital Divide Consults and Devices for VA Video Connect Appointments	21-02668-182	1-2, 5-6, 8	$6,378,000
8/9/2022	The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing	21-01361-192	6	—
9/7/2022	VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims	22-00404-207	3	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/22/2022	Home Improvements and Structural Alterations Program Needs Greater Oversight	21-03906-226	1, 5	$12,676,084
9/22/2022	Inspection of Information Technology Security at the Alexandria VA Medical Center in Louisiana	22-00971-217	4	—
9/27/2022	Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina	21-03203-239	1	—
9/27/2022	Inspection of Information Technology Security at the Harlingen VA Health Care Center in Texas	22-00973-215	5	—
9/28/2022	Buy American Act Compliance Deficiencies at Regional Procurement Office Central	21-02641-229	1-2	—
9/28/2022	Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance	21-00797-248	1-7	—
10/20/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021	22-00811-07	1, 3	—
10/25/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2021	22-00818-03	2	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
10/27/2022	Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative	21-03924-234	1	—
11/3/2022	VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics	21-03777-218	1	—
11/17/2022	Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearms	21-00175-19	1, 3	—
12/8/2022	VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments	21-03063-04	2, 4-5	—
12/13/2022	Comprehensive Healthcare Inspection of the Lexington VA Health Care System in Kentucky	21-03308-24	3-5	—
1/12/2023	Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers	21-03232-37	2-3, 7-8, 11	—
1/18/2023	Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics	22-01836-12	2, 8	—
1/18/2023	Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama	22-01854-13	7	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/19/2023	Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers	21-03231-38	3-6, 10-11, 14-15, 17	—
1/24/2023	Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California	21-03734-32	4, 6	—
1/26/2023	Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison	22-01341-43	5	—
1/31/2023	Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System	21-03864-34	3	—
1/31/2023	Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs	21-01711-50	1-3	—
2/1/2023	Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana	21-02612-53	3	—
2/2/2023	Financial Efficiency Inspection of the VA Palo Alto Health Care System in California	22-01565-29	7, 10	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
2/8/2023	Financial Efficiency Inspection of the Northern Arizona VA Health Care System	22-01721-35	3, 5	—
2/22/2023	Security and Incident Preparedness at VA Medical Facilities	22-03770-49	1-2	—
2/23/2023	Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia	21-03718-47	1-2	—
3/14/2023	Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA	22-02721-77	2-3	—
3/16/2023	Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits	22-01503-65	1-3	—
3/28/2023	Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met	21-01997-69	2, 4	—
4/6/2023	Office of Emergency Management Has Not Deployed a Functional Last-Resort Emergency Communications System	21-03133-48	1-3, 5-6	—
4/26/2023	Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic	21-02805-102	1-3	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
4/27/2023	Comprehensive Healthcare Inspection of the VA Long Beach Healthcare System in California	22-00047-106	3	—
5/9/2023	VHA Can Improve Controls Over Its Use of Supplemental Funds	21-03101-73	3-8	$187,200,000
5/16/2023	Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville	21-03312-114	4, 7	—
5/17/2023	Federal Information Security Modernization Act Audit for Fiscal Year 2022	22-01576-72	1-26	—
5/23/2023	Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System in Prescott	22-00052-121	1-2, 4	—
5/24/2023	Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California	22-00048-120	1-2	—
5/25/2023	Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers	21-03233-122	2, 5-6, 10-14	—
5/25/2023	Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers	21-03269-123	1-2, 4-5, 8-12	—
5/31/2023	Goals Not Met for Implementation of the Beneficiary Travel Self-Service System	21-03598-92	1-2, 4	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/2/2023	**Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2022**	23-00237-124	1-2	—
6/7/2023	**Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania**	22-02960-70	2-4	—
6/7/2023	**Comprehensive Healthcare Inspection of the New Mexico VA Health Care System in Albuquerque**	22-00046-126	1, 3-5, 7	—
6/8/2023	**Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota**	22-02961-71	1, 5, 9-10	—
6/14/2023	**Financial Efficiency Inspection of the VA New York Harbor Healthcare System**	22-02989-103	3-6, 8, 12, 14	$400
6/20/2023	**VA Developed Reporting Metrics for Appeals Modernization Act Decision Reviews but Could Be Clearer on Some Veterans' Wait Times**	22-00488-81	1-2	—
6/21/2023	**Review of Clinical Care Transition from the Department of Defense to the Veterans Health Administration for Service Members with Opioid Use Disorder**	21-02110-138	1-5	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/28/2023	Quality of Care Concerns and the Facility Response Following a Medical Emergency at the VA Southern Nevada Health Care System in Las Vegas	22-02725-132	3	—
6/29/2023	Financial Efficiency Inspection of the VA Philadelphia Healthcare System	22-03503-131	5, 11	—
6/29/2023	Comprehensive Healthcare Inspection of the Phoenix VA Health Care System in Arizona	22-00051-136	4	—
7/11/2023	Inspection of Information Security at the Northern Arizona VA Healthcare System	22-04104-112	1-2, 6-8, 10-11	—
7/18/2023	Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan	22-04099-153	1-2, 7-8	—
7/19/2023	Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff	21-03544-111	3-4	—
8/1/2023	Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York	22-04133-163	4-12	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
8/2/2023	Comprehensive Healthcare Inspection of the Southern Arizona VA Health Care System in Tucson	22-00054-158	1, 6	—
8/3/2023	Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California	22-00231-176	1, 4-5	—
8/8/2023	Concerns with Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina	22-02797-169	1, 3, 7	—
8/9/2023	Comprehensive Healthcare Inspection of the VA Palo Alto Health Care System in California	22-00064-172	2-4	—
8/16/2023	Concern with Veterans Health Administration's Lung Cancer Screening Program Requirements	22-01511-174	2	—
8/23/2023	Additional Measures Would Better Protect Borrowers from Risks Associated with Interest Rate Reduction Refinance Loans	21-01295-149	3-4, 8	—
8/23/2023	Leaders' Failure to Resolve Cardiology Department Challenges at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	22-00029-183	2-4	—
8/24/2023	Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System in California	22-00055-184	1-9	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
8/28/2023	Financial Efficiency Inspection of the VA Milwaukee Healthcare System	22-03768-156	1-5, 8-9	$1,900,000
8/30/2023	VA Should Ensure Veterans' Records in the New Electronic Health System Are Reviewed before Deciding Benefits Claims	22-03806-162	1	—
8/30/2023	Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina	22-01230-185	1-6	—
9/7/2023	Nonadherence to Requirements for Processing Gulf War Illness Claims Led to Premature Decisions	22-02194-152	1, 5	$25,600,000
9/7/2023	VHA Faces Challenges Implementing the Appeals Modernization Act	22-02064-155	1-14	—
9/14/2023	Staff Did Not Limit the Use of Schools and Training Programs That Were Only Approved for the Veteran Readiness and Employment Program	22-02293-188	4-5	$13,000,000
9/14/2023	Comprehensive Healthcare Inspection of the VA Sierra Nevada Health Care System in Reno	22-00230-190	5-6	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/14/2023	A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas	22-00507-211	1-2, 7-9, 11, 14	—
9/19/2023	Comprehensive Healthcare Inspection of the Wilkes-Barre VA Medical Center in Pennsylvania	22-00236-212	1, 4	—
9/19/2023	Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System in Minnesota	22-02666-214	1	—
9/20/2023	Manufacturers Failed to Make Some Drugs Available to Government Agencies at a Discount as Required	22-01624-143	1-8	$28,100,000
9/21/2023	VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement	21-03718-189	1-7	—
9/21/2023	Inspection of Information Security at the VA Beckley Healthcare System in West Virginia	23-00089-144	2-4, 8-9	—
9/22/2023	VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2023	22-00879-196	1	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/22/2023	Comprehensive Healthcare Inspection Program Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities	23-01177-215	1	—
9/25/2023	Improvements Needed for VBA's Claims Automation Project	22-02936-175	1-4	—
9/26/2023	Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans	22-00414-113	1-3	—
9/26/2023	Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania	22-00071-216	2-5, 7	—
9/26/2023	Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth	22-02017-224	1-8, 12-13	—
9/27/2023	VA Should Strengthen Enterprise Cloud Security and Privacy Controls	22-03525-195	1-3	—
9/27/2023	Comprehensive Healthcare Inspection of the VA Northern California Health Care System in Mather	22-00063-220	1-2, 5	—
9/27/2023	Inspection of Information Security at the VA El Paso Healthcare System in Texas	23-01179-204	2, 4-8	—

Table 9. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/28/2023	Review of Veterans Health Administration's Multi-Tiered Patient Safety Program	22-02377-217	2-9	—
9/28/2023	Inspection of Information Security at the VA Dublin Healthcare System in Georgia	23-01138-203	1-3, 5	—
9/29/2023	Comprehensive Healthcare Inspection of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi	22-00074-218	1-6	—
9/29/2023	Comprehensive Healthcare Inspection of the Central Arkansas Veterans Healthcare System in Little Rock	22-00076-222	2, 4-5	—
9/29/2023	Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia	22-02800-225	2-6	—
Total				**$1,657,011,294**

VA Management Decisions

The IG Act requires federal inspectors general to report information regarding any management decision made during the reporting period with respect to any audit, inspection, or evaluation issued during a *previous* reporting period.[24] The VA OIG has no information responsive to this requirement. However, this section identifies instances in which VA management did not concur with VA OIG recommendations made during the current reporting period with additional context provided.

Instances in Which VA Management Did Not Concur with VA OIG Recommendations Issued This Reporting Period

FINANCIAL EFFICIENCY INSPECTION OF THE VA MEMPHIS HEALTHCARE SYSTEM IN TENNESSEE

VA concurred with eight of the OIG's recommendations but did not concur with recommendation 8, which was to develop a plan to align inventory management practices with VHA policy. The executive director agrees that inventory turnover is one method for determining efficiencies within the Pharmacy Service but reported the Pharmacy Benefits Management office provided a quarterly pharmaceutical prime vendor inventory turnover report as a reference. The executive director reported that the healthcare system considers the annual wall-to-wall inventory completed every January as a more comprehensive approach for oversight of pharmaceutical inventory turnover management. The OIG agrees that the annual wall-to-wall inventory is an important part of inventory management but disagrees that the Pharmacy Benefits Management-provided quarterly pharmaceutical prime vendor inventory turnover report is just a reference. VA policy requires the prime vendor inventory turnover report to be reviewed to efficiently manage inventory turnover rates. During the inspection, healthcare system staff stated reviewing the prime vendor inventory turnover report was not part of the current local process. To maintain compliance with all VHA directives and handbooks, the executive director reported the healthcare system uses electronic inventory management software in both the inpatient and outpatient pharmacies for continuous monitoring, setting inventory levels and suggested ordering based upon utilization and local restock levels. However, the OIG received no relevant evidence or supporting documentation by which to evaluate these actions. Beginning on page 45 of the report, appendix D includes the full text of VHA's comments, and the VA OIG's response is on pages 35-36. The OIG stands by this recommendation and considers it open.

VA SHOULD VALIDATE CONTRACTOR ENERGY BASELINE AND SAVINGS ESTIMATES AND ENSURE PAYMENTS ARE LEGALLY COMPLIANT

VHA concurred with two recommendations and the Office of Asset Enterprise Management (OAEM) concurred with one recommendation, but did not concur with recommendation 2, which was to issue payments criteria that aligns with federal law and guidance. OAEM disputes that the $68 million in prepayments exceeded amounts allowable under federal law and the Department of Energy's Federal Energy Management Program guidance. They also dispute incorporating the findings and

24 5 U.S.C. § 405(b)(6) (as amended by Pub. L. 117-263).

recommendations into VA policy because it believes doing so would conflict with legal advice received from VA's Office of General Counsel (OGC). The OIG stands by its conclusion that the prepayments did not comply with 42 U.S.C. § 8287 and the Department of Energy's Federal Energy Management Program guidance. This guidance did not expand the limits to annual aggregate payments that the OIG contends VA exceeded, and the prepayments therefore fall outside the law. In fact, the memorandum specifically states that "The ESPC [Energy Savings Performance Contract] authority as amended, still limits aggregate annual payments under an ESPC to no more than the amount that the agency would have paid for utilities without an ESPC." Beginning on page 28 of the report, appendix C includes the full text of OAEM's comments. The VA OIG's legal opinion, prepared in response to VA's nonconcurrence with recommendation 2, can be found in appendix E, which begins on page 34. The OIG stands by this recommendation and considers it open.

Visit the OIG's **Recommendation Dashboard** to track VA's progress in implementing OIG recommendations.

Other Disclosures

OIG Reviews of Proposed Legislation and Regulations

Inspectors general are required by the IG Act to review existing and proposed legislation and regulations relating to VA programs and operations and to make recommendations, including in the *Semiannual Report to Congress,* concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA.[25] During this reporting period, the OIG reviewed 24 legislative or regulatory proposals and made three comments. The OIG also reviewed 27 internal VA directives and handbooks that guide the work of VA employees and provided no comments.

Refusals to Provide Information or Assistance to the OIG

The IG Act authorizes the OIG to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the Act. When such information or assistance is unreasonably refused or not provided, an inspector general is required to report that to the head of the agency. All federal OIGs are required by the IG Act to provide a summary of each such report.[26] The VA OIG reports no such instances occurring during this reporting period.

Instances of the OIG Exercising Testimonial Subpoena Authority

The VA OIG is authorized by the Strengthening Oversight for Veterans Act of 2021 to require by subpoena the attendance and testimony of witnesses as necessary in the performance of its functions.[27] The act also requires the VA OIG to disclose certain information in its semiannual report to Congress about its use of this authority. The OIG did not serve any testimonial subpoenas during this reporting period. Staff interviewed one individual pursuant to a testimonial subpoena served during the prior period. The US Attorney General did not object to any proposed subpoenas. The inspector general has not encountered any challenges or concerns exercising the authority. There are no other matters to report.

25 5 U.S.C. § 405(a)(2) (as amended by Pub. L. No. 117-263).

26 5 U.S.C. § 405(b)(15)(B) (as amended by Pub. L. No. 117-263).

27 Pub. L. No. 117-136 § 2(a).

Attempts to Interfere with the Independence of the Office of Inspector General

The IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information.[28] The VA OIG reports no such instances occurring during this reporting period.

Instances of Whistleblower Retaliation

Inspectors general are required by the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers as well as any consequences imposed by the Department to hold those officials accountable.[29] The VA OIG's current practice is to refer VA employees alleging whistleblower reprisal to either the VA Office of Accountability and Whistleblower Protection or the US Office of Special Counsel, as each of those offices has specific statutory authority to address reprisal claims that the OIG does not. Therefore, the VA OIG has no information responsive to this reporting requirement.

The VA OIG does however investigate allegations of whistleblower reprisal made by employees of VA contractors or grantees.[30] Federal law prohibits inspectors general from disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not publicly released. In the spirit of transparency, the VA OIG can report that it reviewed four complaints of alleged whistleblower reprisal by VA contractors or grantees during this reporting period, and did not substantiate any of the allegations. Consistent with the statutory requirements for these cases, the OIG refers the findings of completed investigations to the VA Secretary, who is responsible for granting or denying relief to the complainant.[31]

Allegations and Investigations Relating to Human Trafficking

The Trafficking Victims Prevention and Protection Reauthorization Act of 2022 requires federal employees to report any suspected cases of misconduct, waste, fraud, or abuse relating to trafficking in persons to their agency and their agency's inspector general. The act further requires inspectors general to report at least annually on the number of allegations received that pertain to human trafficking as well as information on any investigations that may have resulted and any recommended actions to improve the agency's or department's programs and operations. During this reporting period, the OIG received 22 allegations involving suspected violations related to human trafficking, of which four had a nexus to VA. The OIG is actively investigating one case and declined to investigate the remaining three cases. The OIG did not close any investigations pertaining to this reporting requirement. The VA OIG made no recommendations to improve VA programs and operations pursuant to this information.

28 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

29 5 U.S.C. § 405(b)(14)(A) and §405(b)(14)(B) (as amended by Pub. L. No. 117-263).

30 41 U.S.C. § 4712 (b)(2).

31 41 U.S.C. § 4712(c).

Closed Work Not Disclosed to the Public

The VA OIG is required by the IG Act to provide detailed descriptions of the particular circumstances of each inspection, evaluation, or audit, or any investigation involving a senior government employee, conducted by the OIG that is closed and was not disclosed to the public.[32] The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure by law or regulation; therefore, the VA OIG has no information responsive to this reporting requirement.

When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the US Office of Special Counsel, the OIG may close its own investigation. During this reporting period, OI closed two criminal investigations with unsubstantiated allegations against senior government employees:

- The OIG received a hotline allegation that a senior VHA executive appeared to have a conflict of interest with a VA contractor by whom he was previously employed. The complainant did not provide any information regarding any official acts that the senior executive might have taken to benefit his former employer, and during the course of its investigative efforts, the OIG did not identify any official acts taken by the senior executive that pertained to the former employer. A VA OGC attorney had previously determined that there were no conflicts of interest when reviewing the senior executive's financial disclosure statement, and the OIG found that on multiple occasions the senior executive contacted OGC to obtain ethics guidance regarding his former employer. Having identified no criminal conduct or administrative violations, the OIG did not refer this matter to the DOJ.
- The OIG received a complaint that the chief of dental service for a VA medical center was married to an employee of a dental laboratory that was also a VA contractor. The complaint alleged that the chief referred all denture and implant repair orders to their spouse's employer while also needlessly ordering new sets of dentures for the same veterans from a different VA contractor. The complainant alleged that the chief received kickbacks for these unnecessary orders. The OIG's investigative efforts confirmed that the chief's spouse was employed by this particular dental laboratory. The chief did not report the spouse's income on their annual confidential financial disclosure reports for three recent years, did not consult with OGC regarding a possible conflict of interest, and did not report the spouse's employment status to their supervisor. During an interview, the chief stated that they selected their spouse's dental laboratory to be a VA contractor from a list of prospective bidders with redacted names. The chief denied sending more repair orders to their spouse's employer than to other VA contractors. The OIG was not able to substantiate the claim that the chief was ordering unnecessary sets of dentures or receiving any kickbacks. The OIG was also unable to substantiate that the chief placed more orders with their spouse's employer than with other VA contractors. The DOJ declined this case for criminal prosecution due to a lack of evidence. The medical center director issued a written counseling to the chief.

32 5 U.S.C. § 405(b)(16)(A) and § 405(b)(16)(B) (as amended by Pub. L. No. 117-263).

Peer and Qualitative Assessment Reviews

The IG Act, as amended by the Dodd–Frank Wall Street Reform and Consumer Protection Act, requires inspectors general to report the results of any peer review of its operations conducted by another office of inspector general during the reporting period or identify the date of the last peer review conducted by another office of inspector general, in addition to any outstanding recommendations that have not been fully implemented.[33] This information is presented in table 10. The VA OIG's offices of Investigations, Special Reviews, Audits and Evaluations, and Healthcare Inspections are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by these offices meets the applicable requirements and standards.

The IG Act also requires inspectors general to report the results of any peer review they completed of another office of inspector general's audit operations during the reporting period, as well as any outstanding recommendations that have not been fully implemented from any peer review completed during or prior to the reporting period.[34] This information is presented in table 11. If the VA OIG did not complete any peer reviews of another office this period, then the table lists the most recent peer review completed.

TABLE 10. MOST RECENT PEER REVIEWS CONDUCTED OF THE VA OIG

DATE COMPLETED	TYPE	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
4/26/2022	Audits	DOJ	Pass	None
9/22/2023	Inspections and Evaluations	Department of Interior	Pass	None
12/10/2018*	Investigations	National Aeronautics and Space Administration	Pass	None

* During the COVID-19 pandemic, the Council of the Inspectors General on Integrity and Efficiency paused the peer review program. The program has since resumed, and the VA OIG Office of Investigations is scheduled to undergo a peer review in late 2024.

TABLE 11. MOST RECENT PEER REVIEWS COMPLETED BY THE VA OIG

DATE COMPLETED	TYPE	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
9/14/2021	Audits	US Postal Service	Pass	None
9/14/2021	Inspections and Evaluations	DoD	Pass	None
11/21/2023	Investigations	Federal Deposit Insurance Corporation	Pass	None

33 5 U.S.C. § 405(b)(8)(A), § 405(b)(8)(B), and § 405(b)(9) (as amended by Pub. L. No. 117-263).

34 5 U.S.C. § 405(b)(10) (as amended by Pub. L. No. 117-263).

Awards and Recognition

Employee Recognition of Military Personnel

The inspector general and staff extend their thanks to the OIG employees listed below who are on or have returned from active military duty:

- Matthew Clark, an auditor in Dallas, Texas, was activated by the US Army in February 2022.
- Dillon Fishman, a criminal investigator in Washington, DC, was activated by the US Marine Corps in October 2023.
- Jose Flores, an auditor in Washington, DC, was activated by the US Air Force in October 2023.
- Abraham Raymond, a special agent in Bedford, Massachusetts, was activated for approximately one month by the US Air Force in October 2023 and again in January 2024.
- Ricardo Wallace-Jimenez, a special agent in Spokane, Washington, was activated by the Washington Air National Guard in October 2023.

Presidential Rank Award Recipient

Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, was awarded the 2023 Presidential Rank Award for Meritorious Executive. This prestigious honor, given by the President of the United States, recognizes a select few Senior Executive Service (SES) leaders for a sustained record of exceptional professional, technical, or scientific achievement. Only 5 percent of career SES in the federal government receive a nomination.

As the Deputy Assistant Inspector General for Audits and Evaluations' Headquarters Operations, Mr. Arronte oversees the work of auditors, inspectors, and management analysts across 10 divisions to report on the performance and accountability of VBA and the National Cemetery Administration. VBA had an annual budget of over $167 billion in FY 2023 alone and provides critical compensation and services to veterans, their families, and caregivers in the areas of disability and pension benefits, fiduciary management, education and vocational rehabilitation, home loan guaranty, and insurance.

Between 2016 and 2022, Mr. Arronte frequently testified at congressional hearings and was instrumental in making recommendations to VBA that carried $1.5 billion in monetary benefits. His dedicated work bolstered the passage of legislation that expanded benefits to about five million veterans impacted by toxic exposure to burn pits and contaminated water. He also led teams that revealed the mishandling of benefit claims to vulnerable veterans, such as those with amyotrophic lateral sclerosis (ALS) and posttraumatic stress disorder related to military sexual trauma. Under Mr. Arronte's leadership, the VA OIG identified the remains of more than 400 veterans who had not received burials. His work

continues to drive meaningful advances within the National Cemetery Administration to ensure veterans' remains are treated with dignity.

A first-generation college graduate from rural Arizona and a US Army veteran, Mr. Arronte went on to complete a master's degree in public administration and multiple leadership certificate programs. He was appointed to his current position at the VA OIG in August 2015. He has more than 18 years of inspection and audit experience.

OIG Investigations Recognized by FBI and US Attorney's Offices

Deputy Assistant Inspector General for Investigations (DAIGI) Colin Davis and Executive Special Agent in Charge (ESAC) Keith Vereb received an Outstanding Criminal Investigation award from FBI Director Christopher Wray at the 31st Annual Director's Award for Excellence. DAIGI Davis and ESAC Vereb were recognized for their efforts toward the criminal prosecution of Reta Mays for murder. In July 2020, Reta Mays, a former VA nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, admitted to killing seven veterans, and attempting to kill an eighth, via the administration of insulin. Mays was sentenced in May 2021 to seven consecutive life sentences plus 20 years.

Special Agent (SA) Tiana Fohne, SA Siobhan Wells, Senior SA Jason Grussendorf, Senior SA Darrell Zorn, and Special Agent in Charge Katie O'Neil received the DOJ Assistant Attorney General's 2023 Beatrice "Bea" Rosenberg Memorial Award for Innovative Work in Criminal Justice. This award recognized the team for their contributions to the DOJ's efforts in using data analytics to combat fraud related to the Post-9/11 GI Bill.

SA Kathleen Bernhardt, Forensic Accountant Annie Li, and former SA Ray White were nominated by US Attorney Mark A. Totten, Western District of Michigan, for the Executive Office for United States Attorneys Director's Award for Superior Performance by a Litigative Team for demonstrating outstanding effectiveness, teamwork, and ingenuity. The case involved an interstate scheme to steal and divert diabetic test strips from the Battle Creek VA Medical Center in Michigan. The team prosecuted and secured criminal convictions and civil settlements in *U.S. v. Steven Anderson* and *U.S. v. Jennifer Robertson, et al.* that included possession, transportation, and trafficking of stolen medical products in violation of the Strengthening and Focusing Enforcement to Deter Organized Stealing and Enhance Safety (SAFE DOSES) Act (18 U.S.C. § 670). The team also made innovative and effective use of an infrequently litigated statute that permits the government to charge theft crimes against people who divert properties used in sting operations. In total, the defendants were sentenced to approximately 106 months' incarceration and $1.7 million in restitution, fines, and civil penalties or settlements.

Appendix: Reporting Requirements

As Required by the IG Act (5 U.S.C. § 405(b))

§ 404. DUTIES AND RESPONSIBILITIES

(a) It shall be the duty and responsibility of each Inspector General, with respect to the establishment within which his Office is established—

(2) to review existing and proposed legislation and regulations relating to programs and operations of such establishment and to make recommendations, including in the semiannual reports required by section 5(a), concerning the impact of such legislation or regulations on the economy and efficiency in the administration of programs and operations administered or financed by such establishment or the prevention and detection of fraud and abuse in such programs and operations;

See Other Disclosures

§ 405. REPORTS

(b) Each Inspector General shall, not later than April 30 and October 31 of each year, prepare semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to—

(1) a description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of such establishment and associated reports and recommendations for corrective action made by the Office;

See Investigations and Reports

(2) an identification of each recommendation made before the reporting period, for which corrective action has not been completed, including the potential cost savings associated with the recommendation;

See Unimplemented Recommendations

(3) a summary of significant investigations closed during the reporting period;

See Investigations and Reports

(4) an identification of the total number of convictions during the reporting period resulting from investigations;

See Statistical Performance

(5) information regarding each audit, inspection, or evaluation report issued during the reporting period, including—

(A) a listing of each audit, inspection, or evaluation;

Appendix: Reporting Requirements

(B) if applicable, the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs) and the dollar value of recommendations that funds be put to better use, including whether a management decision has been made by the end of the reporting period;

See Investigations and Reports

(6) information regarding any management decision made during the reporting period with respect to any audit, inspection, or evaluation issued during a previous reporting period;

See VA Management Nonconcurrences

(7) the information described under section 804(b) of the Federal Financial Management Improvement Act of 1996;

See Investigations and Reports (October–March issue only)

(8)(A) an appendix containing the results of any peer review conducted by another Office of Inspector General during the reporting period; or

(B) if no peer review was conducted within that reporting period, a statement identifying the date of the last peer review conducted by another Office of Inspector General;

See Other Disclosures

(9) a list of any outstanding recommendations from any peer review conducted by another Office of Inspector General that have not been fully implemented, including a statement describing the status of the implementation and why implementation is not complete;

See Other Disclosures

(10) a list of any peer reviews conducted by the Inspector General of another Office of the Inspector General during the reporting period, including a list of any outstanding recommendations made from any previous peer review (including any peer review conducted before the reporting period) that remain outstanding or have not been fully implemented;

See Other Disclosures

(11) statistical tables showing—

(A) the total number of investigative reports issued during the reporting period;

(B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period;

(C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and

(D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities;

See Statistical Performance

(12) a description of the metrics used for developing the data for the statistical tables under paragraph (17)[35];

See Statistical Performance

(13) a report on each investigation conducted by the Office where allegations of misconduct were substantiated involving a senior Government employee or senior official (as defined by the Office) if the establishment does not have senior Government employees, which shall include—

(A) the name of the senior Government employee, if already made public by the Office; and

(B) a detailed description of—

(i) the facts and circumstances of the investigation; and

(ii) the status and disposition of the matter, including—

(I) if the matter was referred to the Department of Justice, the date of the referral; and

(II) if the Department of Justice declined the referral, the date of the declination;

See Investigations and Reports

(14)(A) a detailed description of any instance of whistleblower retaliation, including information about the official found to have engaged in retaliation; and

(B) what, if any, consequences the establishment actually imposed to hold the official described in subparagraph (A) accountable;

See Other Disclosures

(15) information related to interference by the establishment, including—

(A) a detailed description of any attempt by the establishment to interfere with the independence of the Office, including—

(i) with budget constraints designed to limit the capabilities of the Office; and

(ii) incidents where the establishment has resisted or objected to oversight activities of the Office or restricted or significantly delayed access to information, including the justification of the establishment for such action; and

(B) a summary of each report made to the head of the establishment under section 6(c)(2) during the reporting period;

See Other Disclosures

(16) detailed descriptions of the particular circumstances of each—

(A) inspection, evaluation, and audit conducted by the Office that is closed and was not disclosed to the public; and

35 As so in original. Probably should be (11).

(B) investigation conducted by the Office involving a senior Government employee that is closed and was not disclosed to the public.

See Other Disclosures

(h) if an Office has published any portion of the report or information required under subsection (a) to the website of the Office or on **oversight.gov**, the Office may elect to provide links to the relevant webpage or website in the report of the Office under subsection (a) in lieu of including the information in that report.

As Required by the Strengthening Oversight for Veterans Act of 2021 (38 U.S.C. § 312(d))

§ 2. TESTIMONIAL SUBPOENA AUTHORITY OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF VETERANS AFFAIRS

(6)(A) Along with each semiannual report submitted by the Inspector General pursuant to section 5(b) of the Inspector General Act of 1978 (5 U.S.C. § 405(b)), the Inspector General shall include a report on the exercise of the authority provided by 38 U.S.C. § 312(d)(1).

(B) Time period. Each report submitted under subparagraph (A) shall include, for the most recently completed six-month period, the following:

(i) The number of testimonial subpoenas issued and the number of individuals interviewed pursuant to such subpoenas.

(ii) The number of proposed testimonial subpoenas with respect to which the Attorney General objected under paragraph (3)(B).

(iii) A discussion of any challenges or concerns that the Inspector General has encountered exercising the authority provided by paragraph (1).

(iv) Such other matters as the Inspector General considers appropriate.

See Other Disclosures

Appendix: Reporting Requirements

Definitions

As defined in the IG Act:

Questioned cost means a cost that is questioned by the Office because of—

(A) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds;

(B) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or

(C) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable;

Unsupported cost means a cost that is questioned by the Office because the Office found that, at the time of the audit, such cost is not supported by adequate documentation;

Disallowed cost means a questioned cost that management, in a management decision, has sustained or agreed should not be charged to the Government;

Recommendation that funds be put to better use means a recommendation by the Office that funds could be used more efficiently if management of an establishment took actions to implement and complete the recommendation, including—

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

(C) withdrawal of interest subsidy costs on loans or loan guarantees, insurance, or bonds;

(D) costs not incurred by implementing recommended improvements related to the operations of the establishment, a contractor or grantee;

(E) avoidance of unnecessary expenditures noted in preaward reviews of contract or grant agreements; or

(F) any other savings which are specifically identified;

Management decision means the evaluation by the management of an establishment of the findings and recommendations included in an audit report and the issuance of a final decision by management concerning its response to such findings and recommendations, including actions concluded to be necessary;

Final action means—

(A) the completion of all actions that the management of an establishment has concluded, in its management decision, are necessary with respect to the findings and recommendations included in an audit report; and

(B) in the event that the management of an establishment concludes no action is necessary, final action occurs when a management decision has been made; and

Appendix: Reporting Requirements

Senior government employee means—

(A) an officer or employee in the executive branch (including a special Government employee as defined in section 202 of title 18, United States Code) who occupies a position classified at or above GS–15 of the General Schedule or, in the case of positions not under the General Schedule, for which the rate of basic pay is equal to or greater than 120 percent of the minimum rate of basic pay payable for GS–15 of the General Schedule; and

(B) any commissioned officer in the Armed Forces in pay grades O–6 and above.

Stay Engaged

Report Misconduct to the OIG Hotline

Visit the OIG Website

Subscribe to Email Alerts

Read Highlights of OIG Work

Explore Career Opportunities

Listen to Podcasts

Connect on LinkedIn

Follow the OIG on X (Twitter)

Other Resources

Strategic Plan

VA's Major Management Challenges

45 YEARS
IMPACTFUL OVERSIGHT

SCAN HERE FOR
VA OIG HOTLINE

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

Website: www.vaoig.gov
Fax: 202.495.5861
VA Inspector General Hotline (53H)
810 Vermont Avenue, NW, Washington, DC 20420

ISSUE 91 | OCTOBER 1, 2023–MARCH 31, 2024