SEMIANNUAL REPORT to Congress

Issue 92 | April 1–September 30, 2024

The OIG thanks its personnel who volunteered on June 9, 2024, to wash the Vietnam Veterans Memorial and honor the 58,318 Americans listed who gave their lives in service to their country.

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.

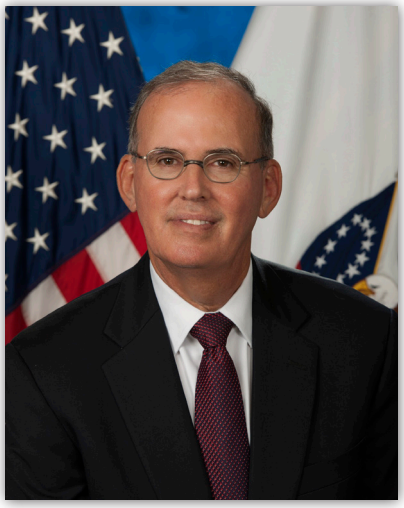
To achieve this vision, the Office of Inspector General (OIG) will

- 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 April 1 through September 30, 2024. This report is being released as the nation prepares for a change in leadership at the highest levels. The elections usher in a new president and Congress, as well as new leadership at VA. VA Secretary McDonough previously announced plans to leave VA in early 2025. I want to thank the Secretary for his great support, responsiveness, and respect for the OIG. We look forward to working with new leaders in both the executive and legislative branches as we continue to strengthen our nonpartisan, independent oversight of VA.

Times of transition offer fresh perspectives and opportunities to improve VA healthcare, operations, benefits, and other services for veterans, their families, caregivers, and survivors. The OIG is structured to be nimble to respond to shifts in priorities, new mandates, and emerging issues. Our use of data and field research also continue to drive proactive efforts that align with concerns raised by the veteran community, VA leaders and personnel, Congress, and other stakeholders.

I am exceedingly proud of the progress our staff has 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 or whose family members have served, are deeply committed to that mission and to leaving a lasting impact on the well-being of veterans and their families. That commitment is demonstrated every day in their work, and often in their personal lives as well. The cover of this report is a photo taken when OIG staff arrived early on a weekend morning this past June to wash the Vietnam Veterans Memorial. Some are featured on the back cover. These snapshots reflect the OIG spirit and culture that bring individuals with diverse backgrounds and experiences together in furtherance of a common goal to honor and serve the nation's veterans.

The oversight work highlighted in this report is meant to assist dedicated VA personnel with making continuous improvements to the department's programs, operations, and services. For this six-month period, we published 180 reports and other products with 710 recommendations for corrective actions—a total of 316 reports and 1,106 recommendations for the full fiscal year (FY). The OIG identified more than $5.1 billion in monetary impact for a return on investment of $44 for every dollar spent on oversight. For FY 2024, that brings the monetary impact to nearly $6.6 billion and a return on investment of $28:1. The OIG hotline received and triaged 18,502 contacts in this reporting period (34,119 for the year) to help identify wrongdoing and address concerns with VA activities. OIG special agents opened 215 investigations and closed 221 (with 393 open for the year and 404 closed). Investigations led to

A Message from the Inspector General

137 arrests in the past six months and 249 for the year. Collectively, the OIG's work over this reporting period also resulted in 502 administrative sanctions and corrective actions (961 for FY 2024).

Conducting oversight of VA during a period of transition can be challenging and complex, but this is what also makes it more vital. Our priorities remain helping VA ensure that veterans and their families are continuing to get the benefits, care, and services they are eligible to receive, while assisting VA in being better stewards of taxpayer dollars. The OIG will continue to oversee VA's many modernization efforts—from the electronic health record system to automation of some benefits processes. Deployment of these massive systems has been the subject of congressional hearings and national media attention for long and costly delays that have had adverse effects on both veterans and VA personnel trying to execute their duties.

OIG leaders and staff join me in recognizing the value of VA leaders' stated commitment to creating a culture of accountability, and we appreciate the many VA personnel who have engaged candidly and cooperatively with us. In closing, I thank the dedicated VA staff who implement our recommendations, and members of Congress, veterans service organizations, and the veteran community for their steadfast support that is so critical 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 is 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

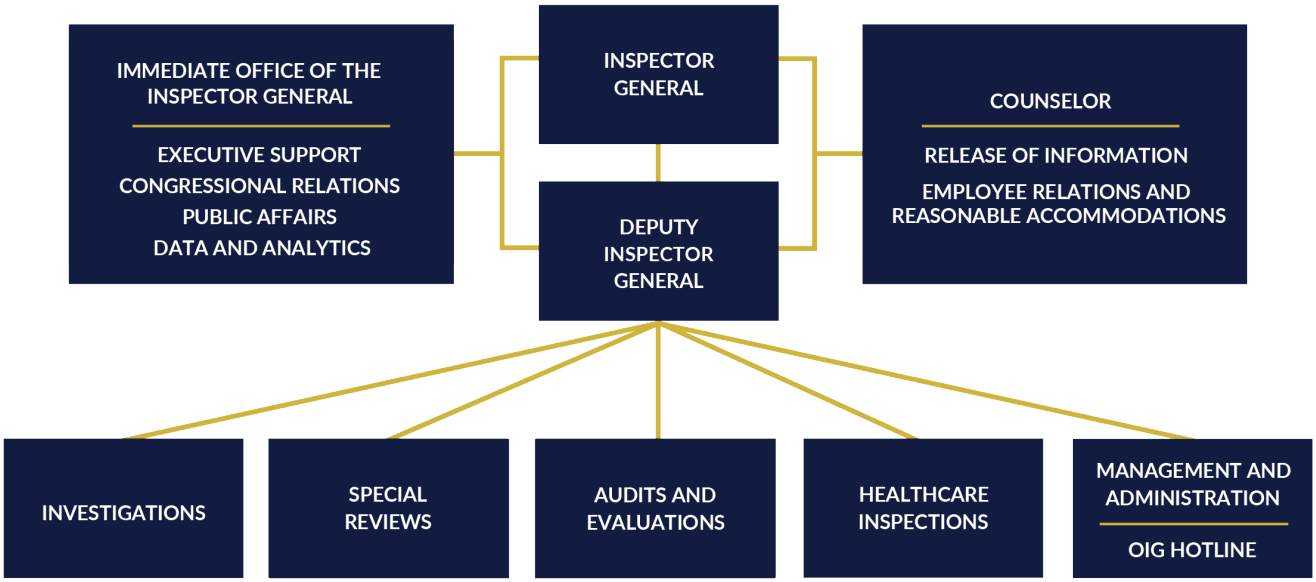
Services Act of 1988 charged the OIG with overseeing the quality of VA health care.[2] Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has more than 1,180 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.

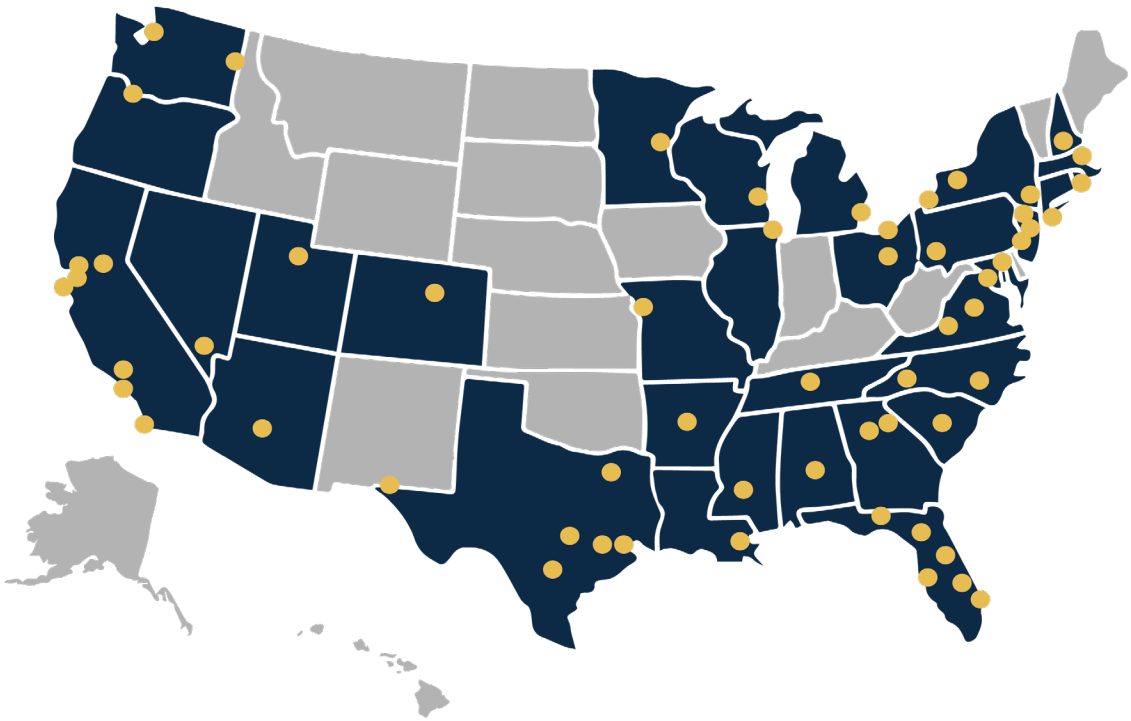
In addition to its Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff 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.

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
El Paso, TX
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
Milwaukee, WI
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, inpatient mental health units, individual medical centers, healthcare systems, networks, and community providers. Field staff participate in Healthcare Facility Inspection Program reviews focusing on culture, patient safety, environment of care, primary care, and programs designed to meet the unique psychosocial needs of veterans. 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.

OIG personnel testified at 10 congressional hearings this period and submitted one statement for the record for an eleventh hearing. Visit the **OIG website** for a full list of topics, statements, and video recordings. From the left, (1) Dr. Jennifer Baptiste, Deputy Assistant Inspector General for the Office of Healthcare Inspections, before the Senate Committee on Veterans Affairs (SVAC) on April 10, 2024; (2) Michael J. Missal, Inspector General, before the House Committee on Veterans Affairs on June 4, 2024; (3) Steve Bracci, Director of the Compensation Programs Inspection Division for the Office of Audits and Evaluations before the HVAC on June 13, 2024; (4) Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for the Office of Healthcare Inspections before the HVAC Subcommittee on Health on June 26, 2024; (5) Steve Bracci before the HVAC Subcommittee on Disability Assistance and Memorial Affairs on July 23, 2024; (6) Michael J. Missal before the HVAC on September 10, 2024; (7) Dr. Julie Kroviak before the HVAC Subcommittee on Health on September 18, 2024; (8) Dr. Jennifer McDonald, Director of the Community Care Division for the Office of Audits and Evaluations before the HVAC, Subcommittee on Technology Modernization on September 19, 2024; (9) Dr. Jennifer Baptiste before the HVAC Subcommittee on Oversight and Investigations on September 24, 2024; and (10) Nicholas Dahl, Deputy Assistant Inspector General for Management and Administration/Chief Information Officer before the HVAC Subcommittee on Economic Opportunity on September 26, 2024.

Highlighted Activities and Findings

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period April 1–September 30, 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, OIG leaders participated in 10 congressional hearings on

- ensuring equity for women veterans served by VA,
- the improper award of millions of dollars in critical skill incentives to VA central office senior executives,
- VBA's contract medical disability exam program impediments facing veterans,
- the inadequacy of the VA healthcare network (VISN) structure,
- VBA's disability claims process deficiencies,
- VA leadership accountability lapses,
- alleged failings of the Veterans Crisis Line's implementation of the National Suicide Prevention Hotline three-digit dialing code "9-8-8 press 1,"
- the impact of VA's pause of the Program Integrity Tool on community care revenue collections,

- findings on the delivery of care at the Hampton VA Medical Center in Virginia, and
- Digital GI Bill platform implementation challenges.

The OIG also submitted a statement for the record for an 11th hearing held by the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs regarding VA's challenges with ensuring high-quality contract disability compensation examinations.

These hearings highlight the impact of OIG work and the demand for independent, expert oversight. OIG testimony helps focus congressional action and elevates national attention on topics of concern within the veteran community. For example, during a hearing before the Senate Veterans' Affairs Committee, the testimony of the OIG's Deputy Assistant Inspector General for Healthcare Inspections focused on the challenges VA faces in its efforts to increase and enhance its services for the growing population of women veterans. Her testimony emphasized the importance of VA improving both access to gender-specific care within their facilities and the coordination of care that women veterans receive in the community, as some services—such as maternity care—are not generally provided by VA. She also noted that VBA should increase the accuracy and timeliness of processing claims for military sexual trauma benefits, and discussed how recommendations that the OIG issues for one VA medical facility should be used as a road map for other facilities to follow as well.

The OIG conducted 109 briefings on oversight reports with members and their staff. Some of the topics addressed included the following:

- Deficiencies in VA medical facilities' supply chain management
- Barriers to executing VHA's hiring initiative to expand veterans' access to substance use disorder treatment
- Extension of OIG testimonial subpoena authority
- Impediments to coordinating veterans' maternity care
- VHA's failure to exclude ineligible healthcare providers from the Community Care Program
- Inadequate reporting of patient safety risks and incidents

Following the briefings, the OIG team keeps congressional offices informed of VA's progress in implementing the oversight report recommendations. The team also coordinates responses to requests for technical assistance from congressional offices and committees during legislative drafting and after bill introduction to clarify anticipated audits, inspections, reviews, or other work. For example, OIG staff reviewed legislation related to the community care program as well as mandated work underway to determine what factors and conditions resulted in the need for additional funding for VBA and the anticipated need for additional funding for VHA. During this reporting period, the congressional relations team also fielded 64 inquiries from House and Senate offices related to constituent matters for review or referral.

In addition, the team assisted with coordinating matters with VA's internal oversight offices and other federal agencies and inspectors general—including 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 OIG-related practices and policy. Staff also ensure that all internal OIG directorates are aware of other agencies' efforts and facilitate information-sharing sessions to shape more impactful audits, reviews, inspections, and investigations.

DATA AND ANALYTICS

The Office of Data and Analytics (ODA) provides advanced analytics, data visualization, and comprehensive data services that enable the OIG to conduct proactive oversight of VA programs and operations. ODA's user-friendly, self-service applications and dashboards use just-in-time information to allow directorate teams across the OIG to identify the areas of greatest risk to veterans and their families, deficiencies in VA programs, and the misuse of taxpayer dollars.

During this reporting period, the office continued work on 97 projects while creating three new internal data-monitoring tools and making enhancements to several others. ODA's work addressed a broad range of subjects, including VA's financial management, staffing levels, veterans' access to VHA health care, community care referrals and usage, special monthly compensation eligibility, PACT Act claims processing, VHA call center responsiveness, and purchase card procurements. Staff also focused on advancing oversight work on VA's electronic health record modernization efforts and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), as well as the home loan guaranty program and inventory management.

In collaboration with directorate teams, ODA is working toward an analytic tool that integrates various human resources data systems within VA. This tool is intended to allow insights into various issues, ranging from VA staffing levels to employee turnover. This information on staffing potentially provides a context to other issues such as access and budget execution.

This office also fulfilled 247 internal data requests and 536 access requests to VA data systems during this reporting period. The responses supported OIG oversight of VA's broad range of healthcare services and benefits programs involving compensation and pensions, education, housing assistance, and veterans' burials. In addition, ODA specialists conducted formal trainings for OIG staff and partnered with directorate teams to develop information packets and training materials. These resources are designed to guide healthcare inspections and support proactive monitoring of fraud, waste, and abuse in VA programs. The office's ongoing 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 441 requests for status updates to various offices within VA tasked with taking action. These efforts facilitated the closing of 482 recommendations during this reporting period.

The public affairs team expanded its presence on LinkedIn and X (formerly Twitter) by roughly 27,000 followers, totaling more than 110,500. Staff published 150 updates on reports, hiring activities, and other news; posted 103 tweets; and released 181 email bulletins through GovDelivery. The number of OIG bulletin subscribers increased by about 6,000 since the previous reporting period, bringing the total to nearly 170,000.

During this period, the previous work of public affairs staff was recognized with several Communicator Awards, a global awards program sanctioned by the Academy of Interactive and Visual Arts to honor the exemplary achievements of marketing and communications professionals. The public affairs office received two awards for excellence for VA OIG website's redesign and for the *Veteran Oversight Now* Podcast episode titled "'*I don't want to die.' Veteran Left Alone in VA Emergency Department Dies from Suicide*." Staff were also recognized with three awards for distinction, including two awards for videos on oversight work related to veteran suicide and on disability claims for burn pit exposure, as well as another for the website redesign in the "government website" category.

The public affairs team produced five *Veteran Oversight Now* podcast episodes this reporting period to supplement and provide context to its inspection reports, including four episodes on deficiencies identified at VA medical facilities in Memphis, Tennessee; Las Vegas, Nevada; Oklahoma City, Oklahoma; and Albuquerque, New Mexico. The fifth episode featured Inspector General Missal, who shared his thoughts on VA's personnel suitability program, as well as a recent fraud alert related to disability benefits questionnaires.

The OIG receives extensive local and national media coverage and is highlighted in more than 70 Department of Justice (DOJ) press releases in just the second half of FY 2024 for its criminal investigations. Among the broadcast and print media outlets that prominently featured the OIG's work are *The New York Times, USA Today, New York Post, The Washington Post, Los Angeles Times,* The Daily Wire, Federal News Network, *Stars and Stripes,* Military.com, Military Times, *Richmond Times-Dispatch,* MeriTalk, CNN, The Hill, Fox News, CBS News, and PBS. The coverage highlighted OIG findings such as those involving the improper incentives awards to VA central office executives, ongoing problems with the new electronic health record system, and patient safety concerns at VA medical centers.

THE OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL

The counselor's office provides legal support to every division of the OIG. Its staff represented the agency in multiple actions before administrative bodies, including the US Equal Employment Opportunity Commission (EEOC) and Merit Systems Protection Board (MSPB). They have also assisted the OIG's Office of Investigations and the Department of Justice in prosecuting criminal cases and defending civil actions in federal district courts. In addition, attorneys and specialists provided training to OIG supervisors addressing prohibited personnel practices, EEOC processes and procedures, and whistleblower protections, as well as to newly hired OIG employees on inspector general authorities, standards of conduct, and the EEO complaint processes. The office instructed managers in the OIG's criminal investigations division on addressing their personnel's performance and conduct issues, including leveraging the agency's Employee Assistance Program, and on how to coordinate with its attorneys before publicly releasing or transferring information or evidence developed during an OIG investigation.

During this reporting period, the Employee Relations and Reasonable Accommodation division addressed 239 matters related to employee discipline, performance, and other workforce issues; responded to 858 reasonable accommodation and leave inquiries; and completed the processing of 19 reasonable accommodation requests and 44 Family and Medical Leave Act requests. The employee relations team also spearheaded 18 fact-finding inquiries in conjunction with attorneys from the Administrative Law division to help management officials in remediating workplace concerns. Following the termination of the Safer Federal Workforce Task Force, the division provided legal advice and inputs for an OIG-wide message rescinding prior OIG COVID-19 guidance. Division staff also updated the medical reasonable accommodations "Essential Functions" worksheet to assist managers in handling telework requests by creating a new section for them to document the essential functions of a position that cannot be performed via telework.

In addition to aiding with fact-finding inquiries involving OIG staff, the Administrative Law division advised managers on specific personnel matters involving concerns about employee performance and misconduct. Attorneys from this division also represented the OIG in addressing 10 formal EEO complaints and six appeals before the MSPB. During the review period, the team resolved on appeal on terms favorable to the agency, received two favorable outcomes for the OIG involving MSPB appeals filed by employees who were removed from federal service, and three petitions for review remained pending final decision as of September 2024. Finally, the division conducted legal reviews of various OIG policies and directives, assisted with oversight work, conducted two internal investigations involving misconduct allegations, and provided live trainings and ethics briefings for new employees and supervisors.

Attorneys in the Oversight and Procurement division reviewed all published oversight reports for legal sufficiency and continued to provide high-quality and impactful legal advice to OIG directorates in connection with audits, inspections,

reviews, investigations, and contracting actions. In support of the Office of Investigations, attorneys in this division reviewed more than 300 subpoenas for documents and worked collaboratively with US Attorneys' Offices to address novel issues arising from the OIG's use of its testimonial subpoena authority. Division attorneys provided refresher training for investigators on developing legal issues affecting criminal and civil cases as well. For audit and healthcare inspection teams, division attorneys attended site visits and provided critical legal advice on issues as they arose, as well as making significant contributions to published reports on such matters as incentive payments to VA central office senior leaders and the Digital GI Bill platform to improve educational benefits processing. Attorney advisors also worked with the OIG's Office of Management and Administration to help ensure OIG procurement actions comply with the Federal Acquisition Regulation and the VA Acquisition Regulation.

The Release of Information (ROI) division responded to more than 500 record requests and appeals; provided substantial litigation support to US Attorneys' Offices in several ongoing Freedom of Information Act and Privacy Act cases; and participated in several multiagency working groups, including the VA Artificial Intelligence (AI) Governance Council to help the OIG comply with new AI reporting requirements. ROI attorneys also worked directly with OIG oversight teams and other legal advisors at every stage of publication development, reviewing all products before release to ensure compliance with the Privacy Act and other statutory information release restrictions including statuses unique to VA. The division further developed a process to implement the requirements in section 5274 of the National Defense Authorization Act for FY 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. The OIG received several responses from such notices and posted them with the related report on its public-facing website, as required. The division responded to numerous requests from federal and state prosecutors for the review of agent files for adverse information, consistent with *Gigoio v. United States*, and related authorities. The division also responded under VA's "Touhy regulations" and other authorities to numerous subpoenas for both OIG records and the testimony of personnel, and coordinated with US Attorneys' Offices as needed.

The Office of Investigations

Personnel from this office 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 137 arrests, 101 convictions, and over $3.17 billion in monetary benefits for VA.

The Office of Investigations (OI) coordinates with other OIG directorates, external law enforcement partners, and the Department of Justice on high-impact cases to ensure veterans, VA employees, and department assets are protected, and wrongdoers are held accountable. In June 2024, OI participated in a strategically coordinated, two-week nationwide law enforcement action led by the Department of Justice. This effort resulted in criminal charges against 193 defendants for their alleged participation in healthcare fraud and opioid abuse schemes that included over $2.75 billion in fraudulent claims, which resulted in $1.6 billion in actual losses to federal, state, and private insurers. OI took part in six investigations that involved 10 defendants, including four licensed medical professionals. These 10 defendants allegedly participated in illegal kickback schemes involving durable medical equipment, wound care products, genetic testing, compound pharmacy prescriptions, and medical imaging services.

During this reporting period, OI issued two fraud alerts pertaining to education program scams and medical billing fraud for massage therapy. The first alert encouraged VBA staff to report non-college-degree schools that do not deliver promised educational courses or do not comply with department requirements in order to defraud VA and exploit veterans. It identified several additional red flags, such as schools charging tuition rates that far exceed those of similar institutions in the same geographic area or disguising courses that are recreational and ineligible for VA benefits. The second alert identified common types of medical billing fraud for massage therapy the OIG has identified that involved billing for services that were not provided or upcharging for the type of massage received. Because VA provides coverage that most other insurers do not, massage therapy has become an area that bad actors have tried to exploit. 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.

Staff conducted many 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.

Highlighted Activities and Findings

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.**

FOR-PROFIT SCHOOLS AND THEIR OWNER AGREE TO PAY $1.35 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS INVOLVING ALLEGED POST-9/11 GI BILL OVERCHARGES

A VA OIG investigation resulted in a civil settlement resolving allegations that two for-profit computer learning center franchises submitted false claims to VA for Post-9/11 GI Bill tuition payments. The companies allegedly overcharged VA by failing to report tuition waivers and scholarships provided to GI Bill students and falsely certifying compliance with the Title 38 ban on incentive compensation tied to student enrollment. If a school offers to waive tuition for a student receiving less than 100 percent assistance, that tuition waiver must be reported to VA and the student's portion must be reduced accordingly. Title 38 also prohibits participating schools from paying any commission, bonus, or other incentive payment based directly or indirectly on securing student enrollments. As a result of the investigation, the VA State Approving Agency withdrew both franchises from participation in the GI Bill program. Between 2014 and 2021, VA paid the two companies about $14 million and $26 million, respectively. Under the settlement reached in the Middle District of Florida, the two franchises and their owner agreed to pay $1.35 million to VA.

VETERAN FOUND GUILTY OF BENEFITS THEFT FOR LYING ABOUT BEING A PARAPLEGIC

Another investigation conducted with the Social Security Administration OIG resulted in charges alleging a veteran fraudulently obtained VA and Social Security Administration disability benefits by falsely claiming he was a paraplegic. Evidence at trial established the veteran misrepresented his physical condition in VA disability compensation claims, in communications with VA, and during medical examinations to gain VA disability benefits—purporting that he was paralyzed and unable to walk. 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 was over $1 million. Of this amount, the loss to VA was 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 SENTENCED IN CONNECTION WITH MULTIPLE FRAUD SCHEMES

A multiagency investigation revealed that a veteran used his position as an Army financial counselor to target Gold Star families to invest their survivor benefits in investment accounts that were managed by his private employer. The investigation also found that the veteran submitted false documents to obtain a VA-backed loan for a property valued at $2.1 million. He was sentenced in the District of New Jersey to 151 months in prison, 36 months of supervised release, and forfeiture of $1.4 million after pleading guilty to wire fraud, securities fraud, making false statements in a loan application, committing acts furthering a personal financial interest, and making false statements to a federal agency. Restitution will be determined on a later date. The investigation was conducted by the VA OIG, Homeland Security Investigations, Defense Criminal Investigative Service, and FBI.

VBA QUALITY REVIEW SPECIALIST PLEADED GUILTY TO THEFT OF GOVERNMENT FUNDS

Between December 2019 and August 2022, a VBA quality review specialist at the St. Paul VA Regional Office created 21 false VA claims in the names of multiple VA beneficiaries and then directed the resulting payments to his personal bank accounts. The total loss to VA was approximately $389,000. The defendant pleaded guilty in the District of Minnesota to theft of government funds. As a stipulation of the plea deal, he agreed to be terminated from VA and to pay full restitution. The VA OIG investigated this case.

VETERAN SENTENCED FOR MAKING FALSE STATEMENTS ABOUT HIS CLAIMED DISABILITY

According to another VA OIG investigation, a veteran lied about being unable to use both his feet, which resulted in his receipt of VA disability compensation benefits for almost two decades and vehicle adaption benefits to which he was not entitled. The veteran was sentenced in the District of New Hampshire to 18 months in prison, 36 months of supervised release, and $662,000 in restitution after pleading guilty to making false statements.

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.**

FORMER VA DOCTOR FOUND GUILTY OF ILLEGALLY DISTRIBUTING OVER 1.8 MILLION DOSES OF OPIOIDS AND ENGAGING IN A $5 MILLION HEALTHCARE FRAUD SCHEME

A multiagency investigation resulted in charges alleging a former chief of medicine at the Alexandria VA Medical Center in Pineville, Louisiana, illegally distributed more than 1.8 million doses of Schedule II controlled substances, including oxycodone and morphine, to more than 350 VA patients and other non-VA patients without a legitimate medical purpose and defrauded healthcare benefit programs of approximately $5.4 million. Evidence at trial established that while working full-time as the facility's

chief of medicine, the defendant maintained a clinic located more than 200 miles away where he signed prescriptions before personally examining the patients, which is outside the usual course of professional practice, and without determining their medical necessity. With the defendant's knowledge, patients filled prescriptions using their insurance benefits, causing healthcare programs to be fraudulently billed. The former chief of medicine was found guilty at trial by a federal jury in the Eastern District of Louisiana of conspiracy to unlawfully distribute and dispense controlled substances, unlawfully distributing and dispensing controlled substances, maintaining a drug-involved premises, and conspiracy to commit healthcare fraud. The VA OIG, Department of Health and Human Services OIG, and FBI completed this investigation.

TWO HEALTH SERVICES COMPANY OWNERS SENTENCED FOR COMPOUNDING PHARMACY CONSPIRACY

According to another multiagency investigation, numerous individuals allegedly engaged in a scheme to solicit and receive kickbacks from multiple North Texas compounding pharmacies in return for directing prescriptions for patients in federal programs to those pharmacies. The total loss to the government was more than $6 million. Of this amount, the loss to VA was over $848,000. Two owners of a health services company pleaded guilty to conspiracy to solicit and receive kickbacks, and were sentenced in the Northern District of Texas to 14 months and 15 months in prison, respectively, with each receiving one year of supervised release. Each owner was also ordered to pay over $4.4 million in restitution. This investigation was conducted by the VA OIG, US Postal Service OIG, Defense Criminal Investigative Service, Department of Labor OIG, FBI, 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.

ACUPUNCTURIST AGREED TO PAY $850,000 TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

A VA OIG proactive investigation resolved allegations that between 2016 and 2020, a medical provider submitted claims to VA for acupuncture services that were significantly overstated, including multiple instances in which the claims submitted for a single day totaled more than 24 hours. The acupuncturist entered into a settlement agreement in the Eastern District of California under which he

agreed to pay $850,000 to resolve the allegations that he violated the False Claims Act by submitting fraudulent healthcare claims to VA.

PERMANENT INJUNCTION ISSUED AGAINST TWO DEBT COLLECTION AGENCIES

A multiagency investigation led to a permanent injunction issued by the Northern District of Oklahoma court that prevents the owners of two debt collection companies from engaging in any healthcare billing activity, including continuing a fraud scheme that targeted veterans, service members, and older Americans. A civil complaint alleged that the two companies distributed tens of thousands of fraudulent collection notices in an attempt to obtain over $70 million from beneficiaries of CHAMPVA, TRICARE, Medicare, and other insurance entities for durable medical equipment that patients received many years ago after their surgeries.[3] The debt collection company owners allegedly obtained over $1.7 million through the scheme while lacking any authority to collect any debt from these beneficiaries. To date, the VA OIG seized fraud proceeds of about $700,000. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, FBI, Department of Health and Human Services OIG, US Postal Service OIG, Small Business Administration OIG, and Department of Labor OIG.

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.**

TWO NONVETERANS SENTENCED IN "RENT-A-VET" CONSTRUCTION FRAUD SCHEME

A VA OIG and FBI investigation, initiated in response to a hotline complaint, found that two nonveterans defrauded VA by falsely obtaining federal set-aside construction contracts intended for service-disabled veteran-owned small businesses (SDVOSBs). Starting in 2007, the two nonveterans had several disabled veterans pose as owners of two companies the nonveterans actually controlled (referred to as a "rent-a-vet" scheme) to fraudulently obtain SDVOSB status. These companies were awarded 77 set-aside government contracts valued at over $78 million. Over several years, the nonveterans provided misleading information to VA indicating that the two companies were operated by service-disabled veterans when the nonveterans were the majority owners who ran and operated both companies. The two nonveterans pleaded guilty to major fraud against the United States and were

3 CHAMPVA refers to the Civilian Health and Medical Program of the Department of Veterans Affairs that covers the cost of some healthcare services and supplies for the spouse or child of a deceased veteran who was receiving disability benefits. TRICARE is the Department of Defense's healthcare program for active-duty and retired service members and their families. Durable medical equipment typically includes items ordered by a physician that can be used by individuals in need of medical support in the home for an extended period and include items such as compression devices, wheelchairs, walkers, respiratory equipment, prosthetic and orthotic devices, and implants.

each sentenced in the Western District of Pennsylvania to one year of probation, including 100 hours of community service; restitution of over $403,000 to VA; and a $50,000 fine.

MEDICAL SUPPLY COMPANY PRESIDENT AND FORMER VA SUPERVISOR SENTENCED FOR ROLES IN KICKBACK SCHEME

A VA OIG investigation revealed a former medical supply company owner paid kickbacks of over $36,000 to a former central supply department supervisor at the Jesse Brown VA Medical Center in Chicago in exchange for the initiation and approval of orders from his company for products that were never delivered to VA. The former medical supply company owner was sentenced in the Northern District of Illinois to 24 months in prison and 24 months of supervised release after pleading guilty to wire fraud. The former VA supervisor was previously sentenced to 84 months in prison and 36 months of supervised release. Both defendants were ordered to jointly pay restitution to VA of over $1.7 million.

VETERAN SENTENCED FOR FIREARM POSSESSION AT THE TULSA VA OUTPATIENT CLINIC

A veteran arrived at the Ernest Childers VA Outpatient Clinic in Tulsa with a loaded handgun and plastic zip ties after previously making threats to "shoot" and "murder people" if he was not scheduled for an appointment with VA. The veteran pleaded guilty in the Northern District of Oklahoma to possession of a firearm in a federal facility and was sentenced to 48 months in prison and 36 months of supervised release. The VA OIG, VA Police Service, Tulsa Police Department, and FBI investigated.

VA PHLEBOTOMIST SENTENCED FOR VIDEO VOYEURISM

According to a VA OIG investigation, a phlebotomist (an individual who draws blood) at the Orlando VA Medical Center installed a hidden camera in multiple unisex bathrooms at the facility to secretly record employees without their consent. The phlebotomist, who was previously suspended by VA pending the completion of the investigation and criminal proceedings, pleaded guilty to video voyeurism and was sentenced in the Circuit Court of the Ninth Judicial Circuit for Orange County (Florida) to 24 months in prison and 48 months of supervised release. He was also ordered to participate in individualized sex offender treatment.

NONVETERAN PLEADED GUILTY IN CASE INVOLVING THOUSANDS OF FAKE PHONE CALLS TO VA'S VETERANS CRISIS LINE

Another 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.

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 significantly affect VA programs and offices. OSR's work also includes oversight projects that focus on issues of ethics, egregious waste of funds, and the effectiveness of VA programs and operations.

During this reporting period, OSR concluded a high-priority investigation of VA's erroneous award of more than $10 million in bonuses to certain senior executives at VA's central office. The resulting report garnered significant national media attention and led to a hearing before the House Committee on Veterans' Affairs as well as numerous briefings with congressional staff. OSR also issued a supplemental memorandum related to whether VA leaders who recommended incentives for their direct reports had done so inappropriately. Both the report and memorandum are summarized below.

Throughout FY 2024, OSR received 21 allegations of possible whistleblower retaliation for review under 41 U.S.C. § 4712, which protects employees of contractors, grantees, subcontractors, and subgrantees from reprisal. 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 releases statistical information about these cases.[4] During the reporting period, OSR completed one investigation that substantiated the allegations of retaliation. As required by statute, the OIG referred the completed report of its investigation to the VA Secretary's designee, who is responsible for making the agency's final determination as to whether the complainant was subject to reprisal and issuing an order granting or denying relief.

VA IMPROPERLY AWARDED $10.8 MILLION IN INCENTIVES TO CENTRAL OFFICE SENIOR EXECUTIVES

In September 2023, VA announced it had erroneously awarded millions of dollars in critical skill incentive (CSI) payments to senior executives at its central office (VACO). VA cancelled the payments, notified Congress, and requested that the OIG review the matter. CSIs are a new recruitment and retention tool authorized by the PACT Act, which significantly expanded access to VA health care and benefits for veterans exposed to toxic substances. CSIs are meant for an employee who "possesses a high-demand skill or skill that is at a shortage," to help VA meet a projected increase in staffing requirements. In total,

4 Other disclosures required by the IG Act with respect to whistleblower retaliation matters are discussed in this report under **Instances of Whistleblower Retaliation**.

Highlighted Activities and Findings

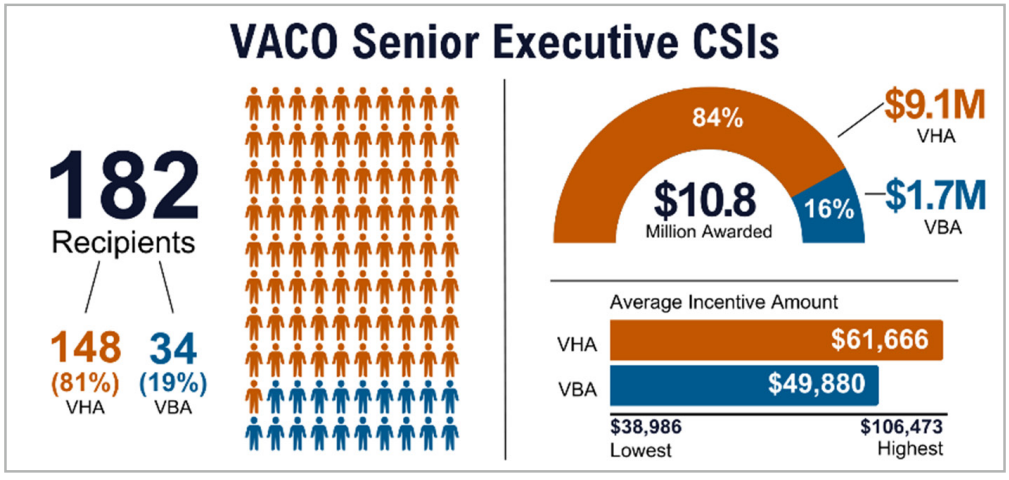
VA awarded $10.8 million in CSIs to 182 senior executives (ranging from nearly $39,000 to over $100,000 each) in VHA and VBA at VA's central office. The OIG found that the award of CSIs to nearly all VHA and VBA central office executives lacked adequate justification and was inconsistent with the PACT Act and VA policy. This was due in part to breakdowns in leadership and controls at multiple levels of VA, including

- insufficient transparency from VHA regarding the scope and costs of its CSI plans for VA central office senior executives;
- excessive deference by VA's Human Resources and Administration/Operations, Security, and Preparedness leaders to under secretaries and other senior leaders, despite concerns that they or their staff had about the incentives;
- missed opportunities by the Office of General Counsel to detect legal issues with the CSIs before payment; and
- failure to leverage VA's existing governance processes to ensure proper risk management of the new CSI authority.

VA concurred with the OIG's two findings and eight recommendations and provided acceptable action plans and completion timelines. The OIG will monitor VA's progress until sufficient documentation has been received to close the recommendations.

SUPPLEMENT TO OIG REPORT, *VA IMPROPERLY AWARDED $10.8 MILLION IN INCENTIVES TO CENTRAL OFFICE SENIOR EXECUTIVES*

Additional analysis of the improper CSI awards raised concerns that the under secretary for health approved incentives for at least 10 senior executives who directly reported to him, which was not permissible under the approval authority delegated to him. The OIG released this supplemental memorandum to further inform the department's assessment of whether additional actions were warranted.



The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) released 44 publications summarizing results from its oversight work, including three VA management advisory memoranda. Overall, its published reports resulted in 195 recommendations with a potential monetary impact for VA of more than $1.76 billion for the reporting period. OAE teams also conducted 41 preaward and postaward contract audits and reviews and two claim 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.[5] OAE's preaward and postaward contract and claim reviews resulted in nearly $187 million in potential cost savings and positioned VA to recover more than $1.6 million in overcharges, bringing the total monetary impact for all OAE products this period to more than $1.95 billion. OAE also completed one **peer review** of the Treasury Inspector General for Tax Administration's audit operations.

During this period, OAE addressed topics of concern related to benefits processing, including impediments to making accurate and timely decisions on disability compensation claims; billing for community care; and modernizing VA systems, specifically the automation of education benefits and the new electronic health record for patients receiving care through VA. OAE's work drew national attention. For example, the director of OAE's Compensation Programs Inspection Division testified before the House Committee on Veterans' Affairs (HVAC) twice this period regarding different aspects of VBA's disability claims process. During the first hearing, held by HVAC's Subcommittee on Disability Assistance and Memorial Affairs, the director's testimony focused on several OIG-identified processing deficiencies, including errors VBA personnel made on veterans' individual unemployability claims, inconsistencies implementing changes to the disability rating schedule, issues with claims automation, and unwarranted medical reexaminations for veterans.[6] At the second hearing before the full committee, the director also testified on the physical barriers to accessibility, safety concerns, and lack of cleanliness at facilities under contract with VA to provide veterans with medical exams required for the disability claims process.[7] He emphasized that

5 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.

6 *Hearing on Is the Veterans Benefits Administration Properly Processing and Deciding Veterans' Claims?*, Before the Subcommittee on Disability Assistance and Memorial Affairs, House Committee on Veterans' Affairs, 118th Cong. (July 23, 2024) (statement of Stephen Bracci, Director, Compensation Programs Inspection Division, Office of Audits and Evaluations, VA Office of Inspector General).

7 *Hearing on A Call to Action: Meeting the Needs of the Spinal Cord Injury and Disorders (SCI/D) Veteran Community*, Before the House Committee on Veterans' Affairs, 118th Cong. (June 13, 2024) (statement of Stephen Bracci, Director, Compensation Programs Inspection Division, Office of Audits and Evaluations, VA Office of Inspector General).

80 percent of the contract facilities did not meet one or more standards under the Americans with Disabilities Act and Occupational Safety and Health Administration, due in part to weak oversight.

The OIG's work on the community care program also garnered significant notice from Congress. A recent OAE report, which was referenced in a letter to the VA Secretary from the Senate Committee on Veterans' Affairs, raised concerns about the adequacy of the existing Community Care Network.[8] Ineffective oversight of this network left VA medical facilities with insufficient access to community providers. Since the report's release, VHA has expanded use of the Advanced Medical Cost Management Solution (AMCMS) network adequacy suite for facilities to track provider availability.

In addition, the director of OAE's Community Care Division testified before the HVAC Subcommittee on Technology Modernization on VHA's pause in using the Program Integrity Tool due to identified errors. The tool is a repository of data on community care claims used to determine if private insurance companies or veterans should pay for the treatment of injuries or conditions unrelated to their military service. The director stated that the pause prevented VHA from collecting hundreds of millions of dollars of revenue from private health insurers and veterans' copayments.[9] The tool is also used to support VHA's fraud, waste, and abuse detection (such as community care duplicate claims payments) and its mitigation efforts. Pausing the tool's use resulted in VHA staff being left with a processing backlog of tens of millions of these community care claims. According to VHA officials, as of July 1, 2024, they had resumed using data from the tool for revenue collection, but not for preventing, detecting, and mitigating fraud, waste, and abuse for paid community care claims. (See the summary of the management advisory memorandum on this tool and the effects of its pause under Featured Reports below.)

Regarding VA's systems modernization, OAE continued to identify weaknesses that often stem from inadequately developed requirements. An audit completed during this period focused on the delayed implementation of VBA's Digital GI Bill platform, which is intended to determine real-time eligibility and benefit information and improve timely and accurate delivery of educational payments. As other oversight reports on IT modernization projects found, inadequate planning led to VBA agreeing to underdeveloped and unrealistic contract requirements and terms. After negotiating various modifications and eventually an altogether new contract, VBA faced platform costs more than double those of the original estimate, totaling nearly $1 billion in overall expenses. The OIG's deputy assistant inspector general for management and administration/chief information officer testified in another congressional hearing on these and other findings from the audit, which are summarized more fully below.[10]

The final matter to highlight in this section relates to previous OAE oversight of VA's management of land use under the West Los Angeles Leasing Act of 2016. That work continued to make a significant impact on veterans and VA contracts during this reporting period, as multiple OIG reports were repeatedly cited

8 VA OIG, *Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance*, Report No. 23-00876-74, April 9, 2024; Senator Jon Tester et al., letter to VA Secretary Denis McDonough, May 7, 2024, https://www.veterans.senate.gov/services/files/B0F9F302-9296-43A9-A89D-227A5AB9F094.

9 *Hearing on VA's Open Cash Register: Fraud, Waste, Abuse and Revenue Operations,* Before the Subcommittee on Technology Modernization, House Committee on Veterans' Affairs, 118th Cong. (September 19, 2024) (statement of Jennifer McDonald, Director, Community Care Division, Office of Audits and Evaluations, VA Office of Inspector General).

10 *Hearing on Digital GI Bill in Disarray: Holding the Biden-Harris Administration Accountable for VA's Costly Mismanagement*, Before the Subcommittee on Economic Opportunity, House Committee on Veterans' Affairs, 118th Cong. (September 26, 2024) (statement of Nicholas Dahl, Deputy Assistant Inspector General for Management and Administration/Chief Information Officer, Office of Management and Administration, VA Office of Inspector General).

in a recent court ruling. Ultimately, the judge ordered VA to construct housing for homeless veterans on the campus and remove lessees in violation of the act from VA's property.[11]

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

THE PAUSE OF THE PROGRAM INTEGRITY TOOL IS IMPEDING COMMUNITY CARE REVENUE COLLECTIONS AND RELATED OVERSIGHT OPERATIONS

As stated above, the Program Integrity Tool pause affected VA's bottom line, billing to patients and insurers, and efforts to prevent and address fraud, waste, and abuse. In February 2023, VHA paused the tool's operations after becoming aware of issues with its database code logic and that stored data had been compromised. While the tool has been offline, community care claims from healthcare providers continued to be received and paid through the related payment systems. However, this report and related congressional testimony underscored that because VHA was unable to bill veterans or private insurance companies for community care claims, an estimated processing backlog accrued of about 40 million paid community care claims. The OIG estimated that the pause resulted in about $665.5 million in unrecovered collections as of February 2024. VA officials have concurred with the OIG's estimates on the community care workload backlog and expect that most of this revenue, though delayed, will ultimately be collected.

VBA NEEDS TO IMPROVE OVERSIGHT OF THE DIGITAL GI BILL PLATFORM

The second report related to congressional testimony above involves VBA's March 2021 move to the new Digital GI Bill platform for education benefits delivery. The OIG found that in addition to the delays related to unclear contract requirements discussed earlier, there were unrealistic expectations, such as VBA not being able to fulfill a contract requirement to deliver three test environments for the new platform for the contractor. Required decommissioning of older systems also caused delays. In addition, the project's integrated master schedule was not updated consistently due in part to lack of tracking for tasks that needed to be completed before other actions could be taken (dependencies). Once an overall schedule was established in February 2023, it was still not consistently shared with the contractor. Poor communication contributed to critical scheduling failures that caused delays and increased costs. VBA has renegotiated the original contract for $453 million to reflect a new overall cost of $932 million. VA concurred with the OIG's three recommendations to increase the chances of successful implementation under the new contract through better monitoring, a consistent and updated master schedule, as well as strategies to address critical path failures and establish a clear timeline.

11 *Post-Trial Opinion; Findings of Fact & Conclusion of Law, Jeffrey Powers, et al., Plaintiffs vs Denis Richard McDonough, in his official capacity as Secretary of Veterans Affairs; et Al., Defendants*, United States District Court, Central District of California, Case No. 2:22-cv-08358-DOC-KS (September 6, 2024); VA OIG, *VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report*, Report No. 20-03407-253, September 29, 2021; and VA OIG, *VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016*, Report No. 18-00474-300, September 28, 2018.

Highlighted Activities and Findings

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 the extent to which VBA identified veterans potentially eligible for disability claims readjudication and retroactive benefits. The OIG found that VBA missed two veteran populations. In the first, of the 86,894 veterans who had eligible diseases documented in VHA records, about 36,125 were entitled to an estimated $836.8 million in unpaid benefits. In the second population, of the 226 veterans with Camp Lejeune records, the OIG estimated 102 were entitled to about $7.5 million in benefits. In response to this report, VA is convening a work group to improve methods 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.[12]

A HIRING INITIATIVE TO EXPAND SUBSTANCE USE DISORDER TREATMENT NEEDED STRONGER COORDINATION, PLANNING, AND OVERSIGHT

In FY 2022, VHA launched a multiyear hiring initiative to expand veterans' access to substance use disorder treatment. This review assessed how well medical centers met the FY 2022 goal of hiring for 90 percent of the approved positions for the initiative. The OIG found that medical centers only hired about 26 percent of approved staff by the end of FY 2022 and spent approximately $8 million of the $96 million available in specific purpose funds for medical centers to hire behavioral health staff. In addition to external factors, the medical centers failed to meet this goal because VHA did not clearly communicate hiring priorities, define and assign responsibilities for implementation and oversight, and generally ensure accountability for achieving the initiative's goals. The OIG also examined FY 2023 hiring and determined the initiative's challenges persisted. By the end of FY 2023, medical centers had hired a two-year total of only 837 people (65 percent rather than the 90 percent goal established for the first year) and spent $97 million of the two-year total of $267 million in specific purpose funds for the initiative. The remaining funds were spent on other nonhiring substance use disorder purposes, retained by medical centers for other unspecified purposes, or returned to the finance office. VHA concurred with the OIG's three recommendations to ensure the $14 million in funds retained by medical centers for other purposes have been properly spent, and to take corrective actions to address the deficiencies identified in the report.

VBA'S AND NCA'S PERSONNEL SUITABILITY PROGRAMS NEED IMPROVED GOVERNANCE

The OIG conducted this audit to evaluate the background investigation process for VBA and NCA staff and determine whether actions were completed on time and recorded reliably. Among its findings, VBA and NCA did not ensure background investigations were completed within required time frames or recorded reliably. The team found problems at every stage of the required background investigation process. Delayed adjudications were especially problematic. About 71 percent of VBA employees and 58 percent of NCA employees were not adjudicated by VA within the required 90 days of the date of the final investigative report. As a result of program deficiencies, both administrations assumed unnecessary

12 VA did not concur with one of the OIG's recommendations. **VA Management Nonconcurrences** contains additional information.

risk by allowing staff who were not fully vetted to handle sensitive personal information and interact with veterans.

VA NEEDS TO STRENGTHEN CONTROLS TO ADDRESS ELECTRONIC HEALTH RECORD SYSTEM MAJOR PERFORMANCE INCIDENTS

This audit—the 21st OIG product addressing the electronic health record (EHR) modernization program and system implementation—examined whether VA and its contractor had sufficient controls to prevent, respond to, and mitigate the impact of major performance incidents affecting the new system. VA and Oracle Health lacked adequate controls to prevent system changes from causing major incidents, such as outages, performance degradations, and incomplete functionality. Between October 24, 2020 (the initial EHR system go-live date), through March 31, 2024, there have been 826 major performance incidents, including one incident that occurred at the Mann-Grandstaff VA Medical Center in Washington when a system change halted operations for more than 27 hours, which caused the need for many patients to have their appointments rescheduled. In addition, VA lacked strong procedures for responding to major incidents uniformly and thoroughly or for mitigating their impact through standard procedures and the use of backup equipment during downtime. Further, VA had no formal process to link reports of patient care delays to specific major performance incidents. Ultimately, limited EHR controls for handling major incidents originated in how the May 2018 contract was written. In May 2023, VA modified the contract to strengthen what requirements it could. Without better controls, incidents will continue that lead to more costly delays in system implementation and increase the risk of patient harm.

INEFFECTIVE OVERSIGHT OF COMMUNITY CARE PROVIDERS' SPECIAL-AUTHORIZATION DRUG PRESCRIBING INCREASED PHARMACY WORKLOAD AND VETERAN WAIT TIMES

VHA purchases community health care by contracting with third-party administrators (TPAs), which in turn contract with community providers. Community providers' prescription requests must be filled at VA pharmacies and must consider VA's approved drugs before others that require special authorization. This audit examined whether VHA's oversight of TPAs ensured community providers prescribed special-authorization drugs consistent with requirements. Community providers were found to have rarely submitted required justifications with these initial prescriptions, leading to about $200.2 million in questioned costs. VHA staffing challenges and increased community care prescriptions also caused a backlog. Community care prescription processing averaged 11 days, exceeding VHA's four-day standard. VHA did not hold TPAs accountable for ensuring community providers followed procedures, and less than 2 percent of community providers completed TPA-developed training. The OIG made seven recommendations to improve community providers' compliance when prescribing special-authorization drugs, such as enhancing prescription system capabilities, addressing training requirements, and clarifying requirements for VA pharmacies to report community providers who are not compliant.

Highlighted Activities and Findings

IMPROVED OVERSIGHT IS NEEDED TO CORRECT VISN-IDENTIFIED DEFICIENCIES IN MEDICAL FACILITIES' SUPPLY CHAIN MANAGEMENT

The OIG examined whether VA's regional VISNs were effectively overseeing supply chain management by their medical facilities. Supply chain management is critical to preventing waste and ensuring unexpired medical products and equipment are available in good condition for patient care when and where they are needed. An audit team assessed data from 140 annual quality control reviews conducted in FY 2023 by the VISNs, in which medical facilities are evaluated on over 100 questions related to VHA requirements. The OIG team also reviewed the resulting corrective action reports. Cumulatively, the VISN supply chiefs' assessments found that VHA facilities did not comply with supply chain management policy in about 18.5 percent of required areas. The OIG team conducted site visits to six medical facilities from different VISNs to delve further into their quality control reviews. Three of the facilities were responsible for but did not correct 127 of the 130 outstanding deficiencies and the team discovered over 150 expired items including catheters, syringes, blood collection tubes, and dental implants. The OIG team also learned of instances of delayed or canceled surgeries because supplies were unavailable. Challenges to medical facilities' complying with supply management requirements included staffing vacancies, leadership turnover, insufficient VISN support, and inadequate storage space. VISN supply chiefs also did not report all noncompliant practices, and Procurement and Logistics Office monitoring was inadequate to identify unimplemented corrective actions or inaccurate assessments. VA concurred with the OIG's six recommendations to strengthen VISN oversight of facility supply chain management.

INDEPENDENT AUDIT REPORT OF A DIALYSIS PROVIDER'S CONTRACT PRICING AND BILLING COMPLIANCE

After previously identifying concerns in pricing accuracy and local billings for a dialysis contractor, the OIG conducted this audit to determine whether the contractor complied with billing terms and conditions. In the OIG's opinion, except for instances of incorrect billings to local VA facilities, the contractor's assertion that it billed in accordance with the terms and conditions of its old and new contracts is fairly stated in all material respects. However, the OIG found the contractor incorrectly received almost $6.4 million by improperly billing local VA facilities. According to the contractor, it had stopped local billings and begun providing refunds. However, not all facilities the OIG contacted were able to confirm these refunds at the time of the audit. The OIG made two recommendations to the contracting officers: Request that the contractor perform a self-audit of local VA claims and verify that the contractor has refunded the claims.

The Office of Healthcare Inspections

OHI's team of healthcare professionals continues to enhance and expand its oversight work while constantly adjusting to the dynamic VA healthcare landscape. VHA faces enormous challenges in meeting the demands and expectations of all its stakeholders. These demands include implementing simultaneous and massive enterprise-wide initiatives, such as community care reforms and the electronic health record modernization effort. OHI conducts meaningful inspections and reviews to identify gaps or weaknesses in VHA's delivery of high-quality and safe health care to veterans. Staff then formulate practical recommendations for improvement and corrective action to help VHA leaders and personnel address identified issues.

Having dedicated and engaged leaders has never been more critical to the success of VHA. Accordingly, OHI has provided the oversight necessary to assess leaders' efforts in building and upholding a culture that prioritizes patient safety and access to high-quality care. Throughout this reporting period, healthcare inspections staff have expanded their proactive reviews to probe subjective and descriptive elements of leadership related to culture, as well as objective compliance with core elements foundational to all healthcare facilities. Collectively, the findings across all OHI reviews have reinforced the connection between the culture created by leaders and the safety of patients and quality of care provided by staff.

This reporting period, three new cyclical inspection programs published inaugural reports that concentrate on key aspects of healthcare delivery that are vital to meeting the complex needs of veterans. The Healthcare Facility Inspections (HFI) program, which replaces the longstanding Comprehensive Healthcare Inspections Program, reviews facility implementation and practice of VHA's high reliability organization principles and explores the staff's perception of facility culture. Healthcare facility inspections also evaluate programs specific to serving a veteran population, such as the programs for veterans experiencing homelessness and the Veterans Justice Outreach Program. OHI released its first two HFI publications this period, focusing on the VA Hudson Valley Healthcare System in Montrose, New York, and the Orlando VA Medical Center in Florida. The latter highlighted the difficulties faced by the medical center's Health Care for Homeless Veterans staff in meeting performance expectations as well as the extraordinary efforts of the Veterans Justice Outreach Program staff to conduct community outreach activities. The OHI inspection team found that leaders responded to facility staff's concerns of burnout by hiring a chief clinical well-being officer and providing a variety of wellness activities. Facility staff also reported effective communication from leaders.

The second cyclical inspection program, OHI's new Mental Health Inspection Program (MHIP), evaluates VA's continuum of mental healthcare services. The program's first report, which is further detailed in the Featured Reports section below, focuses on the VA medical center in Augusta, Georgia. In that facility, the inspection team identified several leadership failures, such as an imbalance between the high

volume of referrals to community providers and the facility's low bed utilization. The team found there was insufficient access to facility mental health inpatient beds. Additional findings included significant confusion and failed communication between leaders and staff at multiple levels regarding a catastrophic ligature risk with toilet seats identified by OHI staff in the inpatient unit bathrooms. Despite leaders' awareness of the risk, it remained unaddressed for several years. The third new cyclical program published this reporting period—Care in the Community inspections at the VISN level—will be discussed below.

OHI's increased proactive oversight efforts complement its in-depth for-cause reviews that analyze the root causes of identified deficiencies, particularly with issues that address leadership and facility culture. For example, one recent review described the impact of leaders failing to ensure basic patient safety activities were being conducted. At the Hampton VA Medical Center in Virginia, healthcare inspections staff found that because of multiple missteps in privileging processes for healthcare providers, quality reviews, and state licensing board reporting, facility leaders failed to hold a surgeon accountable for providing substandard care.

Of the 65 oversight products OHI published in the last six months, 19 were for-cause reports responsive to complaints made to the OIG hotline. In addition to the two HFI reports, one MHIP report, and one Care in the Community report (described below), OHI released eight national healthcare reviews, nine Vet Center Inspections Program reports, one management advisory memorandum, as well as its final 24 CHIP facility reports. All OHI reports and other products are listed in table 8 and on the VA OIG website.

Throughout this reporting period, a common theme emerged: Engaged leaders at every level are essential for

- creating a just culture in which vulnerabilities are identified and acted upon;
- ensuring accountable stewardship of resources; and
- empowering staff to deliver safe, high-quality care.

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.

NATIONAL HEALTHCARE REVIEWS

The eight national healthcare reviews published during this reporting period explore issues such as concerns with VA's new electronic health record, VHA's implementation of the VA Sustainability Plan,

the process for identifying healthcare providers removed from VA employment, perceived barriers in coordinating veteran maternity care, and personnel's preparedness for the National Suicide Prevention Hotline implementation. Two examples follow:

VETERANS HEALTH ADMINISTRATION'S FAILURE TO PROPERLY IDENTIFY AND EXCLUDE INELIGIBLE PROVIDERS FROM THE VA COMMUNITY CARE PROGRAM

The OIG reviewed the process by which VHA identifies healthcare providers who had been removed from VA employment due to violations of policy "relating to the delivery of safe and appropriate care" and excludes them from the VA Community Care Program, as required by the MISSION Act. The OIG found that VHA's process failed to identify all healthcare providers removed from VA employment and did not accurately identify personnel actions that indicated the removal was for violating policies relating to the delivery of safe and appropriate care. The process used does not discern the reason a provider was removed. These breakdowns resulted in ineligible healthcare providers being included in the community care program, as well as eligible providers being excluded. VHA concurred with the OIG's two recommendations to improve the criteria and procedures used to identify ineligible healthcare providers and the reason for their removal from VA employment.

VETERANS CRISIS LINE IMPLEMENTATION OF "988 PRESS 1" PREPARATION AND LEADERS' RESPONSE

This review focused on how Veterans Crisis Line (VCL) personnel prepared for implementation of the National Suicide Prevention Hotline three-digit dialing code "9-8-8 press 1." Specifically, the review team examined call responder and supervisor staffing and training, information technology equipment and support, data on quality metrics, and oversight. While the review revealed that more frontline staff were hired in anticipation of a rise in call volume, VCL leaders had not increased the number of supervisors to meet the required supervisor-to-staff ratio. The review team identified a concern related to frontline staff's unawareness of "postvention" resources, which are interventions designed to support the bereaved following a loved one's suicide. As to information technology, however, the inspection team found that VCL leaders worked effectively with the Office of Information and Technology to assess, plan for, and implement technology changes related to the three-digit transition. Additionally, data on quality metrics were reported monthly to VCL leaders at executive leadership committee meetings and reflected quality oversight. The OIG made two recommendations to the VCL director on determining the optimal supervisor-to-staff ratio and ensuring staff receive training on all available postvention resources.

HEALTHCARE INSPECTIONS

These for-cause inspections (including those referred to as "hotline inspections" in previous semiannual reports to Congress) 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 19 inspections published during the second half of FY 2024, the three summaries below highlight weaknesses in VHA oversight, systems, and processes. Specifically, they focus on inadequate care for a patient who died by suicide on a medical unit, failures by leaders to adhere to high reliability organization principles, and surgical privileging and quality management deficiencies.

INADEQUATE CARE OF A PATIENT WHO DIED BY SUICIDE ON A MEDICAL UNIT AT THE SHERIDAN VA MEDICAL CENTER IN WYOMING

The inspection team substantiated an allegation of inadequate clinical care provided to a patient who died by suicide in the inpatient medical unit. Despite the patient being admitted to the facility for the treatment of suicidal ideations and alcohol withdrawal, clinical staff did not follow policies and procedures related to suicide risk assessments and evaluations, documentation and communication, and environmental safety. The OIG found, however, that clinical staff managed the patient's alcohol withdrawal symptoms by properly using the Clinical Institute Withdrawal Assessment of Alcohol Revised protocol and lorazepam orders, except for one medication error that had no impact on the patient's outcome. Facility leaders evaluated and addressed the issues raised by the patient's suicide through actions that included a root cause analysis in accordance with VHA policy. The OIG made four recommendations related to screenings, evaluations, documentation, and removing environmental risks for suicidal patients.

LEADERS AT THE VA EASTERN COLORADO HEALTH CARE SYSTEM IN AURORA CREATED AN ENVIRONMENT THAT UNDERMINED THE CULTURE OF SAFETY

In an inspection involving the healthcare 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.

MISMANAGED SURGICAL PRIVILEGING ACTIONS AND DEFICIENT SURGICAL SERVICE QUALITY MANAGEMENT PROCESSES AT THE HAMPTON VA MEDICAL CENTER IN VIRGINIA

This inspection reviewed surgical service and quality management concerns at the Hampton VA Medical Center. The OIG found multiple failures in facility leaders' responses to clinical care concerns and subsequent privileging actions involving the assistant chief of surgery, as well as not reporting the surgeon to the state licensing board. The team also identified deficiencies in conducting professional practice evaluations of surgeons; holding morbidity and mortality conferences in accordance with policy; referring cases for peer review; conducting peer reviews with concurrent management reviews; and completing institutional disclosures as required. The OIG issued one recommendation to the VISN director and 11 recommendations to the facility director to correct these issues.

MANAGEMENT ADVISORY MEMORANDUM

FACILITY LEADERS AND STAFF HAVE CONCERNS ABOUT VA'S NEW ELECTRONIC HEALTH RECORD

The OIG issued this management advisory memorandum following Healthcare Facility Inspections conducted at the VA Southern Oregon Healthcare System and the Jonathan M. Wainwright Memorial VA

Medical Center in Walla Walla, Washington. Leaders and staff at the facilities described several notable concerns with the new electronic health record related to efficiency and loss of productivity, staffing, financial impacts, and patient safety. The OIG requested the under secretary for health evaluate whether the issues cited in the memorandum warrant process reviews and/or contract enhancements to improve identified issues.

PROACTIVE, CYCLICAL INSPECTION PROGRAMS

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM

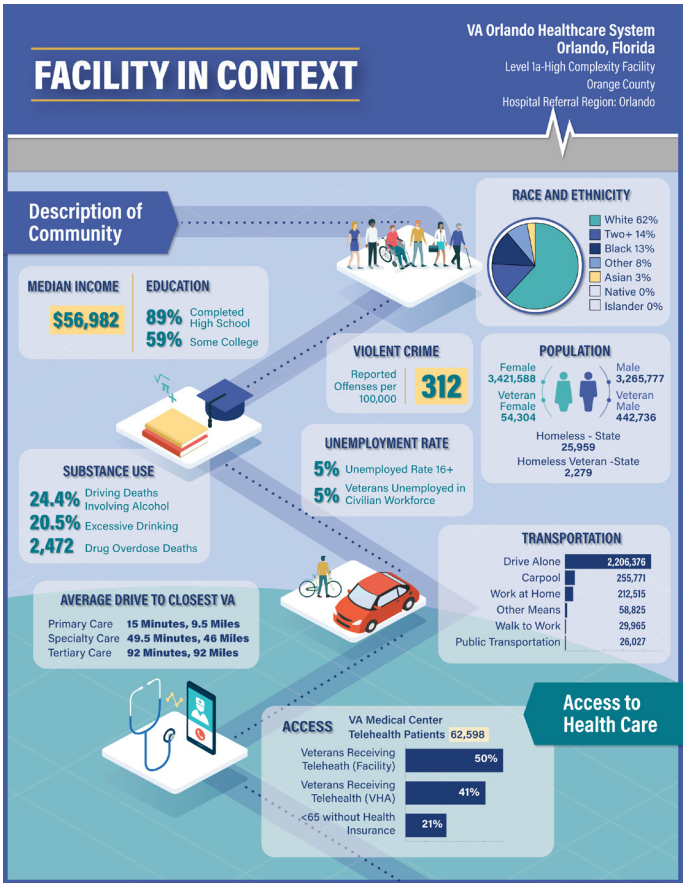
Before being replaced by the HFI program, CHIP reviews had been an important element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. All CHIP reports were based on inspections that were routinely and proactively performed approximately every three years for each VA medical facility to help consistently examine key conditions and activities. CHIP inspections evaluated specific areas of focus on a rotating basis each year. OHI published its last 24 facility-level CHIP reports during this reporting period, which focused on the areas of (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).

HEALTHCARE FACILITY INSPECTIONS PROGRAM

HFI reports also are based on inspections of VHA medical facilities on an approximately three-year cycle. They measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and a veteran-centered safety net (for vulnerable populations such as those served by homeless programs). The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff. As mentioned earlier, one of two HFI reports released during this period focused on the VA Orlando Healthcare System in Florida. The other inspection was conducted at the VA Hudson Valley Healthcare System in Montrose, New York.

CARE IN THE COMMUNITY HEALTHCARE INSPECTION PROGRAM

This program examines key clinical and administrative processes that are associated with providing quality VA and community care, specifically focusing processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results,



Facility in Context (from *Healthcare Facility Inspection of the VA Orlando Healthcare System in Florida*, September 24, 2024)

Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, and Care Coordination: Scheduling and Communication with Patients Referred for Community Care. The OIG published one Care in the Community healthcare inspection report in the second half of FY 2024 that evaluated VISN 9's compliance with processes to ensure eligible veterans receive timely, high-quality care when referred to the community. The OHI team identified widespread noncompliance with basic processes, such as obtaining diagnostic imaging results, processing follow-up care requests from community providers, and reporting patient safety events. As VHA contends with expanding community care services, OHI's inspection program will continue to provide feedback to VISN leaders on indicators critical to the provision of safe, seamless, and coordinated care.

MENTAL HEALTH INSPECTION PROGRAM

MHIP evaluates acute inpatient mental health care across six topic domains: leadership and organizational culture, high reliability principles, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. The first mental health inspection publication, released during this reporting period, was of the VA Augusta Healthcare System in Georgia. The team identified concerns with mental health committee structures, oversight and monitoring, and staffing practices. The inpatient mental health unit had some areas that did not meet VHA standards for a safe, hopeful, and healing environment. The OIG found communication gaps and information discrepancies among leaders regarding low census (fewer patients than bed capacity on the inpatient mental health unit) and the extent of community care used. Staff did not comply with required documentation for medication discussions, safety plans, and discharge summaries and instructions. The OIG also found noncompliance with suicide risk screening and evaluation, ongoing assessment of suicide hazards, and completion of mandatory suicide prevention and environment of care staff trainings. The OIG issued a total of 21 recommendations across all six domains.

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. For the nine VCIP reports published this period, the areas of focus were (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 next year from the multiple site visits already conducted.

The Office of Management and Administration

This office provides the structure and services needed to support OIG operations and has been overseeing the execution of the largest budget to date in FY 2024 at $296 million. Furthermore, the enterprise-wide recruitment and retention efforts—conducted in partnership with all directorates—have contributed to the growth of the OIG to more than 1,180 employees, which is also its highest workforce level to date.

During this reporting period, the Office of Management and Administration (OMA) developed and implemented a forward-leaning staffing model to reduce gaps between vacancies. With most of the OIG's budget allocated for personnel, the staffing model improved planning, oversight, and successful spending execution. OMA also took steps to ensure current staff were supported through updated internal guidance, including records management policies in accordance with National Archives and Records Administration regulations, policy, and guidance. Further, a revamped OIG leadership training program was launched, as was a diversity, equity, inclusion, and accessibility (DEIA) maturity model to evaluate the program's strengths and weaknesses. These efforts bolster the OIG's commitment to cultivating a positive work environment and culture with opportunities for advancement, fostering employees' sense of belonging, and promoting core values across the agency.

Staff promoted further efficiencies by continuing to assess the OIG's real estate footprint to ensure leased space reflects the effective use of resources and meets the needs of personnel. To that end, OMA opened two offices, relocated five offices, and initiated the redesign of an additional site.

The information technology (IT) divisions completed an internal infrastructure refresh and cloud architecture design to meet the agency's complex technology requirements. Upgrades and patches were deployed that mitigate vulnerabilities and strengthen the OIG's security posture. Further, OMA initiated the creation of an IT Steering Committee to help institute comprehensive IT governance that fosters transparency, accountability, and informed decision-making in the management of IT resources, including the responsible integration of artificial intelligence into OIG operations.

OMA also continued to research upgraded call center software for Hotline Division use, which received and responded to a high volume of complaints regarding VA programs and services. During this six-month reporting period, hotline staff screened 18,502 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 661 cases to and required a written response from applicable VA offices for OIG review, 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 780 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 376 cases for which nearly 38 percent of allegations were substantiated, 345 administrative sanctions and corrective actions were taken, and more than $518,924 in monetary benefits were achieved
- Responded to 1,245 requests for senior personnel record reviews from VA staff offices prior to promotions, new jobs, and awards
- Issued 1,774 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 four cases opened by the OIG's hotline that were not included in inspections, audits, investigations, or reviews by other directorates.

FORMER SPOUSE OF DECEASED VETERAN DEFRAUDED VA'S DEPENDENCY AND INDEMNITY COMPENSATION PROGRAM

Hotline staff 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 VBA regional office therefore terminated the benefits and established a $175,000 debt for the former spouse.

VBA FAILURE TO RESOLVE AN ERRONEOUS SUSPENSION OF A DISABLED VETERAN'S BENEFITS RESULTED IN FINANCIAL HARDSHIP FOR THE VETERAN AND HIS FAMILY

Allegations made to the hotline included that VBA erroneously suspended a disabled veteran's benefits and failed to resolve the issue for more than three months, making it difficult for the veteran and his family to pay expenses. In January 2024, the Board of Veterans' Appeals granted service-connected disability compensation to the veteran, including six years of retroactive compensation that resulted in an award of over $150,000. VBA issued the payment to the veteran's financial institution; however, because the institution does not accept deposits greater than $50,000, the payment was returned to VBA. The returned payment caused VBA to suspend the veteran's benefits. Despite 10 or more contacts

from the veteran for over three months, VBA had not restored the veteran's benefits until OIG hotline staff intervened by requesting a review by VA's Winston-Salem Regional Office. The regional office's responsive fact-finding investigation substantiated the allegation. The veteran's benefits were restored within one day of the hotline referral, and the retroactive payment was reissued to the veteran within six days.

VA MEDICAL CENTER IN TUCSON, ARIZONA, FAILED TO FOLLOW NATIONAL GUIDANCE FOR CONTINUOUS GLUCOSE MONITORING

Another complainant alleged that the Tucson VA Medical Center was not following national guidance for continuous glucose monitoring (CGM). CGM assists diabetic patients in managing their blood glucose levels using a wearable device. The matter was referred to and reviewed by VISN 22, which substantiated the allegation. The VISN's fact-finding team conducted interviews with medical center leaders and staff in primary care, pharmacy, and endocrinology. They also reviewed the facility's patient advocate cases associated with CGM. Following its review, the VISN oversaw corrective actions at the medical center, including forming a workgroup to adjudicate CGM prescription and patient safety; developing a plan for making CGM available for veterans who meet VHA guidance criteria; and training staff to help expand and manage the program.

OBSOLETE AND DAMAGED HEMODIALYSIS EQUIPMENT CAUSED PATIENT SAFETY CONCERNS AT THE SAN JUAN VA MEDICAL CENTER IN PUERTO RICO

The medical center conducted a review after receiving an OIG hotline referral, which substantiated allegations of damaged and obsolete equipment in the hemodialysis unit. Specifically, 48 of 61 pieces of assigned property were past their predetermined equipment "duration expectancy"—similar to an expiration date. The medical center review team also found all 14 beds in the hemodialysis unit were within a year of their replacement dates, including one that was not in service and pending repair and six that were missing key functionalities. Of particular concern, the improper functionality of one bed was found to be a contributing factor in three employee injuries. The medical center has since taken that bed out of service and replaced a total of six beds through existing hospital stock. However, the medical center review team recommended that all 14 beds be replaced early.

Check out the latest

MONTHLY HIGHLIGHTS

Each month, the VA OIG publishes highlights of its investigative work, oversight reports, and congressional testimony. The highlights are meant to provide a brief overview of the most significant OIG work conducted in that period. To read more highlights, visit the **OIG website**.

Statistical Performance

At a Glance: Selected Metrics for the Fiscal Year

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

Table 1. Monetary Impact and Return on Investment

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Better Use of Funds	$267,430,319	$180,374,106	$447,804,425
Dollar Recoveries	$4,816,552	$5,823,139	$10,639,691
Fines, Penalties, Restitution, and Civil Judgments[13]	$3,026,233,523	$1,140,774,391	$4,167,007,914
Fugitive Felon Program	$72,075,414	$50,400,000	$122,475,414
Savings and Cost Avoidance	$71,042,185	$35,898,627	$106,940,812
Questioned Costs	$1,689,460,857	$37,679,787	$1,727,140,644
Total Dollar Impact	**$5,131,058,850**	**$1,450,950,050**	**$6,582,008,900**
Cost of OIG Operations[14]	$115,353,828	$117,644,541	$232,998,369
Return on Investment[15]	**$44:1**	**$12:1**	**$28:1**

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

13 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 $2,013,534,367. This amount includes forfeited funds for which VA could submit a petition for remission.

14 The six-month and fiscal year operating costs for OHI ($32,646,172 and $63,001,631, respectively), 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.

15 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	LAST PERIOD	FISCAL YEAR
Administrative Investigations	1	1	2
Audits and Reviews	34	14	48
Care in the Community Inspections (National-Level)	1	1	2
Claim Reviews	2	0	2
Comprehensive Healthcare Inspection Program (National-Level)	1	1	2
Comprehensive Healthcare Inspection Program (VISN- and Facility-Level)	24	38	62
Financial Inspections	4	2	6
Healthcare Facility Inspections	2	0	2
Healthcare Inspections	19	14	33
Information Security Inspections	3	0	3
Mental Health Inspections	1	0	1
National Healthcare Reviews	7	4	11
Postaward Contract Audits and Reviews*	14	10	24
Preaward Contract Audits and Reviews*	27	27	54
Vet Center Inspections	9	0	9
Subtotal	**149**	**112**	**261**
OTHER PRODUCTS	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Budget Request	0	1	1
Congressional Testimonies	11	4	15
Crime Alerts	2	2	4
Major Management Challenges	0	1	1
Management Advisory Memoranda	5	5	10
Monthly Highlights	6	6	12
Peer Reviews Completed of Other OIGs	1	1	2
Podcasts	5	3	8
Press Releases	0	1	1
Whistleblower Reprisal Investigation Memoranda*	1	0	1
Subtotal	**31**	**24**	**55**
Total	**180**	**136**	**316**

* Denotes products prohibited from public release pursuant to federal law.

Table 3. Selected Office of Investigations Activities

TYPE[16]	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Arrests[17]	137	112	249
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	4	35	39
Indictments	106	91	197
Indictments and Informations Resulting from Prior Referrals to Authorities	39	29	68
Criminal Complaints	27	22	49
Convictions	101	78	179
Pretrial Diversions and Deferred Prosecutions	10	7	17
Case Referrals to DOJ for Criminal Prosecution[18]	143	157	300
Case Referrals to State and Local Authorities for Criminal Prosecution[19]	34	25	59
Administrative Sanctions and Corrective Actions	157	101	258
Cases Opened	215	178	393
Cases Closed	221	183	404

16 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**.

17 Total arrests include eight apprehensions of fugitive felons by VA OIG agents this period and 16 for the fiscal year. This total does not include fugitive felon arrests made by other agencies with VA OIG assistance.

18 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.

19 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	LAST PERIOD	FISCAL YEAR
Hotline Referral Reviews	121	118	239
Investigative Interviews	83	98	181
Reviews of Complaints Alleging Whistleblower Reprisal by VA Contractors or Grantees	9	4	13
Substantiated Instances of Contractor/Grantee Whistleblower Reprisal	1	0	1

Table 5. Selected Office of Healthcare Inspections Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Clinical Consultations to Other VA OIG Offices	6	2	8
Clinical Consultations to Other Federal Entities	0	1	0
Hotline Referrals Reviewed	2.344	1,966	4,310

Table 6. Selected Hotline Division Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Contacts	18,502	15,617	34,119
Cases Opened	661	582	1,243
Cases Closed	376	394	770
Administrative Sanctions and Corrective Actions	345	358	703
Substantiation of Allegations Percentage Rate	38%	43%	41%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	20	20	40
Individuals Provided Office of Special Counsel Contact Information	62	62	124
Individuals Provided Merit Systems Protection Board Contact Information	11	7	18
Individuals Provided Office of Resolution Management Contact Information	101	108	209

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.[20] 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.[21] The tables that follow identify OIG investigations and reports by type and date and include hyperlinks to their respective publications (when available).

Significant Criminal Investigations with Judicial Actions This Period

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, none of the investigations listed in table 7 are responsive to this reporting requirement.[22] There is one case meeting this reporting requirement detailed in **Closed Work Not Disclosed to the Public**.

TABLE 7. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD

DATE	TITLE
VHA INVESTIGATIONS	
CHAMPVA, DRUG DIVERSION, AND OTHER HEALTHCARE FRAUD	
4/2/2024	**Three Defendants Sentenced to Prison and $6.9 Million Forfeiture for Roles in Fraudulent Nursing Diploma Scheme**
5/2/2024	**Manufacturer Ordered to Pay Over $1.5 Billion in Criminal Fines and Forfeiture for Distributing Misbranded Opioid Drug**

20 5 U.S.C. § 405(b)(2) and § 405(b)(3) (as amended by Pub. L. No. 117-263).

21 5 U.S.C. § 405(h) (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 7. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
CHAMPVA, DRUG DIVERSION, AND OTHER HEALTHCARE FRAUD (CONTINUED)	
5/22/2024	**Defendant Pleaded Guilty for Role in $51 Million Healthcare Fraud Scheme Involving Durable Medical Equipment, Genetic Cancer Screening Tests, and Compounded Medications**
5/29/2024	**Call Center Owner Sentenced for Role in Multimillion-Dollar Healthcare Kickback Scheme**
5/31/2024	**Pharmacy Owners Sentenced for Paying Illegal Kickbacks in Connection with Healthcare Fraud Scheme**
6/18/2024	**Former VA Registered Nurse Pleaded Guilty to Drug Diversion**
6/25/2024	**Former VA Pharmacist Pleaded Guilty to Theft of VA Pharmaceuticals**
6/26/2024	**Pharmacist and Accountant Sentenced in Connection with Healthcare Fraud Scheme Involving Unlawful Kickbacks**
7/22/2024	**Former VA Doctor Found Guilty of Illegally Distributing Over 1.8 Million Doses of Opioids and Engaging in a $5 Million Healthcare Fraud Scheme**
7/25/2024	**Two Health Services Company Owners Sentenced for Compounding Pharmacy Conspiracy**
7/31/2024	**Permanent Injunction Issued against Two Debt Collection Agencies**
8/22/2024	**Acupuncturist Agreed to Pay $850,000 to Resolve False Claims Act Allegations**
VBA INVESTIGATIONS	
EDUCATION BENEFITS FRAUD	
4/19/2024	**Default Civil Judgment Returned Against Barber School and Owner for Education Benefits Fraud Scheme**
5/28/2024	**School Owner and Certifying Official Admitted to Defrauding VA's Post-9/11 GI Bill Program**
7/8/2024	**For-Profit Schools and Their Owner Agree to Pay $1.35 Million to Resolve False Claims Allegations Involving Alleged Post-9/11 GI Bill Overcharges**
8/8/2024	**Vocational School Owner Agreed to Pay More Than $2 Million to Resolve Education Benefits Fraud Allegations**
THEFT OF GOVERNMENT FUNDS, FIDUCIARY FRAUD, AND LOAN GUARANTY FRAUD	
4/2/2024	**Veteran Sentenced for Misleading VA and the Social Security Administration about His Ability to Walk**
4/3/2024	**Nonveteran Charged with Stolen Valor and Benefits Fraud**
5/1/2024	**Former VA Fiduciary Sentenced for Stealing Benefits from Veteran**

TABLE 7. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
THEFT OF GOVERNMENT FUNDS, FIDUCIARY FRAUD, AND LOAN GUARANTY FRAUD (CONTINUED)	
5/6/2024	**Veteran Sentenced for Making False Statements about His Claimed Disability**
5/7/2024	**Veteran Pleaded Guilty to Theft of Government Funds**
5/31/2024	**Veteran and His Spouse Charged for Defrauding VA for Compensation and Caregiver Support Benefits**
6/7/2024	**Former VA Fiduciary Sentenced for Stealing VA Funds Intended for Veteran**
6/10/2024	**Veteran and Spouse Indicted for Compensation Benefits Fraud Scheme**
6/11/2024	**Veteran Sentenced for Theft of Government Funds**
6/11/2024	**Nonveteran Charged with Stealing Over $450,000 in VA Compensation Benefits from Disabled Veteran**
6/24/2024	**Veteran Sentenced in Connection with Benefits Fraud Scheme**
6/24/2024	**Veteran's Sister Sentenced for Stealing His VA and Social Security Benefits**
6/25/2024	**Veteran Found Guilty for Lying about Being a Paraplegic to Receive Disability Benefits**
8/21/2024	**Veteran Sentenced in Connection with Multiple Fraud Schemes**
8/23/2024	**VBA Quality Review Specialist Pleaded Guilty to Theft of Government Funds**
8/28/2024	**Veteran Indicted for Benefits Fraud Scheme**
9/4/2024	**Daughter of Deceased VA Beneficiary Indicted for Wire Fraud**
9/12/2024	**Former VA Fiduciary Pleaded Guilty to Stealing VA Funds Intended for Veteran**
9/25/2024	**Nonveteran Pleaded Guilty to Stealing Over $450,000 in VA Compensation Benefits from Disabled Veteran**
OTHER INVESTIGATIONS	
EMBEZZLEMENT, BRIBERY, AND KICKBACKS	
4/8/2024	**Former Adult Day Care Center Board Member Pleaded Guilty to Embezzlement**
4/12/2024	**Former Procurement Supervisor Sentenced for Role in Kickback Scheme**
4/29/2024	**Former VA Vendor Found Guilty in Connection with Kickback Scheme**
4/30/2024	**Doctor and Lab Owner Sentenced in Connection with Kickback Scheme**
5/9/2024	**Physician Sentenced for Unnecessary Tests and Taking Bribes and Kickbacks**
6/20/2024	**Transportation Company Owner Sentenced for Role in Bribery Scheme**

TABLE 7. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
EMBEZZLEMENT, BRIBERY, AND KICKBACKS (CONTINUED)	
9/5/2024	**Medical Supply Company Owner and Former VA Supervisor Sentenced for Roles in Kickback Scheme**
SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD, WORKERS' COMPENSATION BENEFITS FRAUD, AND FALSE CLAIMS ACT SETTLEMENTS	
6/14/2024	**Adult Daycare Center Director Charged for Multimillion-Dollar Workers' Compensation Fraud Scheme**
6/21/2024	**Pharmacy Owner and Physical Therapy Clinic Owner Charged in Connection with Workers' Compensation Fraud Scheme**
7/31/2024	**Chemical and Laboratory Supply Company Entered into $5 Million Settlement for False Claims Act Allegations**
8/13/2024	**Two Nonveterans Sentenced in "Rent-A-Vet" Construction Fraud Scheme**
FRAUD RELATED TO COVID-19	
4/23/2024	**Thirteen VA Employees Indicted on Charges Related to COVID-19 Fraud Scheme**
5/17/2024	**VA Employee Sentenced for Fraudulently Obtaining Federal Pandemic Relief Loans**
5/23/2024	**Defendant Pleaded Guilty for Paycheck Protection Act and Economic Injury Disaster Loan Scheme**
5/28/2024	**Defendant Pleaded Guilty for Role in Paycheck Protection Act Fraud Scheme**
7/10/2024	**Owner of Defunct Business Pleaded Guilty to Fraudulently Obtaining Federal Pandemic Relief Loans**
7/18/2024	**Another Defendant Pleaded Guilty to Fraudulently Obtaining Federal Pandemic Relief Loans**
8/27/2024	**Spouse of VA Employee Sentenced for Fraudulently Obtaining Federal Pandemic Relief Loans**
8/29/2024	**Business Owner Sentenced for Paycheck Protection Act and Economic Injury Disaster Loan Scheme**
9/18/2024	**Plumbing and Heating Company Owner Pleaded Guilty to Economic Injury Disaster Loan Scheme**
SEX-RELATED OFFENSES	
4/16/2024	**Former VA Nurse Sentenced for Sexual Contact with Mentally Disabled Veteran**
5/7/2024	**Veteran Charged with Abusive Sexual Contact at the Albany VA Medical Center**
7/30/2024	**VA Phlebotomist Sentenced for Video Voyeurism**

TABLE 7. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
THREATS AND ASSAULTS AGAINST VA EMPLOYEES	
6/27/2024	**Nonveteran Pleaded Guilty in Case Involving Thousands of Fake Phone Calls to VA's Veterans Crisis Line**
7/11/2024	**Veteran Sentenced for Making Threats toward VA Facilities**
7/17/2024	**Another Veteran Pleaded Guilty to Threatening Staff at Edward Hines, Jr. VA Hospital and Local Law Enforcement Officers**
7/25/2024	**Veteran Sentenced for Firearm Possession at the Tulsa VA Outpatient Clinic**
8/13/2024	**Veteran Sentenced for Threatening VA and VA OIG Employees, the White House, and the DC OIG**

Reports and Other Products Issued This Reporting Period

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.[23] Those marked with a dagger (†) indicate reports 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.[24] A key to these symbols is included.

23 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.

24 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF AUDITS AND EVALUATIONS				
AUDITS AND REVIEWS				
4/9/2024	**Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance**	23-00876-74	—	—
5/2/2024	**Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia**	23-02020-85	—	—
5/8/2024	**Delays Occurred in Some Veterans' Benefits Claims While Awaiting Decision**	22-03463-60	—	—
5/8/2024	**Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams**	23-01059-72	—	—
5/14/2024	**Federal Information Security Modernization Act Audit for Fiscal Year 2023**	23-01105-69	—	—
5/23/2024	**Software Delayed the Establishment of Supplemental Claims for Appeals of Benefits Decisions**	23-01232-109	—	—
5/23/2024	**Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2023**	24-00510-167	—	—
5/29/2024	**Evaluation of the May 2023 Power Outage at the Hines Information Technology Center in Illinois**	23-03063-164	—	—
6/11/2024	**Ineffective Use and Oversight of Medical/Surgical Prime Vendor Program Led to Increased Spending**	23-01397-126	$63,100,000	—
6/27/2024	**VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits**	23-01266-78	—	$1,008,400,000

* Denotes products prohibited from public release pursuant to federal law.

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
7/10/2024	**Lessons Learned for Improving the Integrated Financial and Acquisition Management System's Acquisition Module Deployment**	23-00151-117	—	—
7/16/2024	**Better Collection of Family Preference Data May Minimize Risk of Burial Scheduling Delays**	23-01773-166	—	—
7/17/2024	**VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability**	23-01772-162	—	$100,000,000
8/8/2024	**Unauthorized Community Care Dental Procedures Risked Improper Payments**	23-00749-171	—	$325,500,000
8/15/2024	**Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times**	23-01583-183	—	$200,232,348 *($200,232,348 unsupported costs)*
8/28/2024	**VBA Needs to Improve Oversight of the Digital GI Bill Platform**	23-01252-175	—	—
9/3/2024	**Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2022**	23-03356-196	—	—
9/4/2024	**A Hiring Initiative to Expand Substance Use Disorder Treatment Needed Stronger Coordination, Planning, and Oversight**	22-03672-199	—	—
9/5/2024	**A Summary of OIG Preaward Contract Reports Issued in Fiscal Years 2022 and 2023 on VA Federal Supply Schedule Nonpharmaceutical Proposals**	24-00987-225	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
9/10/2024	**Fiscal Year 2023 Risk Assessment of VA's Charge Card Program**	23-02910-197	—	—
9/10/2024	**A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2023 on VA Federal Supply Schedule Pharmaceutical Proposals**	24-00480-220	—	—
9/11/2024	**Summary of Fiscal Year 2023 Preaward Audits for Healthcare Resource Proposals from Affiliates**	24-01199-194	—	—
9/11/2024	**A Summary of Reviews in Fiscal Years 2022 and 2023 of Manufacturers' Noncompliance with Veterans Health Care Act Provisions on Pharmaceutical Pricing**	24-01035-206	—	—
9/12/2024	**Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management**	23-02123-202	—	—
9/17/2024	**VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2024**	22-00879-249	—	—
9/17/2024	**Action Needed to Ensure VA Meets Staffing and Vacancy Reporting Requirements under the MISSION Act of 2018**	24-01170-232	—	—
9/18/2024	**Additional Controls Are Needed to Improve the Reliability of Grant and Per Diem Program Data**	23-02610-226	—	—
9/19/2024	**Independent Audit Report of a Dialysis Provider's Contract Pricing and Billing Compliance**	22-02161-200	—	—

* Denotes products prohibited from public release pursuant to federal law.

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
9/19/2024	**VA Continues Moving toward Full Compliance with Geospatial Data Covered Agency Responsibilities**	24-00122-247	—	—
9/23/2024	**VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents**	22-03591-231	—	—
9/25/2024	**Alleged Mismanagement of Contracts for Wheelchair-Accessible Transportation Services by the Health Administration Service at the Dallas VAMC in Texas**	23-03128-213	—	$3,739,068
9/25/2024	**VHA Needs to Establish Controls for Its Ambulatory Care Budget Estimate**	23-01624-243	—	—
9/26/2024	**Cardiothoracic Services Contracting at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, Needs Improvement**	23-02994-224	—	—
9/30/2024	**VBA's and NCA's Personnel Suitability Programs Need Improved Governance**	23-02890-209	—	—
CLAIM REVIEWS*				
5/7/2024	**Independent Audit Report on a Certified Claim Submitted under a Lease Contract**	24-00630-170	$4,346,625	—
9/10/2024	**Independent Audit Report on a Subcontractor Claim Submitted under a Lease Contract**	24-02348-255	$3,963,826	—

* Denotes products prohibited from public release pursuant to federal law.

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
FINANCIAL INSPECTIONS				
6/6/2024	**Financial Efficiency Inspection of the VA North Texas Health Care System**	23-02181-98	$12,200,000	$24,170,500 *($16,600,000 unsupported costs)*
9/3/2024	**Follow-Up Financial Efficiency Inspection of the Southeast Louisiana Veterans Health Care System in New Orleans**	23-02907-216	—	$14,980,000 *($2,800,000 unsupported costs)*
9/11/2024	**Financial Efficiency Inspection of the VA Pittsburgh Healthcare System**	23-03278-233	$87,000	$403,000
9/19/2024	**Financial Efficiency Inspection of the VA Northeast Ohio Healthcare System**	24-00153-248	$5,500,000	$10,400,000 *($15,164 unsupported costs)*
INFORMATION SECURITY INSPECTIONS				
5/30/2024	**Follow-Up Information Security Inspection at the VA Financial Services Center in Austin, Texas**	23-02186-97	—	—
6/5/2024	**Inspection of Information Security at the VA Bedford Healthcare System in Massachusetts**	23-02330-127	—	—
9/5/2024	**Follow-Up Information Security Inspection at the Southwest Consolidated Mail Order Pharmacy in Tucson, Arizona**	23-03721-180	—	—
MANAGEMENT ADVISORY MEMORANDA				
6/20/2024	**Potential Weaknesses Identified in the VISN 20 Personnel Suitability Program**	23-02949-177	—	—
7/16/2024	**The Pause of the Program Integrity Tool Is Impeding Community Care Revenue Collections and Related Oversight Operations**	21-00846-178	—	—

* Denotes products prohibited from public release pursuant to federal law.

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MANAGEMENT ADVISORY MEMORANDA (CONTINUED)				
7/25/2024	**VBA Did Not Always Properly Implement Compensation Cost-of-Living Adjustments**	24-00493-174	—	—
POSTAWARD CONTRACT AUDITS AND REVIEWS*				
4/8/2024	**Independent Audit Report of a Change Order Request Submitted under a VA Contract**	23-03004-141	—	—
4/9/2024	**Post Award Review of a Federal Supply Schedule Contract**	21-02529-139	—	$7,704
4/15/2024	**Independent Audit Report on a Termination Settlement Proposal Submitted under a VA Contract**	23-03687-159	$111,436	—
4/25/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	23-01541-145	—	$51,245
7/5/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts**	23-02511-184	—	$555,442
7/24/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts**	24-01036-192	—	$21,815
8/1/2024	**Independent Audit Report of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract**	24-01515-215	—	$48,574
8/7/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	24-01034-214	—	$1,002

* Denotes products prohibited from public release pursuant to federal law.

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS AND REVIEWS* (CONTINUED)				
9/11/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	23-00494-241	—	$109,725
9/17/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	24-01298-260	—	$162,804
9/17/2024	**Independent Audit Report of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract**	24-01519-261	—	—
9/19/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	24-01037-258	—	$35,868
9/20/2024	**Independent Audit Report of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract**	24-01158-257	—	$5,096
9/23/2024	**Post Award Review of a Voluntary Disclosure Submitted under a Federal Supply Schedule Contract**	19-00211-263	—	$636,667
PREAWARD CONTRACT AUDITS AND REVIEWS*				
4/2/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under an Offer**	24-00131-140	—	—
4/9/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00381-120	$9,970,728	—
4/24/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03533-154	$245,424	—

* Denotes products prohibited from public release pursuant to federal law.

TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS* (CONTINUED)				
4/24/2024	**Independent Audit Report of a Request for Modification – Product Additions – Submitted under a Federal Supply Schedule Contract**	24-00260-155	—	—
5/2/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00894-163	$1,376,806	—
5/10/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	24-00319-172	$6,894,359	—
5/13/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-00899-165	$974,865	—
6/4/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-01596-181	—	—
6/24/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	24-00723-190	$86,971	—
7/2/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03502-182	$58,373	—
7/2/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-02238-191	$3,739,616	—
7/2/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03689-198	$451,364	—
7/9/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03504-193	$41,854,153	—
7/9/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	24-01198-201	$25,052,756	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS* (CONTINUED)				
8/2/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-01641-219	$11,982,682	—
8/6/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-02235-210	$59,136,240	—
8/6/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	24-01518-228	$3,059,805	—
8/19/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	24-01737-240	—	—
8/20/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-01736-223	—	—
8/20/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-02369-229	—	—
8/21/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02525-239	—	—
8/28/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-01246-244	—	—
8/30/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-01705-242	$6,841,189	—
9/5/2024	**Independent Audit Report of a Product Addition Proposal Submitted under a Contract**	24-00348-245	$3,946,692	—
9/9/2024	**Independent Audit Report of a Contract Extension Proposal Submitted under a Contract**	24-01947-253	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS* (CONTINUED)				
9/12/2024	**Independent Audit Report of a Proposal Submitted under a Contract**	24-02367-252	$719,800	—
9/23/2024	**Independent Audit Report of a Proposal Submitted under a Solicitation**	24-02564-264	$1,729,610	—
OFFICE OF HEALTHCARE INSPECTIONS				
CARE IN THE COMMUNITY INSPECTIONS (VISN- AND FACILITY-LEVEL)				
8/15/2024	**VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers**	23-01737-205	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (NATIONAL-LEVEL)				
4/24/2024	**Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care**	23-00540-146	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL)				
4/2/2024	**VA Central Iowa Health Care System in Des Moines**	23-00096-122	—	—
4/3/2024	**Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan**	23-00111-119	—	—
4/3/2024	**VA Maine Healthcare System in Augusta**	23-00109-121	—	—
4/4/2024	**VA Northern Indiana Health Care System in Marion**	22-04112-125	—	—
4/9/2024	**Syracuse VA Medical Center in New York**	23-00016-132	—	—
4/10/2024	**Bay Pines VA Healthcare System in Florida**	22-04014-130	—	—
4/10/2024	**VA Salt Lake City Health Care System in Utah**	23-00013-128	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL) (CONTINUED)				
4/11/2024	**Martinsburg VA Medical Center in West Virginia**	23-00012-136	—	—
4/11/2024	**VA Bedford Healthcare System in Massachusetts**	23-00101-137	—	—
4/16/2024	**Tuscaloosa VA Medical Center in Alabama**	23-00024-133	—	—
4/16/2024	**Boise VA Medical Center in Idaho**	23-00116-148	—	—
4/17/2024	**G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi**	23-00094-123	—	—
4/17/2024	**Jesse Brown VA Medical Center in Chicago, Illinois**	23-00103-138	—	—
4/17/2024	**Edward Hines, Jr. VA Hospital in Hines, Illinois**	23-00118-157	—	—
4/23/2024	**Louis A. Johnson VA Medical Center in Clarksburg, West Virginia**	23-00108-149	—	—
4/24/2024	**VA Illiana Health Care System in Danville, Illinois**	23-00107-135	—	—
4/24/2024	**VA Nebraska-Western Iowa Health Care System in Omaha**	23-00098-151	—	—
4/25/2024	**Central Virginia VA Health Care System in Richmond**	23-00104-134	—	—
4/25/2024	**VA Eastern Kansas Health Care System in Topeka**	23-00102-150	—	—
4/25/2024	**Kansas City VA Medical Center in Missouri**	23-00119-156	—	—
4/30/2024	**VA Finger Lakes Healthcare System in Bath, New York**	23-00121-158	—	—
5/1/2024	**Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri**	23-00112-161	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL) (CONTINUED)				
5/2/2024	VA Maryland Health Care System in Baltimore	23-00159-160	—	—
5/15/2024	Roseburg VA Health Care System in Oregon	23-00110-168	—	—
HEALTHCARE FACILITY INSPECTIONS				
9/24/2024	VA Orlando Healthcare System in Florida	24-00585-246	—	—
9/24/2024	VA Hudson Valley Healthcare System in Montrose, New York	24-00601-254	—	—
HEALTHCARE INSPECTIONS				
4/23/2024	Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California	23-01602-147	—	—
4/30/2024	Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VAMC in Albuquerque, New Mexico	23-02383-152	—	—
5/21/2024	System Leaders' Response to Allegations Related to Access to Behavioral Health Care at the El Paso VA Health Care System in Texas	23-03167-173	—	—
6/18/2024	Deficiencies in Oversight and Leadership Response to Optometry Concerns at the Cheyenne VA Medical Center in Wyoming	23-00460-185	—	—
6/24/2024	Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety	23-02179-188	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
6/24/2024	**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**	23-02179-189	—	—
7/10/2024	**Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana**	23-02898-195	—	—
7/23/2024	**Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia**	23-00995-211	—	—
7/24/2024	**Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona**	23-02958-203	—	—
7/25/2024	**Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming**	23-03159-204	—	—
7/31/2024	**Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas**	23-00776-207	—	—
7/31/2024	**Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10**	23-01601-208	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
8/1/2024	**Deficiencies in Informed Consent for Admission and Against Medical Advice Discharge Processes for a Patient at the VA Southern Nevada Healthcare System in Las Vegas**	24-00160-212	—	—
8/13/2024	**Failures by Telemetry Medical Instrument Technicians and Leaders' Response at the VA Eastern Colorado Health Care System in Aurora**	23-03531-218	—	—
8/21/2024	**Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at the VA Central Western Massachusetts Healthcare System in Leeds**	23-01965-217	—	—
8/28/2024	**Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida**	23-03677-237	—	—
8/29/2024	**Deficiencies in Facility Leaders' Summary Suspension of a Provider and Patient Safety Reporting Concerns at the VA Black Hills Health Care System in Fort Meade, South Dakota**	23-01502-234	—	—
9/26/2024	**Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama**	23-02393-250	—	—
9/27/2024	**Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo**	23-03679-262	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MANAGEMENT ADVISORY MEMORANDUM				
9/23/2024	**Facility Leaders and Staff Have Concerns about VA's New Electronic Health Record**	24-02874-256	—	—
MENTAL HEALTH INSPECTION				
9/26/2024	**VA Augusta Health Care System in Georgia**	24-00675-259	—	—
NATIONAL HEALTHCARE REVIEWS				
4/4/2024	**Deficiencies in Attention Deficit Hyperactivity Disorder Diagnostic Assessment, Evaluation of Stimulant Medication Risks, and Policy Guidance**	22-03013-129	—	—
4/9/2024	**Veterans Health Administration's Failure to Properly Identify and Exclude Ineligible Providers from the VA Community Care Program**	22-02398-131	—	—
4/25/2024	**Opportunities Exist to Better Integrate Health-Related Social Needs and Social Determinants of Health into Discharge Assessment and Planning**	23-00674-153	—	—
6/27/2024	**Review of Perceived Barriers in Coordinating Veteran Maternity Care**	22-00900-186	—	—
8/7/2024	**OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024**	24-00803-222	—	—
8/14/2024	**A Select Review of VHA's Implementation of the VA Sustainability Plan**	23-00539-221	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
NATIONAL HEALTHCARE REVIEWS (CONTINUED)				
8/22/2024	Veterans Crisis Line Implementation of 988 Press 1 Preparation and Leaders' Response	23-00925-227	—	—
VET CENTER INSPECTIONS				
4/18/2024	Inspection of Select Vet Centers in Southeast District 2 Zone 1	22-03939-142	—	—
4/18/2024	Inspection of Select Vet Centers in Southeast District 2 Zone 2	22-03940-143	—	—
4/18/2024	Inspection of Southeast District 2 Vet Center Operations	22-03941-144	—	—
8/27/2024	Inspection of Select Vet Centers in Continental District 4 Zone 2	22-04108-235	—	—
8/27/2024	Inspection of Select Vet Centers in Continental District 4 Zone 1	22-04107-236	—	—
8/27/2024	Inspection of Continental District 4 Vet Center Operations	22-04109-238	—	—
9/30/2024	Inspection of Select Vet Centers in Pacific District 5 Zone 1	24-00386-265	—	—
9/30/2024	Inspection of Select Vet Centers in Pacific District 5 Zone 2	24-00388-266	—	—
9/30/2024	Inspection of Select Vet Centers in Pacific District 5 Zone 3	24-00389-267	—	—
OFFICE OF SPECIAL REVIEWS				
ADMINISTRATIVE INVESTIGATION				
5/9/2024	VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives	23-03773-169	—	—

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TABLE 8. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MANAGEMENT ADVISORY MEMORANDUM				
5/30/2024	**Supplement to OIG Report, VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives**	23-03773-179	—	—
WHISTLEBLOWER REPRISAL INVESTIGATION (CONTRACTORS AND GRANTEES)*				
7/13/2024	**Report of Investigation of Whistleblower Retaliation Claim Under 41 U.S.C. § 4712**	23-02535-269	—	—
Total			**$267,430,320**	**$1,689,460,857** *($219,647,512 unsupported costs)*

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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.[25] Table 9 identifies recommendations made prior to this reporting period that are open (unimplemented) as of March 31, 2024.

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	—
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	—
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	—

25 5 U.S.C. § 405(b)(2) (as amended by Pub. L. 117-263).

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	$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	—
6/15/2021	**Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs**	20-01487-142	2	$129,700,000
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	1-2, 4-7	$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	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	—
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	—

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	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	—
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	—
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	6	—
12/15/2021	Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains	19-09592-262	3	—
12/20/2021	Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers	21-01804-56	4, 6	—
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, 7	—

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	4	—
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	1-4	—
5/24/2022	VHA Continues to Face Challenges with Billing Private Insurers for Community Care	21-00846-104	1-3	$805,200,000
6/1/2022	Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas	21-03305-139	5	—
6/22/2022	Mission Accountability Support Tracker Lacked Sufficient Security Controls	21-03080-142	3	—

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	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	—
9/7/2022	VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims	22-00404-207	3	—
9/22/2022	Home Improvements and Structural Alterations Program Needs Greater Oversight	21-03906-226	1	$12,676,084
9/22/2022	Inspection of Information Technology Security at the Alexandria VA Medical Center in Louisiana	22-00971-217	4	—
10/20/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021	22-00811-07	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	—
10/27/2022	Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative	21-03924-234	1	—

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	—
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	5	—
1/12/2023	Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers	21-03232-37	3, 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	—
1/19/2023	Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers	21-03231-38	4-5, 11, 14-15	—
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	—
1/31/2023	Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs	21-01711-50	1-2	—

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
2/22/2023	Security and Incident Preparedness at VA Medical Facilities	22-03770-49	1	—
3/14/2023	Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA	22-02721-77	2	—
3/28/2023	Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met	21-01997-69	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	2-3	—
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	7	—
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	—
6/7/2023	Comprehensive Healthcare Inspection of the New Mexico VA Health Care System in Albuquerque	22-00046-126	1, 7	—
6/7/2023	Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania	22-02960-70	3-4	—
6/8/2023	Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota	22-02961-71	1, 5, 9	—

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	—
7/11/2023	Inspection of Information Security at the Northern Arizona VA Healthcare System	22-04104-112	1-2, 6, 10	—
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	—
7/19/2023	Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff	21-03544-111	3	—
8/1/2023	Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York	22-04133-163	5-6, 10	—
8/3/2023	Comprehensive Healthcare Inspection of the San Francisco VA Health Care System in California	22-00231-176	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	—
8/23/2023	Additional Measures Would Better Protect Borrowers from Risks Associated with Interest Rate Reduction Refinance Loans	21-01295-149	3-4, 8	—

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
8/24/2023	Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System in California	22-00055-184	1-3, 5-9	—
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	6	—
9/7/2023	VHA Faces Challenges Implementing the Appeals Modernization Act	22-02064-155	1-14	—
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, 9	—
9/20/2023	Manufacturers Failed to Make Some Drugs Available to Government Agencies at a Discount as Required	22-01624-143	1-6, 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	Information Security Inspection at the VA Beckley Healthcare System in West Virginia	23-00089-144	2-4, 8-9	—
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	—

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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, 3-7, 12	—
9/27/2023	Comprehensive Healthcare Inspection of the VA Northern California Health Care System in Mather	22-00063-220	1-2	—
9/27/2023	VA Should Strengthen Enterprise Cloud Security and Privacy Controls	22-03525-195	1-3	—
9/27/2023	Inspection of Information Security at the VA El Paso Healthcare System in Texas	23-01179-204	2, 5, 7-8	—
9/28/2023	Review of Veterans Health Administration's Multi-Tiered Patient Safety Program	22-02377-217	3	—
9/28/2023	Inspection of Information Security at the VA Dublin Healthcare System in Georgia	23-01138-203	1-3, 5	—
10/3/2023	VHA Should Continue to Improve Water Safety and Oversight of Prevention Practices to Minimize the Effects of Legionella	22-03247-198	1-2	—
10/19/2023	VBA Generally Helped Veterans Obtain Damaged or Destroyed Records	22-03522-209	2-3	—
10/31/2023	Improvements Needed in Lung Cancer Screening Through Use of Community Care	22-00416-10	1, 4	—
11/1/2023	Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington	22-04135-06	6	—
11/14/2023	Delayed Receipt of Patients' Colorectal Cancer Screening Tests at the Phoenix VA Health Care System in Arizona	23-00383-21	3	—

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
11/16/2023	Better Coordination Needed to Negotiate Consistent Prices for Prescription Eyeglasses	21-02984-179	1-2	$6,500,000
11/29/2023	Care in the Community Summary Report for Fiscal Year 2022	22-03772-28	1-4, 6	—
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, 7-8	—
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	3-4	—
12/13/2023	Significant Deficiencies Found in VA's Denver Logistics Center Inventory Management Operations and Systems	22-02739-210	1, 3, 5, 7, 9-19	—
12/14/2023	VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds	22-00410-197	1-4	—
12/14/2023	VA Should Validate Contractor Energy Baseline and Savings Estimates and Ensure Payments Are Legally Compliant	22-02934-208	1-4	$68,000,000
12/19/2023	Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina	23-00004-37	1	—
1/4/2024	Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal	21-01488-44	2-3	—
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	2-7	—

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/4/2024	**Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA**	23-01690-31	1-2, 5	—
1/9/2024	**Comprehensive Healthcare Inspection of the Wilmington VA Medical Center in Delaware**	23-00093-51	2	—
1/10/2024	**Comprehensive Healthcare Inspection of the Tomah VA Medical Center in Wisconsin**	22-04132-48	2, 5	—
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	5	—
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	1-6	—
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	1-4	—
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	2-10	—
2/7/2024	**Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina**	23-00005-62	1	—
2/8/2024	**Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk**	21-03255-02	1, 3, 5	—

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
2/8/2024	Comprehensive Healthcare Inspection of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin	22-04134-63	3	—
2/13/2024	Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York	23-00011-73	5, 7, 9	—
2/14/2024	Financial Efficiency Inspection of the VA Memphis Healthcare System in Tennessee	23-01198-47	6	—
2/21/2024	Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied	23-00153-41	1	$3,300,000
2/22/2024	Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage	23-00017-81	2-3	—
2/28/2024	Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont	23-00015-86	1, 4-5	—
2/29/2024	Comprehensive Healthcare Inspection of the Aleda E. Lutz VA Medical Center in Saginaw, Michigan	22-03166-88	3-4	—
3/6/2024	Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia	22-01315-90	1-2, 4, 6, 9	—
3/6/2024	Comprehensive Healthcare Inspection of the Manchester VA Medical Center in New Hampshire	22-03157-95	1-3, 5-6	—
3/12/2024	Deficiencies in Quality of Care at VA Maine Healthcare System in Augusta	23-00528-92	1-5, 7	—
3/12/2024	Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery	23-00106-94	1-2	—

Unimplemented Recommendations

TABLE 9. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
3/20/2024	**Logistics Managers Improperly Allowed Employees to Auction Off Government Property**	23-06147-111	5	—
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	2	—
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	1-2	—
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	1-9	—
3/26/2024	**Comprehensive Healthcare Inspection of the VA Ann Arbor Healthcare System in Michigan**	22-03164-106	1	—
3/26/2024	**Comprehensive Healthcare Inspection of the VA Black Hills Health Care System in Fort Meade, South Dakota**	23-00097-113	1-4	—
3/26/2024	**Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming**	23-00122-118	4	—
3/28/2024	**Veteran Readiness and Employment Staff Improperly Sent Participants to Veteran Employment Through Technology Education Courses**	23-00967-64	1	$387,000
Total				**$1,682,910,084**

VA Management Nonconcurrences

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.[26] 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. The OIG stands by each of these recommendations and considers them open.

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

FOLLOW-UP INFORMATION SECURITY INSPECTION AT THE VA FINANCIAL SERVICES CENTER IN AUSTIN, TEXAS

VA did not concur with recommendation 5: implement more effective configuration control processes to ensure network devices maintain vendor support and receive security updates. The assistant secretary for information and technology and chief information officer indicated that OIT has implemented effective configuration control processes to ensure network devices maintain vendor support and receive security updates. While the assistant secretary provided evidence that six of the network devices the OIG identified were updated and supported by the vendor, OIT did not provide documentation to demonstrate the remaining 12 devices were updated to meet baseline security requirements. Accordingly, the OIG disagrees with management's assertion that OIT has implemented effective configuration control processes and stands by its recommendation. Beginning on page 30 of the report, appendix D includes the full text of OIT's comments, and the VA OIG's response is included on pages 14–15.

VBA DID NOT IDENTIFY ALL VIETNAM VETERANS WHO COULD QUALIFY FOR RETROACTIVE BENEFITS

VBA did not concur with recommendation 1, which was to ensure staff use improved methodologies, similar to those used by the OIG, to identify eligible veterans, readjudicate claims, and send outreach letters to potential *Nehmer* class members who could qualify for retroactive benefits under the National Defense Authorization Act (NDAA). Specifically, VBA claimed the OIG incorrectly concluded that medical records anywhere in VA's healthcare system at the time of a prior claim can trigger the requirements of the stipulation even if those records were not relevant to the claim or associated with the claim file. VBA contested the OIG's reliance on the VA adjudication manual over the *Nehmer* consent decree, on the basis that the decree's terms and subsequent court orders interpreting it take precedence over the VA manual. VBA also asserted that the OIG erred by including an unknown number of veterans who did not serve in Vietnam in its report findings. Upon further analysis of its findings, the OIG estimated that 80 percent of the veterans in the VHA dataset and 99 percent of the veterans in the Camp Lejeune dataset identified by the OIG had medical records in their VBA claims files showing a diagnosis of an NDAA-covered condition while a claim was pending during the review period. The OIG and VBA

26 5 U.S.C. § 405(b)(6) (as amended by Pub. L. 117-263).

agree that veterans who had such medical records in their claims files while a claim was pending warrant readjudication. While VBA noted the manual does not supplant its interpretation of the *Nehmer* court decree or resulting regulation, as of the publication of this report, VBA has not amended the manual's language to comport with its stated position. Significantly, no court has held that the manual is inconsistent with the court decree. In fact, whether the manual should be applied to readjudications under the *Nehmer* court decree is a question being litigated before the United States Court of Appeals for Veterans Claims and, at the time of the report's publication, has yet to be resolved. VBA's comments that the OIG erred by including an unknown number of veterans who did not serve in Vietnam in the report findings reflects a misunderstanding of the OIG team's analysis. The team's estimate for veterans who warranted retroactive payments were all shown to have definitively served in Vietnam or its designated waters. The report was modified to clarify the analysis. Appendix D includes the full text of VA's management comments, starting on page 38 of the report. The OIG's response can be found on pages 21–24.

CARE IN THE COMMUNITY INSPECTION OF VA MIDSOUTH HEALTHCARE NETWORK (VISN 9) AND SELECTED VA MEDICAL CENTERS

VA did not concur with recommendation 8, which states that the VISN director, in conjunction with facility directors, should require facility community care staff to use the significant findings alert when administratively closing community care consults without medical documentation. The VISN director maintains that significant finding alerts should not be used for all administrative closures and instead reserved only for abnormal test, study, or procedure results or for no records returned on screening/testing referrals, citing the field guidebook and a 2021 memorandum from the assistant under secretary for health. The OIG notes that the VISN response contradicts current Office of Integrated Veteran Care (IVC) requirements for administrative closure as described in the field guidebook and clarified through OIG's interview with IVC leaders. The OIG expects the VISN to follow the current IVC process for administrative closure of community care consults, which includes use of the significant findings alert. VA's management comments, as well as the OIG's response, can be found on page 40 of the report.

FOLLOW-UP INFORMATION SECURITY INSPECTION AT THE SOUTHWEST CONSOLIDATED MAIL ORDER PHARMACY IN TUCSON, ARIZONA

VA did not concur with recommendation 4, which states that the assistant secretary for information and technology and chief information officer should ensure network segmentation controls are applied to all network segments with special-purpose systems. The OIG maintains that not segmenting special-purpose systems is inconsistent with VA guidance on this topic. VA guidance states that the agency will restrict access to segments that contain special-purpose systems or place the special-purpose systems in a standalone network. During the inspection, OIT representatives stated that an authorizing official accepted the risk of not applying access control lists to the special-purpose systems network segments because these segments are subject to the VA's vulnerability remediation processes. The OIG team reviewed OIT's June 2024 scan results of the special-purpose systems network segments and found that no critical or high vulnerabilities existed on these network segments for more than one month. While the scan results demonstrated that existing scanning processes mitigated inherent risks to special-purpose systems devices on the network for the month reviewed, OIT would benefit from following VA guidance to ensure adequate protection of such devices. The full text of OIT's management comments, as well as the OIG's response, can be found on page 18 of the report.

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.[27] During this reporting period, the OIG reviewed seven legislative or regulatory proposals and made one comment. The OIG also reviewed 26 internal VA directives and handbooks that guide the work of VA employees and provided two comments.

Peer and Qualitative Assessment Reviews

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, as amended, 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 such review, in addition to any outstanding recommendations that have not been fully implemented.[28] This information is presented in **table 10**. The IG Act also requires inspectors general to report the results of any peer review they completed of another office of inspector general during the reporting period, as well as any outstanding recommendations that have not been fully implemented.[29] 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 (CIGIE) 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 December 2024.

27 5 U.S.C. § 405(a)(2) (as amended by Pub. L. No. 117-263).

28 5 U.S.C. § 405(b)(8)(A), § 405(b)(8)(B), and § 405(b)(9) (as amended by Pub. L. No. 117-263).

29 5 U.S.C. § 405(b)(10) (as amended by Pub. L. No. 117-263).

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

DATE COMPLETED	TYPE	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
9/18/2024	Audits	Treasury Inspector General for Tax Administration	Pass	None
9/14/2021	Inspections and Evaluations	DoD	Pass	None
11/21/2023	Investigations	Federal Deposit Insurance Corporation	Pass	None

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.[30] 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.[31] 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 nine complaints of alleged whistleblower reprisal by VA contractors or grantees during this reporting period. The OIG substantiated one of the allegations and determined that the remaining either failed to meet the criteria for investigation or were not substantiated. 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.[32]

Attempts to Interfere with the Independence of the OIG

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.[33] The VA OIG reports no such instances occurring during this reporting period.

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

30 5 U.S.C. § 405(b)(14)(A) and §405(b)(14)(B) (as amended by Pub. L. No. 117-263).

31 41 U.S.C. § 4712 (b)(2).

32 41 U.S.C. § 4712(c).

33 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

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.[34] The VA OIG reports no such instances occurring during this reporting period.

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.[35] 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 involving senior government employees, substantiating allegations in one of the two cases:

- An anonymous hotline allegation reported that a nurse executive at a VA medical center also worked for a private company that sold patient repositioners (a device used to change a bedridden individual's position to prevent pressure ulcers). The complainant further alleged that the nurse executive was stalling the roll out of new beds throughout the VA medical center until the facility could acquire patient beds that were compatible with these devices. The investigation revealed that the nurse executive served as a keynote speaker during a webinar hosted by this company. This was the only promotional activity involving the nurse executive and this company. The investigation further determined that VA made only limited purchases from the company and the nurse executive's facility did not purchase any devices from the company. Having identified no criminal conduct, the OIG did not refer this matter to the Department of Justice. This investigation was closed on May 10, 2024.
- The OIG received an allegation forwarded by VA's Office of Accountability and Whistleblower Protection indicating a now former VHA associate director falsely claimed to have earned a master's degree on both his resume and background investigation applications submitted in 2018 and 2023. The investigation determined that VA personnel favorably adjudicated the former associate director's background investigation in 2018 despite an inability to substantiate his claimed academic credential. In June 2024, the former associate director resigned from VA after confronted with evidence obtained during a periodic background investigation showing that, although he had completed more than 90 percent of the required coursework, he had not earned a master's degree. This case was not referred to the US Attorney's Office because of VA's deficient adjudication of his 2018 background investigation, and because he voluntarily resigned from VA. This investigation was closed on July 10, 2024.

34 5 U.S.C. § 405(b)(15)(B) (as amended by Pub. L. No. 117-263).

35 5 U.S.C. § 405(b)(16)(A) and § 405(b)(16)(B) (as amended by Pub. L. No. 117-263).

Other Disclosures

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.[36] The act also requires the VA OIG to disclose certain information in its semiannual report to Congress about its use of this authority. During the reporting period, the Inspector General served testimonial subpoenas on two former VA employees, and OIG staff took testimony from one of those individuals. OIG staff are scheduled to take the testimony of the second witness in October 2024. 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.

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 four allegations involving suspected violations related to human trafficking, of which two had a nexus to VA. Both allegations are under investigation. The OIG closed one investigation (summarized below) pertaining to this reporting requirement, which concerned an allegation made during a previous reporting period. The OIG made no recommendations to improve VA programs and operations pursuant to this information.

On March 5, 2024, the VA Police Service at the Marion VA Medical Center in Illinois notified an OIG criminal investigator that an employee reported to having viewed the screen of a laptop computer belonging to a veteran inpatient and observed a written chat in which the veteran appeared to have asked an unknown individual about procuring children for sexual purposes. At the time of this notification, the OIG agent who received the notification was several hours from the facility. The agent recommended that VA contact the Illinois State Police, who immediately arrived at the facility to investigate due to the highly perishable nature of the electronic evidence. At the direction of the U.S. Attorney's Office for the Southern District of Illinois, the Illinois State Police's Internet Crimes Against Children task force forensically examined the veteran's electronic devices. Although the veteran admitted during an interview to engaging in an online chat conversation about child sex trafficking, the forensic analysis determined that he had not been successful in any attempts to traffic and was likely conversing with scam artists attempting to financially exploit him. The U.S. Attorney's Office declined to pursue charges due to the facts of the case and the veteran's physical condition—wheelchair bound and bedridden at the Marion VA Medical Center's community living center. As a result, the veteran was not criminally prosecuted. Because the investigative activity occurred in such a short time frame, the OIG did not participate in this investigation.

36 Pub. L. No. 117-136 § 2(a).

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 and returned in June 2024.
- Jose Flores, an auditor in Washington, DC, was activated by the US Air Force in October 2023.
- Steven Hodge, a criminal investigator in Kansas City, Missouri, was activated by the US Air Force for approximately two weeks in July 2024.
- Ricardo Wallace-Jimenez, a special agent in Spokane, Washington, was activated by the Washington Air National Guard in October 2023 and returned in May 2024.

Council of the Inspectors General on Integrity and Efficiency (CIGIE) Awards

Each year, CIGIE presents awards for remarkable accomplishments in the inspector general community. These awards offer an opportunity to recognize some of the very best work conducted by OIGs as determined by a panel of peers. VA OIG staff were recognized by CIGIE for these outstanding achievements:

- The Sentner Award for Dedication and Courage was presented to two OIG employees who, while on official government travel in Chicago, witnessed a violent incident taking place in a public parking lot. They immediately dialed 911 and provided critical information to emergency dispatch and remained on scene to help police apprehend the assailant who was fleeing on foot.
- An Award for Excellence in Audit recognized two OIG audit teams that published *VA's Governance of its Personnel Suitability Program for Medical Facilities Continues to Need Improvement* and *Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk,* which identified failures in VA's personnel suitability program and exposed significant risks to VA when it does not properly vet contractor employees. These deficiencies increase opportunities for bad actors to compromise veteran and employee safety as well as the security of information and systems.
- An Award for Excellence in Evaluations was given to OAE and OHI teams that found significant problems with VA's multibillion-dollar effort to replace its electronic health record system, as detailed in the reports *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, *Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus*, and *VA Should Ensure Veterans' Records in the New Electronic Health System Are Reviewed before Deciding Benefits Claims*.

- A second Award for Excellence in Evaluations was awarded to the audit team that produced the report, *Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA*. The team's projections suggested that the risk could be approximately $390 million, spurring VBA to take immediate action to avoid fraud.
- An Award for Excellence in Inspections recognized the OHI team for *Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault*, which found opportunities to improve policy adherence and guidance addressing the management of such patients.
- Another Award for Excellence in Inspections was earned by the OHI team for *Review of Transition of Care for Service Members with Opioid Use Disorder*, which identified deficiencies in documentation of opioid use disorder for service members transitioning from the DoD to VHA.
- An Award for Excellence in Investigations recognized the Endo Health Solutions Inc./Opana ER investigative team, which resulted in the second-largest criminal financial penalty ever imposed against a pharmaceutical company.

OIG Agents Recognized by US Department of Justice

Resident Agents in Charge Jake Karn and Colin Upson received awards from the Department of Justice's Health Care Fraud Unit for their outstanding work and achievements on the *United States v. Noryian* investigation. David Noryian was one of three codefendants found guilty in November 2023, following a 10-week trial in the Northern District of Texas, of numerous charges in connection with a $145 million healthcare fraud scheme related to compound pharmacies. This investigation was conducted by the VA OIG, US Postal Service OIG, Department of Labor OIG, and the Internal Revenue Service Criminal Investigation.

The US Attorney's Office for the Eastern District of Washington recognized the multiagency COVID-19 Fraud Strike force, which included VA OIG Special Agent David Huntoon, with an award for their work combating COVID-19-related fraud. In 2023-2024, the strike force charged 18 defendants, obtained felony fraud convictions in 10 cases, and sentenced nine defendants to sentences of incarceration or probation, including significant sentences of incarceration. The strike force's work also resulted in the seizure and forfeiture of millions of dollars in assets, including homes, vehicles, jewelry, cash, firearms, and drugs, and millions of dollars in restitution judgments. In one case, as a result of Agent Huntoon's efforts, the spouse of a VA employee admitted to fraudulently obtaining more than $360,000 in COVID-19 relief funding. The defendant was sentenced to 12 months' imprisonment, 36 months' supervised release, and ordered to pay $402,020.32 in restitution.

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)[37];

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

37 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

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;

Appendix: Reporting Requirements

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

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.


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