JUNE 2024 HIGHLIGHTS

Congressional Testimony

Inspector General Testifies on VA's Improper Decision to Award VA Central Office Executives Millions in Incentives

Inspector General (IG) Michael Missal's June 4 testimony before the House Committee on Veterans' Affairs (HVAC) focused on an OIG oversight report that found VA improperly awarded $10.8 million in critical skills incentives to VA central office executives in August and September 2023. The IG stated that VA's actions to make a blanket award of these incentives to 182 VACO senior executives was inconsistent with the PACT Act, which authorizes these incentives for VA employees who possess "a high-demand skill or skill that is at a shortage."[1] Because VA's internal controls were ineffective in preventing these improper awards, the IG's testimony discussed several recommendations for corrective action, including clarifying roles and responsibilities for vetting award justifications and ensuring that VA's Office of General Counsel reviews the implementation of any new legislation that has the potential for substantial financial or reputational risk. The IG's written statement can be found on the OIG website, and the hearing can be viewed on the committee website.

Director of the Compensation Programs Inspection Division Testifies on VBA's Contract Medical Disability Exam Program

Stephen Bracci, director of the Compensation Programs Division in the OIG's Office of Audits and Evaluations, testified before the HVAC on June 13. Mr. Bracci's testimony highlighted a May 2024 OIG report that examined VA's oversight of its contracts for medical disability exams used when deciding veterans' compensation and pension claims. He noted that VA was not ensuring the contractors performed effective oversight of subcontracted exam facilities, many of which were found to have deficiencies in accessibility, safety, and cleanliness. Of the 135 facilities the OIG inspected, 114 had deficiencies that constituted noncompliance with the Americans with Disabilities Act and/or Occupational Safety and Health Administration standards. Mr. Bracci pointed out that VA's lack of oversight can lead to veterans being directed to exam locations that they cannot access. In response to questions, he provided the example that some veterans using wheelchairs were sent for hearing exams to locations that did not have accessible audio booths. This resulted in several veterans being injured trying to use the booth. Other veterans were turned away, which created an additional travel and rescheduling burden and also delayed the processing for some disability claims. Visit the congressional relations

[1] The full name of the law is the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Pub. L. No. 117-168, 136 Stat. 1759.

section of the OIG website to read Mr. Bracci's written statement to Congress. Watch the entire hearing on the committee website.

Principal Deputy Assistant Inspector General for Healthcare Inspections Testifies on Oversight by Veterans Integrated Service Networks

Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for Healthcare Inspections, was a witness before the HVAC Subcommittee on Health on June 26. She emphasized that the OIG repeatedly found inadequate oversight by the leadership of VA's Veteran Integrated Service Networks (VISNs) that oversee medical facilities within their respective regions. Her testimony drew attention to OIG reports highlighting inconsistent practices across the 18 VISNs and inefficiencies that run counter to the Veterans Health Administration (VHA) initiative to transform into a high reliability organization. These failures allowed toxic cultures for staff and patient safety risks in medical centers to persist. She called for standardization and clarification of the roles and responsibilities for VISN leaders to better support and hold accountable VA medical facilities. Dr. Kroviak's written statement to Congress can be found on the OIG website. The full hearing can be viewed on the committee website.

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 following investigations had significant developments in June.

Healthcare Investigations

Pharmacy Owners Sentenced for Paying Illegal Kickbacks in Connection with Healthcare Fraud Scheme

A multiagency investigation resulted in charges alleging that numerous defendants participated in a scheme to defraud federal healthcare programs by billing over $75 million for expensive compounded medications. 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 VA is approximately $3.3 million. The owner of several compounding pharmacies was sentenced in the Northern District of Texas to 52 months in prison and 36 months of supervised release after being found guilty at trial for paying unlawful kickbacks and conspiracy to launder monetary

instruments. Another owner of several compounding pharmacies was sentenced in the Northern District of Texas to 24 months in prison and 12 months of supervised release after pleading guilty to the payment of kickbacks and conspiracy to defraud the United States. The defendants were also ordered to jointly pay over $59.8 million in restitution with several others convicted in connection with this case. The investigation was conducted by the VA OIG, Defense Criminal Investigative Service, FBI, Department of Health and Human Services OIG, and Department of Labor (DOL) OIG.

Call Center Owner Sentenced for Role in Multimillion-Dollar Kickback Scheme

According to another multiagency investigation, numerous defendants allegedly participated in a healthcare fraud scheme in which telemarketers solicited durable medical equipment and cancer screening tests to prospective patients. Telemedicine doctors with whom the patients did not have an existing relationship wrote the resulting prescription orders. Many of the target companies identified in the scheme billed VA's Civilian Health and Medical Program (CHAMPVA). The total loss to federal and private healthcare benefit programs is approximately $11 million. The total loss to VA is approximately $330,000. One defendant—the owner of multiple marketing call centers—was sentenced in the District of New Jersey to 96 months in prison and 36 months of supervised release after pleading guilty to conspiracy to commit healthcare fraud and conspiracy to defraud the United States in connection with a scheme to violate the Anti-Kickback Statute. This investigation was conducted by the VA OIG, FBI, Defense Criminal Investigative Service, and Department of Health and Human Services OIG.

Former VA Registered Nurse Pleaded Guilty to Drug Diversion

A VA OIG investigation revealed that a former registered nurse at the West Haven VA Medical Center in Connecticut diverted controlled substances intended for the facility's intensive care unit patients approximately three times a week during a six-month period. To cover up her crimes, she misrepresented in VA medical records and tracking systems that she administered the narcotics to the patient or properly disposed of the remaining portion that was not used. The former nurse pleaded guilty in the District of Connecticut to obtaining a controlled substance by fraud, deception, or subterfuge.

Benefits Investigations

School Owner and Certifying Official Admitted to Defrauding VA's Post-9/11 GI Bill Program

The owner of a non-college-degree school and its certifying official conspired to submit fraudulent information to conceal the entity's noncompliance with the rules and regulations of the Post-9/11 GI Bill program. In response to an inspector general subpoena, the owner and certifying official provided fraudulent information, including falsified contracts and rosters.

Between September 2012 and August 2018, VA paid over $17.8 million to the school, which subsequently withdrew from the Post-9/11 GI Bill program. The defendants pleaded guilty in the District of New Hampshire to conspiracy to commit a false statement. The VA OIG conducted the investigation.

Veteran and Spouse Indicted for Compensation Benefits Fraud Scheme

A multiagency investigation resulted in charges alleging that a veteran and his wife submitted falsified documents to VA, claiming that the veteran required constant medical care, suffered from posttraumatic stress disorder, and experienced the loss of the use of his feet. It is alleged, however, that the veteran can walk without assistance. The total loss to the government is almost $998,000, including an $820,000 loss to VA. The veteran and his spouse were indicted in the Eastern District of Virginia on charges of conspiracy to defraud the government, false statements, and false statements related to healthcare matters. This investigation was conducted by the VA OIG, Social Security Administration (SSA) OIG, and FBI.

Veteran Found Guilty for Lying about Being a Paraplegic to Receive Disability Benefits

A VA OIG and SSA OIG investigation resulted in charges alleging a veteran fraudulently obtained VA and SSA disability benefits by falsely claiming he was a paraplegic. The veteran allegedly misrepresented his physical condition in VA disability compensation claims, in communications with VA, and during medical examinations in pursuit of VA disability benefits by purporting that he is paralyzed and unable to walk. It is also alleged that agents observed over an extended period the veteran performing various physical activities without the assistance of a wheelchair, such as walking, ascending and descending stairs, entering and exiting vehicles, lifting, bending, and carrying items. During the course of their surveillance, the only time agents observed the veteran using a wheelchair was in connection with his VA medical appointments. The total loss to the government is over $1 million. Of this amount, the loss to VA is approximately $767,000. The veteran was found guilty at trial in the District of Maryland on charges of wire fraud and theft of government property.

Veteran and His Spouse Charged for Defrauding VA for Compensation and Caregiver Support Benefits

Another VA OIG and SSA OIG investigation resulted in charges alleging that a veteran and his wife provided false information to VA related to the veteran's compensation benefits, rated disabilities, and the need for his wife to be his caregiver. The defendants claimed the veteran relies on a wheelchair and is unable to feed or bathe himself. On numerous occasions during the investigation, the veteran was observed walking, running unassisted, and performing numerous tasks contrary to his reported disabilities. The veteran received over $393,000 in VA

compensation benefits and his wife received over $213,000 from the VA Caregiver Support Program. The defendants were arrested in the Western District of New York after being charged with theft of government funds, wire fraud, conspiracy to commit wire fraud, conspiracy to defraud the government, and false statements.

Nonveteran Charged with Stealing Over $450,000 in VA Compensation Benefits from Disabled Veteran

A VA OIG, US Postal Inspection Service, and SSA OIG investigation resulted in charges alleging that a nonveteran deposited into his personal bank account at least four stolen VA disability checks that were intended for a hospital-bound veteran who had been diagnosed with amyotrophic lateral sclerosis (ALS). It is alleged that after the bank refused to deposit the checks due to a name mismatch, the individual and a coconspirator used stolen identity documents to open another bank account in the victim's name and then successfully made the deposits. Between 2015 and 2020, the individual and his coconspirator allegedly stole approximately $450,000 in VA disability benefits checks intended for the veteran. The defendant was arrested after being charged in the District of Massachusetts with theft of government benefits and conspiracy to steal government benefits.

Veteran Sentenced for Theft of Government Funds

According to an investigation by the VA OIG, Department of Transportation OIG, and SSA OIG, a veteran received VA individual unemployability and Social Security disability benefits because he maintained that he was unable to work. However, the veteran owned and operated two construction companies that were designated as service-disabled veteran-owned small businesses. Investigators also found that, in order for the veteran to obtain a medical certificate to receive a pilot's license, he withheld information on multiple Federal Aviation Administration medical certifications regarding a service-related disability for which he received both VA and SSA disability benefits. A federal jury found him guilty at trial of making false statements to the Federal Aviation Administration in February 2024. The jury was deadlocked on the theft of government fund charges pertaining to VA and SSA, but the veteran pleaded guilty to theft of government funds to resolve these remaining charges. The veteran was sentenced in the Western District of Louisiana to 36 months of supervised probation, of which six months will be home incarceration, and was ordered to pay a fine of $850,000. In accordance with the plea agreement, he also forfeited previously seized funds totaling over $141,000.

Former VA Fiduciary Sentenced for Stealing VA Funds Intended for Veteran

A VA OIG and SSA OIG investigation revealed that a former VA-appointed fiduciary made large monthly cash withdrawals of VA funds intended for a veteran and used the funds for her own personal expenses. The former fiduciary was sentenced in the Middle District of Florida to

six months of home confinement, 36 months of supervised release, and restitution of over $103,000 after pleading guilty to theft of government funds.

Investigations Involving Other Matters

Defendant Pleaded Guilty for Role in Paycheck Protection Act Fraud Scheme

Two defendants conspired to defraud the government by obtaining Small Business Administration–backed Paycheck Protection Program (PPP) loans for many unqualified individuals. These unqualified individuals paid the defendants to submit fraudulent PPP sole proprietor loan applications on their behalf and then made additional payments to the defendants if the loans were funded. One of the defendants, who served as an applicant recruiter, lied about participating in the scheme and knowing his codefendant. This applicant recruiter pleaded guilty in the Eastern District of Louisiana to making false statements. The total loss to the government is over $1 million. The VA OIG conducted the investigation, which was the result of a referral from the COVID-19 Pandemic Response Accountability Committee (PRAC). As a PRAC member, the VA OIG assists federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

Adult Daycare Center Director Charged for Multimillion-Dollar Workers' Compensation Fraud Scheme

According to a multiagency investigation, from 2017 until 2020, the director of an adult daycare center allegedly conspired to defraud the DOL's Office of Workers' Compensation Program (OWCP) by enrolling physicians as providers in the program without their knowledge or authorization and then submitting claims on behalf of injured VA and other federal agency employees for prescription drugs that were medically unnecessary. The defendant allegedly referred forged prescriptions for high-reimbursing drugs to a coconspirator pharmacy in exchange for illegal kickbacks. It is further alleged that the pharmacy then filled medically unnecessary prescriptions for injured VA and other federal agency workers who had benefits through OWCP (which seeks reimbursement from VA and the other federal agencies for these claims through "charge backs"). The defendant was arrested after being charged in the Southern District of Texas with conspiracy to defraud the United States and to pay and receive healthcare kickbacks. The total loss to OWCP based on this scheme is over $5.6 million. Of this amount, the loss to VA is approximately $526,000. This investigation was conducted by the VA OIG, DOL OIG, US Postal Service OIG, and FBI.

Transportation Company Owner Sentenced for Role in Bribery Scheme

A VA OIG and FBI investigation revealed that 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 owner controlled. The company owner

was sentenced in the Western District of Texas to 25 months in prison and 36 months of supervised release after pleading guilty to conspiracy to commit bribery and fraud in connection with identification documents or authentication features. The former VA contracting officer pleaded guilty to conspiracy to commit bribery and is awaiting sentencing.

Nonveteran Pleaded Guilty in Case Involving Thousands of Fake Phone Calls to VA's Veterans Crisis Line

A VA OIG investigation revealed that between December 2016 and December 2022, a nonveteran made over 13,000 calls to the Veterans Crisis Line (VCL) during which he used Voice over Internet Protocol to mask his identity. The nonveteran reported experiencing suicidal ideations or actively being engaged in a suicide attempt during these calls. The caller sometimes reported having cut himself with a knife, possessing a gun, or being on the verge of falling asleep after taking pills; provided false names, dates of birth, social security numbers, and addresses; and made false claims of being a veteran during these calls. Based on this information, the VCL contacted local emergency services on hundreds of occasions for the dispatch of first responders to locations around the country. The defendant pleaded guilty in the Eastern District of North Carolina to making a false statement or representation to an agency of the United States.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to advance the integrity of its programs and operations. Its work helps VA improve 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 released the following reports in June.

Benefits

Featured Report

VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits

As a result of *Nehmer v. US Department of Veterans Affairs*, VA was required by consent decree to readjudicate Vietnam veterans' disability compensation claims for service-connected herbicide-related conditions. The 2021 National Defense Authorization Act added three diseases carrying presumptive service connection due to herbicide exposure during the Vietnam War. The OIG conducted this review to determine to what extent VBA identified veterans potentially eligible for disability claims readjudication and retroactive benefits and identified two missing veteran populations. Of the 86,894 veterans in the first dataset who had

eligible diseases documented in VHA records, 36,125 were entitled to an estimated $836.8 million in unpaid benefits. Of the 226 veterans in the second dataset with Camp Lejeune records, the OIG estimated that 102 were entitled to about $7.5 million in benefits. VA has plans to convene a work group to improve methodologies for identifying eligible veterans consistent with the *Nehmer* consent decree and has agreed to send outreach letters to potential beneficiaries, improve claims processors' identification of claims possibly warranting readjudication, and update procedures to include veterans' medical records.

Financial Efficiency

Financial Efficiency Inspection of the VA North Texas Health Care System

The OIG inspected the following financial activities and administrative processes at the VA North Texas Health Care System: managerial cost accounting information, open obligations oversight, purchase card use, and inventory and supply chain management. The inspection found the following issues:

- The healthcare system used managerial cost accounting information to compare budgeted amounts to actual results, as VA policy requires, but that information was not used to make effective economic choices.
- Monthly reviews and reconciliations of open obligations to release unneeded funds were not always completed, and the healthcare system used funds from future obligations to pay for current-year services, which may have violated law and regulations.
- The healthcare system did not always process purchase card transactions correctly.
- The healthcare system did not conduct thorough supply chain management oversight or follow inventory procedures.

VA concurred with all nine of the OIG's recommendations. The recommendations address issues that, if left unattended, may eventually interfere with financial efficiency practices and the stewardship of VA resources.

Ineffective Use and Oversight of Medical/Surgical Prime Vendor Program Led to Increased Spending

The VA OIG conducted this audit to assess the extent to which VHA medical facilities use the Medical/Surgical Prime Vendor (MSPV) program for cost-effective ordering and distribution of healthcare supplies. The OIG found that medical facilities did not always purchase supplies through the program. Items were often unavailable on the MSPV product list, or staff did not check it before ordering from the open market. Issues with availability often go unreported due

to challenges with the reporting tool and quicker results through local workarounds. The OIG found the program office and medical center leaders have not provided effective oversight. In 2022, VHA could have saved approximately $35.5 million if facilities had ordered MSPV-eligible items through the program instead of the open market. Further, the OIG determined that medical facilities spent about $1.5 billion on items not available through MSPV at all. The OIG made nine recommendations to the under secretary for health, including identifying a VA-owned system where staff can check product availability and price, reviewing open market purchases, improving training on MSPV usage and tools, and ensuring staff report unavailable items.

Management Advisory Memorandum

Potential Weaknesses Identified in the VISN 20 Personnel Suitability Program

A whistleblower alleged that untrained human resources (HR) officials from VISN 20 were overturning prescreening determinations for potential employees. The complainant's documentation identified five candidates initially found unsuitable for employment due to potentially disqualifying conduct, such as domestic violence and driving under the influence. This memorandum outlines VISN 20's prescreening process, relevant requirements, and the OIG's findings on the inconsistent vetting of personnel. The team determined that VISN 20 HR officials reversed an adjudicator's unfavorable determination in two of the five instances but did not violate VA policy. However, these officials did not complete required adjudicator training for staff reviewing suitability determinations. The team also identified inconsistencies in managing and monitoring the prescreening process. Lack of national guidance and a deficient monitoring program can increase risks to VA and veterans. In its comments to the memorandum, VHA reported taking action to establish decision-making roles and improve the review process for suitability coordinators.

Information Technology

Inspection of Information Security at the VA Bedford Healthcare System in Massachusetts

The OIG inspects information security at VA facilities to assess whether the facilities are meeting federal security requirements. The OIG selected the VA Bedford Healthcare System because it had not been recently visited as part of the annual Federal Information Security Modernization Act of 2014 audit. This information security inspection focused on configuration management, security management, and access controls. Deficiencies included databases hosting personally identifiable information not being monitored quarterly and devices not being updated with vendor-supported systems software. Special-purpose systems did not have an authorization to operate and warranted higher security levels. In addition, the Lynx Duress panic button

system, which allows user to send a silent alarm alerting VA facility police if there is an emergency situation requiring their immediate attention, was not sufficiently monitored. Finally, restricting and monitoring physical access, as well as implementing appropriate physical and environmental controls, were deficient. The OIG made five recommendations for corrective action.

Office of Healthcare Inspections

This office assesses 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. The Office of Healthcare Inspections released the following reports in June.

National Review

Review of Perceived Barriers in Coordinating Veteran Maternity Care

To better understand the coordination of VHA maternity care services for women veterans, the OIG conducted a national survey of its maternity care coordinators (MCCs) regarding their staffing, duties, and challenges. According to the survey, MCCs at 40 percent of VHA facilities reported having insufficient time for their duties due to patient caseloads and collateral duties. Timely access to maternity care was a common concern among MCCs, with half reporting challenges with scheduling routine prenatal visits within the first trimester and more than a third citing difficulties expediting appointments for high-risk patients or those seeking care in later pregnancy. Barriers to timely access were primarily attributed to community maternity care provider availability and delays related to facility community care processes. The OIG made two recommendations to the under secretary for health regarding the review of designated time, caseload, and collateral duties for MCCs, as well as community care referrals for maternity care.

Healthcare Inspections

Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming

This inspection reviewed leaders' response to allegations that an optometrist was not practicing to the standard of care at the Cheyenne VA Medical Center. Facility leaders' analysis of a focused clinical care review of the optometrist's practice concluded the optometrist "did not meet the standard of care," resulting in the failure to diagnose patients and delayed testing for 15 of 16 identified patients. However, the OIG found facility leaders did not assess the potential

harm to the optometrist's other patients and failed to initiate state licensing board reporting of the optometrist due to a lack of understanding of reporting requirements. Additionally, the optometrist's supervisors failed to complete two annual proficiency reports and address deficiencies identified in other completed proficiency reports. The OIG made three recommendations involving a comprehensive review of the optometrist's care, compliance with state licensing board reporting, and assessment of the optometry service proficiency processes.

Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora

The OIG reviewed allegations that healthcare system leaders implemented staffing changes that adversely affected the provision of cardiothoracic surgeries and changed the medical intensive care unit (ICU) from an open unit to a closed unit without appropriate planning (a shift that changes which care providers have primary responsibility). The inspection found that the lack of ICU provider coverage for surgical patients adversely affected the provision of cardiothoracic surgical services and that these surgeries were paused for 11 months. The team substantiated that the medical ICU model change was made without adequate planning, resulting in a lack of resident supervision and an ineffective teaching environment, but did not substantiate that the model change resulted in patient harm. The OIG made one recommendation to the under secretary for health to evaluate the VISN leaders lack of awareness of the surgical pause; three recommendations to the VISN director related to cardiothoracic surgeries, high reliability organization implementation, and resident education needs; and two recommendations to the facility director related to call escalation and root cause analysis training.

Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety

In another inspection involving the health care system in Aurora, the OIG substantiated allegations that key senior leaders did not employ high reliability organization principles and created an environment in which a significant number of clinical and administrative leaders and frontline staff from many services felt psychologically unsafe, deeply disrespected, dismissed, and afraid of reprisal if they were to speak up or offer a difference of opinion. The OIG found instability in leadership at the service level, with many clinical service and section-level resignations and vacancies. Former facility leaders cited that a psychologically unsafe work environment was a major factor in their decision to leave facility employment. VA concurred with the OIG's seven recommendations, which included standardizing VISN leaders' roles and responsibilities across the system, implementing an avenue for facility employees to provide periodic feedback regarding the culture of safety, and using employee exit survey data to identify challenges with retention.

Featured Hotline Case

The OIG's hotline staff accepts complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse, and gross mismanagement of VA programs and operations. The following is a case opened by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

Former Spouse of Deceased Veteran Defrauded VA's Dependency and Indemnity Compensation Program

The OIG Hotline received allegations that the former spouse of a deceased veteran was fraudulently receiving VA Dependency and Indemnity Compensation (DIC) benefits. According to the allegation, the two divorced and the veteran's former spouse remarried before the veteran died. The matter was referred to the VA regional office in Saint Paul, Minnesota, for review. The regional office sent the former spouse a due process notice that termination of benefits was being proposed, and she responded by submitting documents that purported she was married to the veteran at the time of his death. However, the regional office conducted an online records search that found a marriage certificate for the former spouse and another party before the veteran's death. A review of the veteran's electronic claims folder found that the veteran self-reported his divorce. Annotations in his VA medical center records also indicated he was divorced. The regional office therefore terminated the benefits and established a $175,000 debt for the former spouse.

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To listen to the podcast on the June 2024 highlights, go to the monthly highlights page on the OIG website.