US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT to Congress

Issue 90 | April 1—September 30, 2023

IMPACTFUL OVERSIGHT

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.

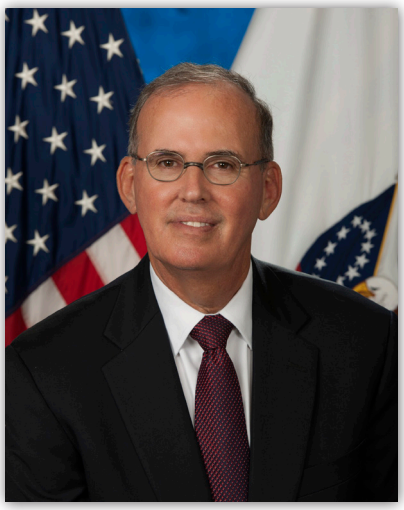
To achieve this vision, the Office of Inspector General (OIG) will

- 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) as we commemorate our 45th anniversary of being authorized by the Inspector General Act of 1978 as an independent oversight agency.[1] Since that time, the office has grown from about 300 staff to more than 1,100 during this reporting period. About 30 percent of VA OIG personnel are veterans, with an even greater number who have family members who have served in the military. Their faces and those of their loved ones fill the covers of this report to honor them and all the veterans and their families we are committed to supporting through oversight of VA programs, services, and operations.

Much of our oversight work is detailed in the 137 reports we issued in the second half of fiscal year 2023. These are complemented by a growing number of podcasts, monthly highlights of criminal investigations and other activities, and additional communications that improve our transparency. We have worked diligently to make meaningful recommendations to VA that address the root causes for the problems we have identified. In this six-month period from April 1 through September 30, 2023, our office identified nearly $1.14 billion in monetary impact for a return on investment of $11 for every dollar spent on oversight. The OIG hotline received more than 18,000 contacts that have helped to identify wrongdoing, waste, abuse, and inefficiencies or deficiencies in VA programs and activities. OIG investigators opened 230 investigations and closed 190. Collectively, the OIG's work resulted in 581 administrative sanctions and corrective actions.

Landmark anniversaries are a time to take stock—to examine lessons learned and how they can be applied as we look ahead. One recent significant enhancement is the tremendous strides that we have made using data and other sources to identify and inform proactive initiatives. This has allowed an increasing number of our projects to involve complex issues that make our oversight work that much more impactful. This has never been more important as VA is expending billions of dollars on system modernization efforts for financial management, patients' electronic health records, and supply chain management. VA will also be implementing one of the greatest increases in benefits and healthcare services in its history with the PACT Act.[2] As with all new initiatives, these changes increase the risk for fraud, waste, and barriers to implementation that can affect the quality and timeliness of health care,

1 Inspector General (IG) 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).

2 The full title of the act is the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. VA, "Veterans and survivors have filed more than 500,000 toxic exposure-related benefits claims under the PACT Act," April 26, 2023, https://news.va.gov/press-room/veterans-and-survivors-have-filed-more-than-500000-toxic-exposure-related-benefits-claims-under-the-pact-act; VA, "Veterans and survivors filed more than 1 million benefits claims under the PACT Act," September 14, 2023, https://news.va.gov/press-room/more-than-1-million-benefits-claims-under-the-pact-act.

A Message from the Inspector General

benefits, and services to veterans, their families, caregivers, and survivors. The OIG recognizes and appreciates VA leaders' commitment to creating a culture of accountability and the many VA personnel who have engaged candidly and cooperatively with us. With the support we have received from Congress, veterans service organizations, and other stakeholders, the OIG is well-positioned to provide the meaningful oversight required for these and other high-risk ventures, while remaining vigilant to issues involving more routine operations.

MICHAEL J. MISSAL

Contents

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

Organization Profile

The Department of Veterans Affairs

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

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

VA is the second-largest federal employer. For fiscal year (FY) 2023, VA is operating under a $308.5 billion budget with more than 433,000 employees serving an estimated 18.6 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.[3] 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

3 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

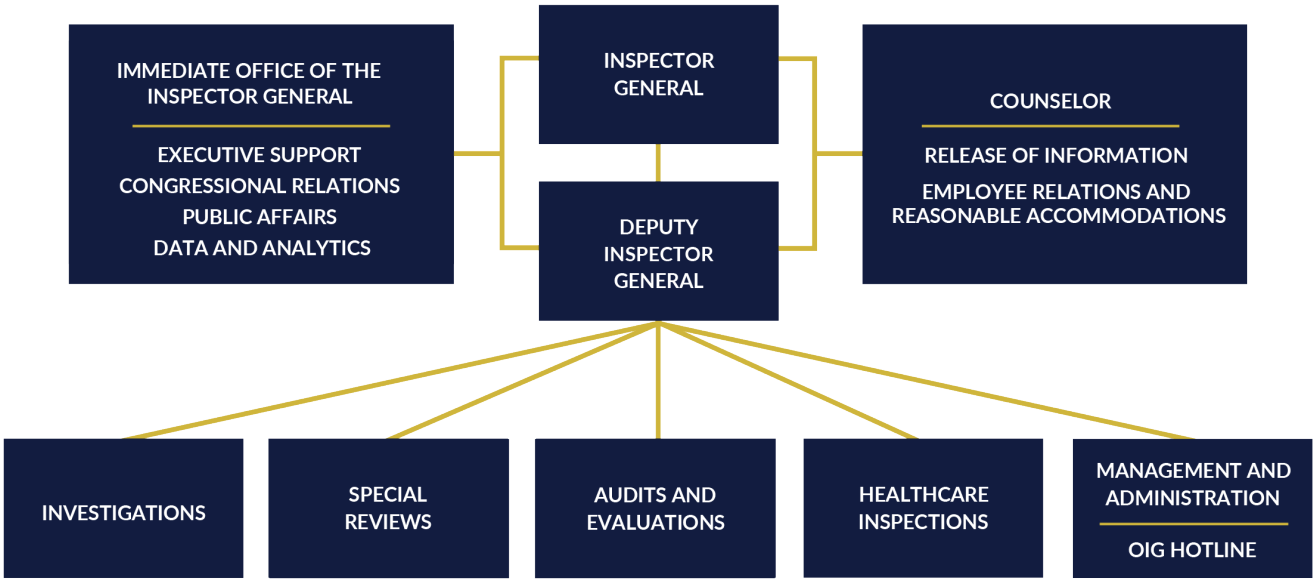
Services Act of 1988 charged the OIG with overseeing the quality of VA health care.[4] Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has more than 1,100 staff organized into five primary directorates: the Offices of Investigations, Special Reviews, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline). The OIG also has offices for the counselor to the inspector general, data and analytics, congressional relations, and public affairs, as well as staff dedicated to executive support. The FY 2023 funding from ongoing appropriations provided $273 million for OIG operations—a $34 million increase from the previous year.

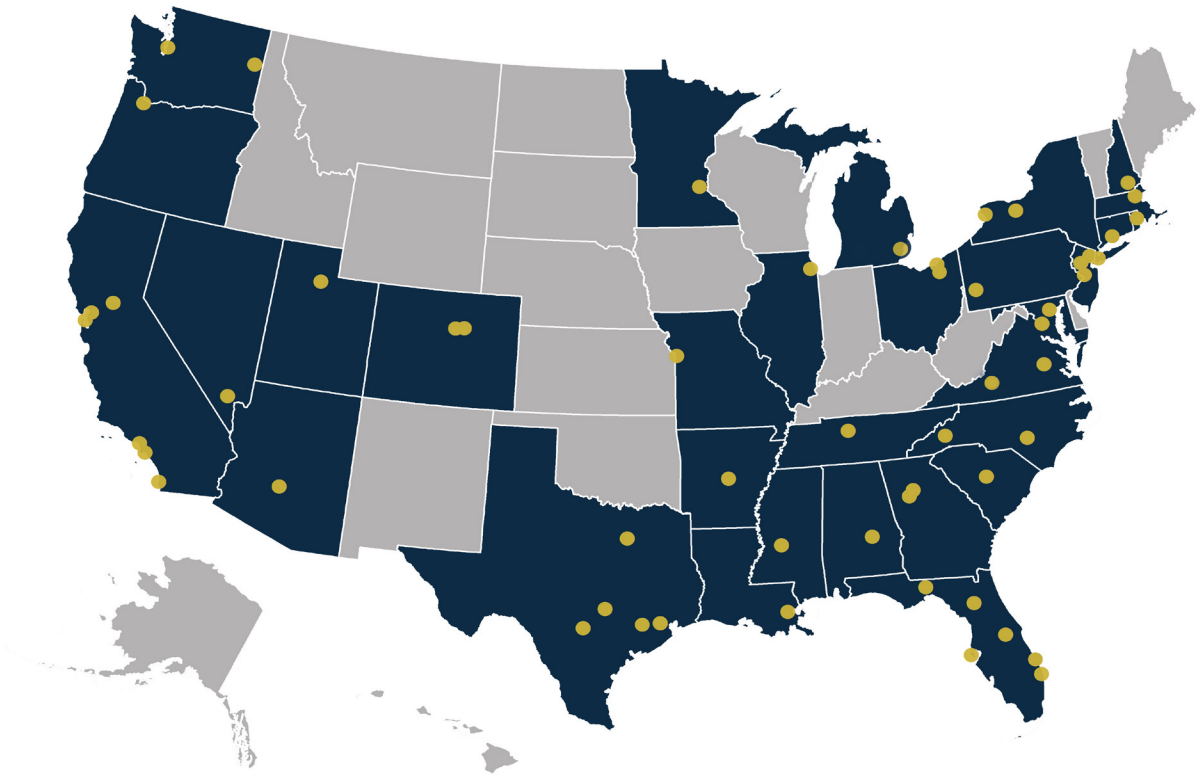
In addition to its Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff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



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

OIG FIELD OFFICES MAP



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

Offices of the Inspector General

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

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

THE OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL

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

THE OFFICE OF INVESTIGATIONS

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

THE OFFICE OF SPECIAL REVIEWS

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

THE OFFICE OF AUDITS AND EVALUATIONS

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

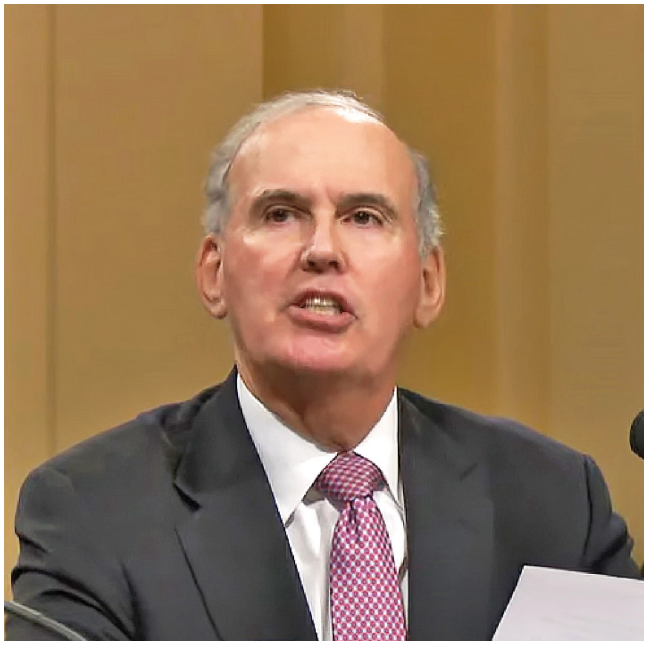
utilization, acquisitions, construction, and information security. This work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care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

THE OFFICE OF HEALTHCARE INSPECTIONS

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

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

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



From the left, Inspector General Michael J. Missal testifies before the House Veterans' Affairs Committee on *COVID-19 Supplemental Funding: Did it Protect and Improve Veteran Care?* (May 23, 2023); Nicholas Dahl, Deputy Assistant Inspector General for Audits and Evaluations testifies before the House Veterans' Affairs Committee's Subcommittee on Technology Modernization on *The Status of VA's Financial Management Business Transformation* (June 20, 2023).

From the left, Stephen Bracci, Director, Claims and Medical Exams Inspection Division for Audits and Evaluations testifies before the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs on *VA Disability Exams: Are Veterans Receiving Quality Services?* (July 27, 2023); and Lisa Van Haeren, Director, Claims and Fiduciary Inspection Division for Audits and Evaluations testifies before the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs on *VA's Fiduciary Program: Ensuring Veterans' Benefits are Properly Managed* (September 28, 2023).

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, 2023. 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 on critical issues affecting VA programs and operations. During this reporting period, the OIG participated in eight congressional hearings on topics such as care coordination between VA and community providers, VA spending related to the COVID-19 pandemic, contract disability exams, and care for veterans suffering from substance use disorders. During a hearing before the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations, Deputy Inspector General David Case testified in support of H.R. 2733, the *Department of Veterans Affairs Office of Inspector General Training Act of 2023*. He outlined how this bill would help ensure that VA employees properly and promptly report suspected crimes; risks to patient safety; and misconduct affecting veterans and VA's programs, benefits, and services. In addition to

Deputy Inspector General David Case testifies before the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations on the *Department of Veterans Affairs Office of Inspector General Training Act of 2023* (H.R. 2733) on July 12, 2023.

testifying before Congress, OIG experts also attend congressional roundtables, such as the one on women veterans' safety this reporting period.

The OIG conducted 63 briefings on oversight reports and activities with members and their staffs. Some of the topics addressed included

- insufficient VA oversight regarding the opioid prescribing practices of community care providers;
- radio network deployment in VHA facilities to ensure reliable communications and capabilities during crises and natural disasters;
- the evaluation of a medical facility's responses to findings of misconduct and inappropriate relationships between leaders and staff and between clinical staff and patients in Black Hills, South Dakota;
- deficiencies in care provided in the emergency department at the VA St. Louis Health Care System;
- deficient oversight and delays in disbursing deceased veterans' funds managed by VA-appointed fiduciaries;
- leaders' responses to VA's Office of the Medical Inspector's recommendations for the Dingell VA Medical Center in Detroit, Michigan; and
- challenges VHA faces in implementing the Appeals Modernization Act.

Following the briefings, the OIG team keeps congressional offices informed of VA's progress in implementing OIG recommendations. The team also coordinates responses to requests for technical assistance from congressional offices and committees during legislative drafting and after introduction of a bill to clarify anticipated oversight efforts. During this reporting period, the congressional relations team fielded 75 inquiries from House and Senate offices related to constituent matters for review or referral.

Staff also serve as the OIG's liaison to the Government Accountability Office, as well as other oversight entities such as the Pandemic Response Accountability Committee. Active engagement with these entities is crucial to avoiding duplicating efforts and to leveraging one another's work. Staff also ensure that other OIG directorates are aware of external agencies' efforts and facilitate information-sharing sessions to shape more impactful projects.

DATA AND ANALYTICS

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

and refined user-friendly, self-service dashboards to empower all staff to improve their work using just-in-time information.

During this reporting period, ODA continued work on 105 ongoing projects, created nine new internal data-monitoring tools, and made enhancements to several others. ODA work addressed a broad range of subjects, including financial issues, staffing, access to VHA health care, community care referrals and usage, PACT Act, and contracts and procurements. ODA also focused on advancing work on VA's IT requirements, suicide prevention, homeless programs, and pharmaceutical practices.

ODA plays a pivotal role in the oversight of the VHA Community Care Program. When VHA temporarily halted the processing of community care claims due to data errors, ODA initiated an independent effort to assess the scope and impact of these errors and developed a workaround solution for the community care dataset. This allowed the OIG to continue its healthcare inspections, audits, and fraud investigations without interruption while VHA addressed the errors and explored process improvements connected to the pertinent data.

This office fulfilled a total of 250 internal data requests and 510 access requests to VA data systems during this period that supported OIG oversight of VA's broad range of healthcare services and benefits programs involving disabilities, pensions, education, housing assistance, and veterans' burials. In addition, ODA continued to offer formal trainings to OIG staff and partnered with directorate teams to develop facility-level information to guide proactive healthcare inspections. The ongoing ODA training series enriches OIG staff expertise through continuing professional education. Data and analytics personnel also provided topic-specific training sessions and monthly senior leader briefings—all of which enhance the skills of OIG oversight staff and leverage available data resources.

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 continued to work 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 677 requests for status updates to various offices within VA tasked with taking action. These efforts led to the closing of 346 recommendations during this reporting period.

The public affairs team continued to reach a diverse audience, including expanding its presence on LinkedIn and X (formerly Twitter) by roughly 6,500 followers, totaling more than 85,500. Staff published 271 updates on reports, hiring activities, and other news and posted 209 tweets. The office released 167 email bulletins through GovDelivery, reaching nearly 154,000 subscribers—an increase of about 26,000 subscribers compared to the previous reporting period. Outreach efforts were further supplemented by two podcast series,

Veteran Oversight Now and *Inside Oversight*, which are both available on all popular podcast platforms. *Veteran Oversight Now* features interviews with senior OIG leaders, discussions on high-profile reports, and highlights of OIG activities. *Inside Oversight* offers in-depth conversations with report authors who describe how the team conducted its work, what it found, and the impact on veterans and the public. The public affairs office also continued the *My VA OIG Story* video series during this reporting period, which features the unique background stories of individual OIG employees. The videos are used as a recruitment tool designed to support the OIG's efforts to attract individuals with a broad range of perspectives and lived experiences.

Several broadcast and print media outlets prominently featured the OIG's work, and these included the *Washington Post*, Fox News, CBS News, CNBC, C-SPAN, *New York Post, Washington Examiner, Military.com, Atlanta Journal-Constitution, Politico, Miami Herald, Military Times,* and *Stars and Stripes*. The coverage highlighted OIG findings regarding the challenges VA faces in implementing its Financial Management Business Transformation program; the multiple events of patient harm caused by VA's electronic health record modernization efforts; as well as investigations involving a VA primary care physician at the Atlanta VA Medical Center who allegedly sexually assaulted his patients; and a dental technician employed at the VA medical center in Albany, New York, who stole precious metals used to make crowns and other artificial materials for teeth.

The Office of the Counselor to the Inspector General

During this reporting period, the Counselor's office performed a range of activities, including publishing the OIG's first comprehensive Employee–Management Relations directive; issuing interim policy guidance to implement provisions of the recently enacted Pregnant Worker's Fairness Act; and provided training to agency personnel on whistleblower rights, reasonable accommodation, administrative investigation evidentiary requirements, and other matters. Representatives of each of the divisions within the Counselor's office also continued working with a contractor to develop and test a new case management system that will automate certain processes to enhance the efficiency of the OIG's legal operations.

The Employee Relations and Reasonable Accommodation (ER/RA) Division processed 233 actions in the six-month reporting period for OIG managers and employees on matters involving employee discipline, performance and grievances, and other workforce issues, bringing the total for FY 2023 to 389 actions. Its staff also responded to 952 inquiries or requests for reasonable accommodation and leave administration, ending the year with a total of 1,448 separate actions successfully resolved. In addition, ER/RA staff provided targeted advice on five internal inquiries completed by the OIG's Office of Professional Responsibility. Working jointly with attorneys in the Administrative Law Division, the ER/RA team also completed 12 fact-finding inquiries addressing employee concerns ranging from allegations of a hostile work environment to unfair treatment.

The Administrative Law (AL) Division represented the OIG in all phases of litigation, including in nine cases before the Equal Employment Opportunity Commission and six cases before the Merit Systems

Protection Board, the majority of which were successfully resolved in the agency's favor. Both the AL and ER/RA staff continue working together to advise leaders on various workplace issues, including numerous reasonable accommodation requests.

During the prior reporting period, attorneys from the Oversight and Procurement Law (OPL) Division were providing support to the US Attorney's Office for the District of Montana in an action to enforce a testimonial subpoena issued to a former VA employee in September 2022. This was the first challenge to an OIG testimonial subpoena since the OIG received the authority to issue them in June 2022. In April 2023, the court granted the OIG's petition for summary enforcement and OIG employees subsequently interviewed the former VA employee to obtain valuable information in support of a healthcare inspection. OPL attorneys also prepared and presented a training on recent Supreme Court decisions including cases involving threats to VA personnel to a national audience of OIG criminal investigators. In another forum, staff provided information to medical consultants from the Office of Healthcare Inspections on reporting requirements to the National Practitioner Data Bank and state licensing boards. OPL lawyers continued to support OIG criminal investigators by completing legal reviews of 258 draft subpoenas during this review period, bringing the end-of-year total for FY 2023 to 490.

The Release of Information Office reviewed all OIG reports before publication for compliance with the Privacy Act and other disclosure laws and responded to more than 580 record requests and appeals during this reporting period, bringing the total to over 1,000 for the fiscal year. Staff also continued to support US Attorney's offices in several FOIA and Privacy Act cases, including the successful conclusion of a Privacy Act case before the North Dakota federal district court that was dismissed for lack of jurisdiction, and which preserved the OIG's ability to publicly report on the oversight of VHA medical facilities. Staff also reviewed each of the 100 reports published by the OIG during the review period to ensure compliance with the Privacy Act, as well as statutory information release restrictions unique to VA.

Highlighted Activities and Findings

The Office of Investigations

Office of Investigations (OI) staff investigate potential criminal activity and civil violations of law, including fraud related to VA benefits, construction, education, procurement, and health care, as well as drug offenses, crimes of violence, threats against VA employees or facilities, and cyberthreats to VA information systems. During this six-month reporting period, investigative efforts resulted in 95 arrests, 99 convictions, and nearly $531.4 million in monetary benefits for VA.

OI continues to prioritize high-impact investigations. Its personnel coordinate with other OIG directorates, external law enforcement partners, and the Department of Justice to ensure that veterans, VA employees, and VA assets are protected and wrongdoers are held accountable. In addition, OI provides expert advice to Congress on VA-related anticrime measures. For example, OI personnel provided comments pertaining to a bill that was drafted to refine the requirements for VA's utilization of public disability benefits questionnaire (DBQ) forms. Public DBQs are medical forms that veterans submit to their healthcare providers (within VA or in the community) to provide information that helps VA evaluate their disability benefit claims.

OI also issued a fraud alert regarding DBQ schemes, which typically involve unaccredited individuals trying to improperly obtain payments from veterans for assistance with getting DBQs completed by physicians (often with promises of a higher disability rating) and then filing the related claim. Veterans were reminded that VA offers free services and should work only with its accredited individuals for assistance with filing DBQ claims. Another fraud alert released this period was issued jointly by OI and the FBI. It focused on scammers who steal or use the personal information of others to receive medical care or submit fraudulent health insurance claims. Both alerts identified multiple fraud indicators and included several proactive measures veterans can take to avoid becoming a victim. These and other OI efforts enhance the detection of high-dollar fraud in a number of risk areas to help prevent harm to veterans, their families, and caregivers.

During this reporting period, OI's staff conducted numerous successful investigations resulting in arrests, indictments, and sentencing. The selected investigations summarized below illustrate OI's emphasis on cases that lead to monetary recoveries for VA that can be reinvested in its programs, services, and benefits; address fraud, waste, and abuse by VA employees in positions of trust; and help ensure benefits and services meant for veterans and other eligible beneficiaries are being received.

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

VBA implements a number of programs for eligible veterans and family members, including education, insurance, and monetary benefits, as well as VA-guaranteed home loans. Investigations routinely concentrate on benefits provided to ineligible individuals. With respect to home loans, the OIG conducts

investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. The OIG also investigates 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.**

CHIEF EXECUTIVE OFFICER OF A TECHNICAL SCHOOL SENTENCED FOR DEFRAUDING VA OF NEARLY $105 MILLION IN EDUCATION BENEFITS

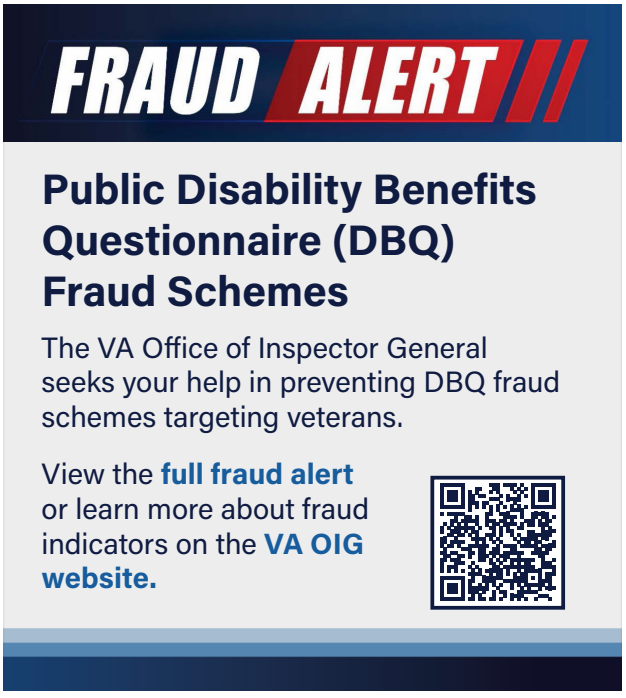
A VA OIG investigation revealed that the chief executive officer of a non-college-degree-granting technical school admitted to his role in the largest known incident of Post-9/11 GI Bill benefits fraud prosecuted by the Department of Justice. The defendant and multiple coconspirators defrauded the benefits program by falsifying attendance records, student grades, and professional certifications to conceal they were not complying with VA's "85/15" rule. This rule is intended to ensure VA is paying fair market value tuition by requiring that at least 15 percent of enrolled students pay VA's same rate with non-VA funds. Non-college-degree-granting schools require students to attend in-person classes; online courses are not permitted. In addition to falsifying records and allowing students to complete coursework online at their own pace, the coconspirators posed as students when contacted by the state approving agency to confirm graduation and job placement data so they could maintain school eligibility. The chief executive officer was sentenced in the District of Columbia to 60 months in prison, 36 months of supervised release, and restitution to VA of over $104.6 million.

BUSINESS OWNERS PLEADED GUILTY TO DEFRAUDING VA OF MORE THAN $4 MILLION FOR HOME ASSISTANCE NOT PROVIDED TO VETERANS OR THEIR SURVIVING SPOUSES

The owners of a business that claimed to provide home health services to veterans submitted fraudulent applications on behalf of unwitting VA beneficiaries for VA pension with aid and attendance benefits. Qualified veterans or surviving spouses who receive aid and attendance benefits receive a higher monthly pension amount to assist with daily living activities. The investigation, which was conducted by the VA OIG, revealed that the defendants falsely claimed to have provided home assistance to the beneficiaries before submitting the applications and disguised their role in the application process during their interactions with the victims. They received more than $4 million in VA funds intended for more than 300 veterans or their surviving spouses. The business owners pleaded guilty in the Eastern District of Louisiana to wire fraud.

MORTGAGE LENDER AGREED TO PAY $23.7 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

An investigation by the VA OIG and Department of Housing and Urban Development (HUD) OIG resolved allegations that a mortgage lender failed to comply with material program requirements when it originated and underwrote mortgages guaranteed by VA or insured by HUD's Federal Housing



Administration. The requirements included maintaining quality control programs to prevent and correct underwriting deficiencies, self-reporting any materially deficient loans that they identify, and ensuring that the underwriting process is free from conflicts of interest. The lender entered into a civil settlement agreement under which it agreed to pay over $23.7 million to resolve False Claims Act allegations. Of this amount, VA will receive approximately $8.1 million.

VETERAN INDICTED IN CONNECTION WITH MULTIPLE FRAUD SCHEMES INCLUDING TARGETING GOLD STAR FAMILIES

According to a multiagency investigation, a veteran allegedly submitted false documents to VA to obtain a VA-backed loan for a property valued at $2.1 million. The investigation also alleges that the 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. He was indicted in the District of New Jersey on charges of 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. The investigation was conducted by the VA OIG, Homeland Security Investigations, FBI, and Defense Criminal Investigative Service (DCIS).

FORMER VA FIDUCIARY INDICTED FOR WIRE FRAUD

A VA OIG and Social Security Administration OIG investigation resulted in charges alleging that the sister of a veteran used his government benefits for her personal expenses after he became a full-time resident at the Orlando VA Medical Center's Community Living Center. The defendant, who previously served as her brother's VA-appointed fiduciary and Social Security Administration representative payee, allegedly conducted large monthly wire transfers from his bank account to her own personal bank account after the deposits of his VA and Social Security benefits. She was arrested after being indicted in the Middle District of Florida for wire fraud. The loss to VA is approximately $150,000.

SELECTED VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

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

VA PHYSICIAN INDICTED FOR SEXUALLY ASSAULTING FEMALE VETERAN PATIENTS

A VA OIG investigation resulted in charges alleging that a primary care physician at the Atlanta VA Medical Center in Georgia sexually assaulted four female patients during routine examinations. The physician was arrested after being indicted in the Northern District of Georgia on charges of deprivation of rights under color of law (civil rights) and abusive sexual contact.

FORMER PHARMACY TECHNICIAN AND CODEFENDANT SENTENCED FOR SCHEME INVOLVING STOLEN DIABETIC TEST STRIPS

A former pharmacy technician at the Battle Creek VA Medical Center in Michigan used her position to steal more than $400,000 in diabetic test strips from the facility and then sold them to individuals not affiliated with VA. Following an investigation by the VA OIG, Food and Drug Administration Office

of Criminal Investigations, and VA Police Service, the pharmacy tech and a codefendant admitted to the scheme and were sentenced in the Western District of Michigan to 18 and 10 months in prison, respectively. They also each received three years of supervised release and were ordered to jointly pay restitution of more than $427,000.

THREE EXECUTIVES INDICTED FOR MULTIBILLION-DOLLAR HEALTHCARE FRAUD SCHEME IN WHICH VA ALSO PAID FOR CREAMS AND DEVICES IMPROPERLY PRESCRIBED

A multiagency investigation resulted in charges alleging that three executives of a healthcare software and service company conspired to use telemarketers to reach out to targeted individuals—including Medicare, TRICARE, and CHAMPVA beneficiaries—and generate standardized orders for the individuals to receive medically unnecessary orthotic braces and pain creams and then getting doctors to sign the orders in exchange for kickbacks and bribes. Allegedly, the templates for the doctors' orders were based on the patients' interactions with the telemarketers, not the prescribing providers, who were limited in their ability to modify the orders. The prescribing providers received a fee in exchange for each order, and routinely did not contact the patients. The three executives' company received payment from VA, Medicaid, and other sources for the devices and creams that were improperly prescribed. The total loss to the government is $2.8 billion, including a more than $1 million loss to VA. The defendants were indicted in the Southern District of Florida. This investigation was conducted by the VA OIG, DCIS, FBI, and Department of Health and Human Services (HHS) OIG.

MULTIPLE COMPANIES AND INDIVIDUALS CHARGED IN CONNECTION WITH FOREIGN MEDICAL PROGRAM FRAUD SCHEME WITH LOSS TO VA OF ABOUT $67 MILLION

According to an investigation by the VA OIG and the US Department of State's Diplomatic Security Service, 12 individuals and 24 companies allegedly participated in a long-term scheme that targeted veterans overseas. The defendants are accused of creating a network of medical and pharmaceutical service providers that submitted thousands of false claims to VA's Foreign Medical Program for services that were double billed, grossly overpriced, unnecessary, or not rendered. They then allegedly deposited and transferred the proceeds received from VA and their private business entities among several banking institutions to disguise their illicit activities. The total loss to VA is approximately $67 million. The Panamanian judicial system is prosecuting this case as a result of a filing by the Department of Justice in coordination with the US Embassy in Panama.

DOCTOR TO PAY $7 MILLION TO RESOLVE CIVIL FRAUD ALLEGATIONS

A VA OIG investigation resolved allegations that a doctor and others engaged in a scheme to defraud VA's CHOICE/Patient-Centered Community Care program by submitting claims for higher levels of service than was medically reasonable or necessary. The doctor entered into a civil settlement in the Eastern District of Oklahoma under which he agreed to pay $7 million to resolve these allegations.

COMPOUNDING PHARMACY OWNER CONVICTED OF ILLEGAL KICKBACKS AND MONEY LAUNDERING WITH A $3 MILLION LOSS TO VA

A multiagency investigation resulted in charges alleging that numerous defendants—including pharmacists, physicians, recruiters, and beneficiaries—participated in a scheme to defraud federal healthcare programs by billing for nonreimbursable medications in compounded prescriptions. Coconspirators from a compounding pharmacy in the Dallas–Fort Worth area recruited beneficiaries to visit specific physicians and receive a prescription for compounded pain medication. These prescriptions were filled by the pharmacy, which then fraudulently billed VA and other federal programs. This investigation revealed that the medications contained several nonreimbursable ingredients and that the pharmacy overcharged for the medications. After the pharmacy was reimbursed for the medication, the beneficiaries, physicians, and recruiters were then paid a percentage of the proceeds. The total loss to the government is estimated at over $75 million, including an approximate $3 million loss to VA. The owner of the compounding pharmacy was found guilty in the Northern District of Texas on charges of payment of kickbacks and conspiracy to launder monetary instruments. This investigation was conducted by the VA OIG, DCIS, HHS OIG, FBI, and Department of Labor (DOL) 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. Additional cases are listed in **table 7.**

FORMER VA EMPLOYEE SENTENCED FOR LEADING $3.5 MILLION UNEMPLOYMENT INSURANCE FRAUD SCHEME

A former registered nurse at the Richmond VA Medical Center in Virginia and three defendants engaged in a conspiracy to defraud at least five states of more than $3.5 million in pandemic-related unemployment insurance benefits. The former employee, who was the leader of the conspiracy, used a VA-issued computer to research available benefits, file and access claims, and falsify documents in furtherance of the scheme. The former employee was sentenced in the Eastern District of Virginia to 18 years' imprisonment and ordered to pay restitution of $2 million and forfeiture of $1.4 million after pleading guilty to conspiracy to commit aggravated identity theft as well as mail and wire fraud. Three coconspirators were previously sentenced to a total of 138 months' imprisonment in connection with this fraud scheme. The VA OIG and DOL OIG conducted this investigation.

FOUR DEFENDANTS SENTENCED IN CONNECTION WITH MULTIMILLION-DOLLAR WORKERS' COMPENSATION FRAUD SCHEME

A multiagency investigation resulted in charges alleging that a Texas company recruited injured federal workers by offering to assist in filing their claims with the DOL's Office of Workers' Compensation Programs. The defendants allegedly funneled those employees to medical clinics where doctors wrote prescriptions for compounded medications in exchange for kickbacks from pharmacies. The coconspirators allegedly billed DOL, as well as the Department of Defense's (DoD) TRICARE

program, for more than $126 million. The portion of the billed amount attributable to VA employees is approximately $1.3 million. Four defendants were sentenced in the Southern District of Texas to 150 months in prison, 11 years of supervised release, and restitution of $24 million. This investigation was conducted by the VA OIG, DOL OIG, US Postal Service OIG, and DCIS.

FORMER VA POLICE OFFICER INDICTED ON FEDERAL CIVIL RIGHTS AND ASSAULT CHARGES

According to another multiagency investigation, a former VA Police Service officer at the West Los Angeles VA Medical Center allegedly used a department-issued baton to illegally strike a man about 45 times during an arrest at the facility in January 2022. The defendant was indicted in the Central District of California on charges of deprivation of rights under color of law resulting in bodily injury and assault with a dangerous weapon with the intent to do bodily harm. This investigation was conducted by the VA OIG, VA Office of Security and Law Enforcement, and FBI.

FORMER VA LICENSED PRACTICAL NURSE SENTENCED FOR DISTRIBUTION AND POSSESSION OF CHILD PORNOGRAPHY

A former licensed practical nurse at the Northampton VA Medical Center in Leeds, Massachusetts, used the facility's public Wi-Fi to upload and download thousands of files containing child pornography to his personal computer. The nurse was sentenced in the District of Massachusetts to eight years in prison and five years of supervised release after previously pleading guilty to distribution and possession of child pornography. The defendant was also ordered to pay a total of $10,000 in restitution to two victims. The investigation was conducted by the VA OIG, US Secret Service, and VA Police Service.

VETERAN INDICTED FOR STARTING A FIRE AT THE CLEVELAND VA MEDICAL CENTER

A multiagency investigation resulted in charges alleging that a veteran started a fire in a VA medical center's emergency department. The fire caused damages of approximately $100,000 and resulted in the evacuation of patients and staff. The veteran allegedly was also in possession of a stolen VA computer and another individual's debit card and, earlier the same day, threatened to physically harm a VA nurse. The defendant was indicted in Cuyahoga County Court (Ohio) on charges of aggravated arson, receiving stolen property, and aggravated menacing. This investigation was conducted by the VA OIG; VA Police Service; Cleveland Fire Department; and Bureau of Alcohol, Tobacco, Firearms and Explosives.

The Office of Special Reviews

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Hotline Referral Reviews

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1
Investigative Memorandum

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

During this reporting period, OSR made investments in staff development to enhance eDiscovery analysis supporting its investigations. For the full fiscal year, this office also experienced a nearly four-fold increase over the prior year in the volume of allegations received that reported potential whistleblower retaliation by employees of contractors and grantees. Special Reviews investigators made their first use of the OIG's recently received testimonial subpoena power to compel an interview of a former VA employee in an administrative investigation. OSR also conveyed one nonpublic report to VA.

NONPUBLIC REPORT OF INVESTIGATION OF WHISTLEBLOWER RETALIATION CLAIM UNDER 41 U.S.C. § 4712

OSR investigates allegations of whistleblower reprisal made by employees of VA contractors or grantees pursuant to 41 U.S.C. § 4712. Federal law prohibits inspectors general from disclosing "any information from or about any person alleging the reprisal" other than as necessary to conduct its investigation; therefore, the details of these investigations are not publicly released. To promote transparency of its activities to the greatest extent permitted by law, the OIG does release statistical information about these cases. During the reporting period, OSR completed one of these investigations and determined that the allegations of reprisal were not substantiated. As required by statute, the OIG referred the completed investigation to the VA secretary, who is responsible for making the final determination to grant or deny relief.

The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) released 40 publications summarizing results from its oversight work, including five VA management advisory memoranda. Overall, its published reports resulted in 215 recommendations with a potential monetary impact for VA of more than $325.4 million for the reporting period. Specialized OAE teams also conducted 44 preaward and postaward contract audits and reviews to help VA obtain fair and reasonable pricing on products and services as well as compliance with contract terms. OAE identified potential cost savings of nearly $273.5 million and recovered more than $5.7 million in overcharges from preaward and postaward contract audits and reviews.

This review period, OAE addressed key topics involving VA system modernization (including financial management and the electronic health records for VA patients). It also examined areas of tremendous growth, such as care in the community paid for by VA and the processing of specialized disability benefits—even more pressing following passage of the PACT Act that is expected to generate 1.9 million claims for proper processing. To ensure VA is also being an effective steward of taxpayer dollars, OAE staff continue to monitor significant spending. With the designated authority to negotiate the availability and price of pharmaceuticals on behalf of VA and other federal agencies at over $14 billion per year, audit staff continue to oversee these and other high-impact activities.

OAE's work also continues to delve into root causes for deficiencies. It has found that weaknesses in VA's governance and oversight have affected many aspects of program performance and operations. Several of these issues were highlighted in congressional testimony and media coverage over the past six months. For example, OAE continues to spotlight the risks associated with VA's outdated financial management system. An audit leader testified before Congress in June 2023 on concerns with VA's financial management transformation effort.[5] VA has also struggled to ensure accountability and transparency in how it obligates and expends funds.[6]

This was particularly evident when accounting for the supplemental funds VA received to prevent, prepare for, and respond to the COVID-19 pandemic. Because VA's financial management system does not support the direct obligation of supplemental funds for all expenses, staff used expenditure transfers to shift funds between appropriation accounts. However, due to VHA's lack of guidance, staff did not always sufficiently document the transfers. In addition, even when staff directly obligated Coronavirus

5 VA OIG, Statement of Nicholas Dahl, Deputy Assistant Inspector General for Audits and Evaluations, Hearing on *"The Status of VA's Financial Management Business Transformation,"* June 20, 2023.

6 VA OIG, *VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2023*, Report No. 22-00879-196, September 22, 2023.

Aid, Relief, and Economic Security (CARES) Act funds, they did not always follow key fiscal controls, such as segregating staff duties and properly tracking the receipt of goods. As some transactions were noncompliant with these controls, VHA and Congress lack assurance that CARES Act funds were used for veterans' COVID-19-related needs, and the OIG questioned an estimated $187.2 million.[7] Inspector General Missal testified before Congress in May 2023 on the need for corrective action in regard to financial management problems and supplemental funding oversight deficiencies.[8]

As VA referrals to community care have increased, OAE has increasingly dedicated resources to ensure VA personnel comply with all requirements and assess opportunities to better serve veterans. For example, a report released this period identified strategies to improve veterans' access to community care services under the MISSION Act that are paid for by VA. This includes ensuring medical facility leaders identified, authorized, recruited, and retained nurses and medical support assistants to meet increased demand for community care. Audit staff found that VHA does not have reliable data or sufficient tools to assess community care staffing levels and needs at the network or national level.[9] OAE's current work continues to focus on identifying opportunities to improve fiscal controls and veterans' access to community care services, such as determining whether community care network administrators met network adequacy requirements, which helps to ensure timely care for veterans, and whether payments made under VHA's community care network contracts are on time and accurate.

OAE also continued to focus on ensuring benefits are processed in accordance with regulations for veterans. Claims processing often involves tremendously complicated processes, evaluations, and decision-making and is subject to rigorous timelines to promptly provide eligible recipients with the accurate amount or level of benefits. Prior OIG reports have found manual processing can contribute to inaccurate benefit payments. In March 2023, VA deployed a Digital GI Bill Enrollment Manager to eliminate the need to manually process vacation breaks. That change was made following a prior OIG report that found VBA underpaid Post-9/11 GI Bill benefits because they did not accurately adjust for vacation breaks.[10] During this reporting period, OAE assessed concerns with disability exams and the questionnaires health providers complete for benefits determination.[11] Staff also examined whether VBA processed Gulf War illness disability claims per VA regulatory requirements. Gulf War illness refers to a group of unexplained or ill-defined chronic symptoms found in veterans deployed to the Persian Gulf during Operations Desert Storm and Desert Shield.[12] The OAE assessment found that VBA's Gulf War illness claims process did not ensure all requirements were met before claims processors decided disability compensation claims. As a result, VBA prematurely decided an estimated 3,200 of

7 VA OIG, *VHA Can Improve Controls Over Its Use of Supplemental Funds*, Report No. 21-03101-73, May 9, 2023.

8 VA OIG, Statement of Inspector General Michael J. Missal, Hearing on "*COVID-19 Supplemental Funding: Did It Protect And Improve Veteran Care?*" May 23, 2023.

9 VA OIG, *Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff*, Report No. 21-03544-111, July 19, 2023.

10 VA OIG, *Processing of Post-9/11 GI Bill School Vacation Breaks Affects Beneficiary Payments and Entitlement*, Report No. 21-02437-120, May 3, 2022

11 VA OIG, Statement of Stephen Bracci, Director, Claims and Medical Exams Inspection Division, Office of Audits and Evaluations, Hearing on *"VA Disability Exams: Are Veterans Receiving Quality Services?*," July 27, 2023; VA OIG, *Inconsistent Disability Benefits Questionnaires May Lead to Inaccurate Mental Competency Determinations*, Report No. 22-03543-193, September 13, 2023. OAE also worked with OI to develop a public disability benefits questionnaire **fraud alert**.

12 VA OIG, *Nonadherence to Requirements for Processing Gulf War Illness Claims Led to Premature Decisions*, Report No. 22-02194-152, September 7, 2023.

the 13,800 Gulf War illness claims (23 percent) completed in the audit period, leading to at least $5.1 million in improper overpayments. The OIG's report made five recommendations for corrective action.

Audit staff also continued to scrutinize VA's oversight of its vast spending across the enterprise, including pharmaceutical purchases. The Veterans Health Care Act of 1992, passed to help control the cost of pharmaceuticals purchased by the federal government, mandates that manufacturers discount drugs they sell to VA, DoD, the Public Health Service, and the Coast Guard. In return, manufacturers supply the largest government agencies with needed drugs and become eligible to participate in and receive funds from federal-funded programs such as Medicare and Medicaid. The OIG found manufacturers did not make 22.8 percent of drugs covered by the law available on the Federal Supply Schedule as required. This resulted in an estimated $28.1 million in overcharges to VA and the DoD. To reduce noncompliance and keep drugs more affordable, the OIG made eight recommendations.[13]

The following publications serve as examples of the type of work OAE staff conduct that results in significant changes within VA and improvements for the veterans it serves. In addition, this directorate has been advancing its proactive inspections that focus on financial efficiency and information security at VA healthcare facilities—with nine of these inspections published during this review period. All published OAE reports and other products are listed in *table 8* and on the VA OIG **website**.

FEATURED REPORTS

THE FIDUCIARY PROGRAM NEEDS TO VERIFY THE PROMPT RETURN OF DECEASED BENEFICIARIES' FUNDS TO VA

In this report, the OIG reviewed an anonymous allegation received in June 2022 that two fiduciaries under the jurisdiction of the fiduciary hub in Indianapolis, Indiana, had not released four beneficiaries' funds who died in 2010, 2013, 2015, and 2020. A team identified two additional beneficiary cases warranting examination. The report's findings indicated that between August and November 2022 both fiduciaries returned six deceased beneficiaries' remaining funds to either VA or an heir, but with delays ranging from 19 months to 12 years from the beneficiary's death or the date VA received the fiduciary's final accounting of the fund's distribution. Although federal regulations include a timeliness standard for a fiduciary to submit a final accounting within 90 days of the beneficiary's death, neither statute nor regulation include a timeliness standard for fiduciaries to disburse VA-derived funds of deceased beneficiaries to heirs or return them to VA. An audit leader also testified before Congress in September 2023 on concerns related to fiduciaries' management of veteran benefits.[14] While neither statute nor regulation includes a timeliness standard for disbursement, as stewards of taxpayer dollars, VA should be

13 VA OIG, *Manufacturers Failed to Make Some Drugs Available to Government Agencies at a Discount as Required*, Report No. 22-01624-143, September 20, 2023.

14 VA OIG, Statement of Lisa Van Haeren, Director, Claims and Fiduciary Inspection Division, Office of Audits and Evaluations, Office Of Inspector General, Hearing on "*VA's Fiduciary Program: Ensuring Veterans' Benefits Are Properly Managed*," September 28, 2023.

promptly reclaiming funds when there is no valid will or heir to receive them. Heirs also should not have to wait excessive periods to receive funds to which they are entitled. Moreover, a fiduciary can dispose of related records after two years from the date that VA either removes the fiduciary or the fiduciary withdraws. As a result, there is a potential risk of fraud, theft, and loss, if there has been no verification within those two years that funds were properly distributed. The OIG recommended VA reinstate a policy to validate that fiduciaries disbursed funds when a valid will or heir exists, but VA has declined as it is not required by law.

VA SHOULD ENSURE VETERANS' RECORDS IN THE NEW ELECTRONIC HEALTH SYSTEM ARE REVIEWED BEFORE DECIDING BENEFITS CLAIMS

VBA staff need access to VA patients' new electronic health records for benefits claims processing. OAE assessed whether VBA staff followed procedure to identify and route benefits claims involving new health system records to processors with access. The OIG found 27 percent of such claims decided between August 1, 2021, and July 31, 2022, did not consider new health system records. A claims sample indicated veterans' benefits were not ultimately affected in the 30 cases reviewed, but the risk of error increases if claims involving new health system records are not checked before a decision. If checks are not completed, veterans may not receive the benefits to which they are entitled. VBA concurred with the OIG's recommendations to conduct refresher training and update guidance to improve staff's handling of claims involving new health system records and strengthen oversight by clarifying staff accountability for failure to consider all evidence.

VHA FACES CHALLENGES IMPLEMENTING THE APPEALS MODERNIZATION ACT

VA implemented the Appeals Modernization Act (AMA) in 2019 to offer veterans faster resolution of disagreements with VA benefits decisions. Although it largely focuses on VBA benefits decisions, it also applies to decisions made by VHA, such as clothing allowances related to prosthetics use and reimbursement of non-VA emergency care. Previous OIG reports found difficulties with the appeals modernization rollout. Additional concerns prompted this review to determine whether VHA processed and tracked appeals of benefits decisions in accordance with the AMA's requirements and two VHA interim policy notices. The OIG found VHA program offices did not give claimants the information needed to initiate higher-level reviews and supplemental claims (discussed below) regarding benefits decisions. In addition, VHA did not accurately track reviews because it did not implement effective systems, sufficient policies, or adequate training. The report includes 14 recommendations to improve information given to claimants, centralize intake, and better track and standardize retention of decision reviews.

VA DEVELOPED REPORTING METRICS FOR APPEALS MODERNIZATION ACT DECISION REVIEWS BUT COULD BE CLEARER ON SOME VETERANS' WAIT TIMES

The AMA offers three options for contesting a VBA benefit decision: (1) direct appeals to the Board of Veterans' Appeals; (2) a higher-level review by a senior technical expert with no new evidence presented; and (3) a supplemental claim with new information. Higher-level reviews and supplemental claims each have a completion goal of 125 days on average. VA must report its performance to Congress and the public. The OIG found VA developed reporting metrics for AMA decision reviews but could be clearer on some veterans' wait times when higher-level reviews have errors that are then completed as supplemental claims. Reports on each process do not clearly illustrate the combined expected wait times when a veteran's claim must go through both a higher-level and supplemental review. The

OIG also determined reporting did not consider the full time allotted for final actions and made two recommendations to increase VA's transparency.

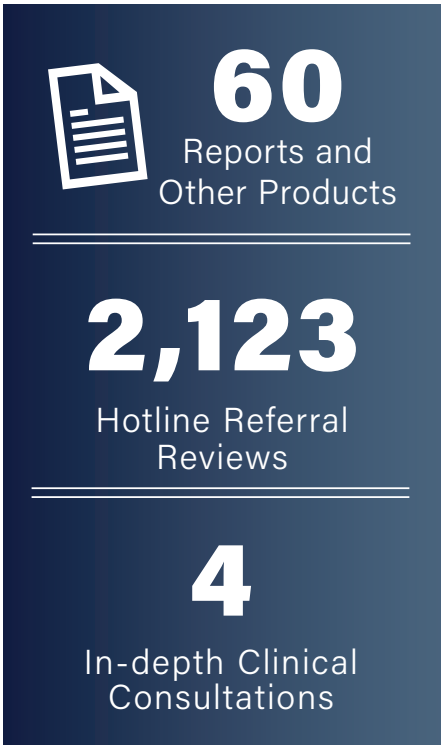
OVERSIGHT COULD BE STRENGTHENED FOR NON-VA HEALTHCARE PROVIDERS WHO PRESCRIBE OPIOIDS TO VETERANS

The MISSION Act of 2018 requires VA to ensure that non-VA providers (community care providers) who prescribe opioids to veterans receive and certify they have reviewed VA's Opioid Safety Initiative guidelines that require providers to query state prescription drug monitoring program (PDMP) databases that track controlled substance prescriptions. The OAE team assessed whether VA ensured non-VA providers received and certified reviewing the guidelines, whether non-VA providers in an OIG sample conducted required PDMP queries, and whether a sample of veterans' medical records included opioid prescriptions. VA's Office of Integrated Veteran Care was found to have inadequate oversight to ensure non-VA providers received the Opioid Safety Initiative guidelines and certified their review. The office also did not monitor VA's third-party administrators to ensure non-VA providers completed PDMP queries. Non-VA provider opioid prescription information was generally documented in the OIG sample's medical records but was recorded in different sections, making it more difficult for care providers to access this critical information. Three recommendations were made to improve compliance with MISSION Act requirements.

VA'S GOVERNANCE OF ITS PERSONNEL SUITABILITY PROGRAM FOR MEDICAL FACILITIES CONTINUES TO NEED IMPROVEMENT

Applicants for VHA positions undergo background investigations as a condition of their employment to help ensure their suitability to care for veterans and be entrusted with sensitive information and resources. This audit is a follow-up to a 2018 OIG report that identified deficiencies and governance concerns with the VHA personnel suitability program. This follow-up audit found VHA staff did not initiate or adjudicate all background investigations within required time periods and did not maintain documentation to validate the completion of favorable adjudications. These deficiencies allowed some personnel in direct patient care to be employed without vetting for long periods, although identified cases were eventually favorably completed. VA concurred with seven OIG recommendations to address the lack of program monitoring, insufficient staffing, the lack of a single system for tracking investigations with adequate data, and the need for more robust oversight.

The Office of Healthcare Inspections



OHI remains committed to ensuring that veterans have access to timely, high-quality health care. Its staff continues to assess allegations of wrongdoing and other concerns it identifies that affect key functions within VHA. During this reporting period, OHI focused on assessing areas for which continuous improvements and accountability were key to providing appropriate health care and advancing patient safety. These reports emphasized the importance of strong leadership within VA medical facilities and at every level of VHA in which people at the top stress the need to ensure our nation's veterans receive the caliber and comprehensiveness of care they are due.

As the largest integrated healthcare system in the country, VHA requires its leaders to be engaged and proactive to make certain that veterans receive the care they need. Leaders must establish and maintain a culture of safety and accountability, including a work environment in which all staff members fully understand their roles and responsibilities, as well as their duty to report problems and potential risks to patients. OHI has published several reports that highlight the negative impact of absent or passive leadership in overseeing critical healthcare operations, such as suicide prevention and care coordination. Undefined leadership roles and responsibilities, as well as conflicting or unclear guidance, repeatedly undermine the ability of staff and leaders to deliver high-quality care.

OHI continues to assess VHA's challenges with recruiting and retaining the clinical talent and support staff required to meet the needs of veterans. Inspection teams have captured and analyzed important data that demonstrates the need for VHA to develop a staffing model that can direct hiring actions for critical positions and support decisions related to purchasing healthcare services in the community. This extensive work has included surveying facility leaders across the system on their clinical and nonclinical critical staffing shortages and surveying front-line patient safety managers to understand the perceived barriers to carrying out their essential duties. OHI's new cyclical Care in the Community (CITC) Program evaluates many of the processes in place to facilitate and coordinate care among VA and local healthcare providers as well as those related to patient safety. As the complexity and cost of health care increase, VA must look to standardizing processes and organizational structures across the system, including for purchasing care, to effectively monitor costs and quality and to address concerning trends immediately.

OHI leaders recognize the need to continually evaluate and enhance oversight tools to remain relevant and effective in conducting its independent work. During this six-month reporting period, the Comprehensive Healthcare Inspection Program (CHIP), which is one of OHI's most recognized programs, has been redesigned. The updated program will launch in FY 2024. Teams are modifying the data collection tools to streamline production and publication as well as soliciting the experiences of veterans and staff at each facility to give stakeholders a broader perspective of each local facility than previous compliance-oriented inspections offered. The Mental Health Inspection Program will also

launch in FY 2024, using principles of a recovery-based model of care to evaluate mental health inpatients units across the system.

The office published 60 oversight reports and other products during the six-month reporting period, including six national healthcare reviews, one national-level CHIP summary report, 16 reports responsive to OIG hotline complaints, and one management advisory memorandum. These 24 products addressed a wide variety of topics, such as weaknesses in credentialing and privileging healthcare providers, noncompliance with community care referrals, and failure to adhere to opioid safety protocols. Of the remaining 36 reports, two were generated from the Vet Center Inspection Program (VCIP); 31 were facility-level CHIP inspections; two were VISN-level CHIP products; and one was a joint report developed as part of the Pandemic Response Accountability Committee's Health Care Subgroup.

Principal Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testifies before the Senate Veterans' Affairs Committee on *Connections to Care: Improving Substance Use Disorder Care for Veterans in Rural America and Beyond* on June 14, 2023.

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

NATIONAL HEALTHCARE REVIEWS

The six national healthcare reviews published during this reporting period explore issues such as VHA's patient safety program, lung cancer screenings, access to telehealth before and during the pandemic, clinical care transition from the DoD to VHA for patients with opioid use disorder, and VHA's severe occupational staffing shortages. The reports regarding the latter three issues are summarized below.

REVIEW OF VETERANS HEALTH ADMINISTRATION'S MULTI-TIERED PATIENT SAFETY PROGRAM

The OHI team conducted surveys of VISN patient safety officers (PSOs) and medical facility patient safety managers (PSMs), including questions about oversight, culture, staffing, and training. The team also conducted interviews with VHA quality and patient safety leaders and PSOs. The OIG identified opportunities to strengthen patient safety programs at VISNs and facilities, such as evaluating communication barriers, establishing facility patient safety program oversight requirements, revising National Center for Patient Safety quarterly reports, developing a PSM staffing configuration, implementing formalized PSO and PSM training, and reviewing factors contributing to their burnout. VHA concurred with the OIG's nine recommendations.

REVIEW OF ACCESS TO TELEHEALTH AND PROVIDER EXPERIENCE IN VHA PRIOR TO AND DURING THE COVID-19 PANDEMIC

VA OIG Nurse Consultant shares challenges for veterans with opioid use disorder transitioning from DoD to VHA on the *Inside Oversight* **podcast** (Season 2, Episode 15).

OHI personnel reviewed the implementation and use of VA Video Connect (VVC) prior to and during the pandemic, why providers used telephone communication more frequently than VVC at the onset of the COVID-19 pandemic, and how VHA resolved technology issues. The OIG found telephone and VVC use increased as presumed in-person encounters decreased at the start of the pandemic. In contrast, telephone use decreased and VVC encounters continued to increase after the initial months of the pandemic. The OIG concluded the pandemic served as the impetus for VVC use. VHA providers identified the benefits of employing VVC, such as convenience and increased patient engagement. They also described barriers to using VVC, including patients' challenges with the video technology, video appointments not emulating in-person appointments, and provider difficulty with scheduling video appointments. The OIG made three recommendations to the under secretary for health related to provider knowledge and use of VVC technology, clinical and administrative support, and VVC scheduling processes.

REVIEW OF CLINICAL CARE TRANSITION FROM THE DEPARTMENT OF DEFENSE TO THE VETERANS HEALTH ADMINISTRATION FOR SERVICE MEMBERS WITH OPIOID USE DISORDER

This national review evaluated the transition of clinical care from the DoD to VHA for service members with opioid use disorder (OUD). The OIG reviewed VHA electronic health records for OUD diagnosis or acknowledgment of a history of opioid misuse documentation in an initial primary care or mental health comprehensive intake evaluation; OUD documentation in VHA problem lists; and substance use disorder treatment or medication-assisted treatment offered by VHA providers. Provider perceptions of training and barriers to documenting OUD and using risk-mitigation strategies were evaluated. The OIG made five recommendations related to barriers for providers when documenting OUD in electronic health records; training on the use, navigation, and retrieval of DoD treatment record information; the evaluation of barriers to accessing and using Defense treatment records; and assessing and updating processes for identifying patients with OUD.

HEALTHCARE INSPECTIONS

These for-cause inspections (including those previously referred to as "hotline" inspections) assess allegations pertaining to VA medical care that are made by patients or their families, VA employees, members of Congress, and other stakeholders. Of the 16 healthcare inspections published during the second half of FY 2023, two summaries are highlighted below—one on a patient's suicide following deficient Veterans Crisis Line management and VHA's oversight of community care providers' opioid prescribing.

A PATIENT'S SUICIDE FOLLOWING VETERANS CRISIS LINE MANAGEMENT AND DEFICIENT FOLLOW-UP ACTIONS BY THE VETERANS CRISIS LINE AND AUDIE L. MURPHY MEMORIAL VETERANS HOSPITAL IN SAN ANTONIO, TEXAS

The OIG found that a Veterans Crisis Line (VCL) responder inadequately assessed suicide risk and alcohol use for a patient who died by suicide within an hour after the patient's VCL text contact. The responder failed to effectively develop a safety plan, involve a family member, confirm access to lethal

means had been reduced, and consider transferring contact to telephone. The OIG found that VCL leaders failed to provide adequate oversight and quality assurance. Following notification of the patient's death, VCL leaders and staff did not complete a root cause analysis, consider disclosure, alert Audie L. Murphy Memorial Veterans Hospital staff of the patient's death, address a complaint, and discontinue caring letters (brief messages of concern sent to patients following contact with the VCL), and they potentially interfered in the OIG inspection. Facility leaders and staff also failed to update the patient's electronic health record and complete a behavioral health autopsy. The OIG made fourteen recommendations, including eleven to the VCL director and three to the facility director.

Listen to a *Veteran Oversight Now* **podcast** in which a hotline director discusses deficiencies in quality of emergency department care for a veteran who died by suicide. (Season 2, Episode 7).

REVIEW OF VHA'S OVERSIGHT OF COMMUNITY CARE PROVIDERS' OPIOID PRESCRIBING AT THE EASTERN KANSAS HEALTH CARE SYSTEM IN TOPEKA AND LEAVENWORTH

OHI personnel examined concerns related to care coordination for patients at the VA Eastern Kansas Health Care System who received care and were prescribed both opioids and benzodiazepines from Community Care Network (CCN) providers. The resulting report findings identified issues related to incomplete and delayed CCN provider documentation, risk-mitigation strategies, prescriptions dispensed at VHA and non-VA pharmacies, medication reconciliation, and medication profile updates. The OIG identified two patients who received multiple controlled substance prescriptions from a combination of VHA and CCN providers. The VISN director and system staffs' oversight of CCN providers' opioid-prescribing practices and reporting of unsafe provider practices was also inadequate. The report includes seven recommendations to the under secretary for health, two recommendations to the VISN director, and four recommendations to the system director related to ensuring oversight of CCN providers' prescribing practices, documenting CCN-prescribed medication and risk-mitigation strategies, and training.

PROACTIVE, CYCLICAL INSPECTION PROGRAMS

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM

CHIP reviews are an important element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. All CHIP reports are based on inspections that are routinely and proactively performed approximately every three years for each VA medical facility to help consistently examine key conditions and activities. CHIP inspections evaluate specific areas of focus on a rotating basis each year. For the 31 facility-level and two VISN-level CHIP reports published during this reporting period, the areas of focus were (1) leadership and organizational risks; (2) quality, safety, and value; (3) medical staff privileging; (4) environment of care; and (5) mental health (emergency department and urgent care center suicide prevention initiatives).

CARE IN THE COMMUNITY HEALTHCARE INSPECTION PROGRAM

The CITC healthcare inspection program examines key clinical and administrative processes that are associated with providing quality VA and community (non-VA) care, specifically focusing on congestive

heart failure management, home dialysis care, mammography services and results communications, and diagnostic evaluations following positive screenings for depression and alcohol misuse. No CITC reports were published during this reporting period, but OHI plans to release reports in FY 2024.

VET CENTER INSPECTION PROGRAM

VCIP reports provide a focused evaluation of the quality of care delivered at vet centers. These centers are community-based clinics that offer critical interventions for psychological and psychosocial readjustment problems related to various types of military service and deployment stressors, such as combat-related trauma and military sexual trauma. Their services are meant to support a successful transition from military to civilian life and are open to eligible veterans, active-duty service members, National Guard members, reservists, and their families. Currently, the VCIP reports' areas of focus are (1) leadership and organizational risks; (2) quality reviews; (3) suicide prevention; (4) consultation, supervision, and training; and (5) environment of care. OHI issued two VCIP reports that included a review of vet center and district operations across two zones and eight vet centers.

The Office of Management and Administration

18,031
Hotline Contacts

477
Administrative Sanctions and Corrective Actions

38%
Percent of Allegations Substantiated

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations. OMA has been overseeing the execution of the OIG's largest budget to date for FY 2023 at about $273 million. Furthermore, OMA's ongoing recruitment and retention efforts, conducted in partnership with all directorates, have contributed to the growth of the office to more than 1,100 employees.

In keeping with the OIG's commitment to cultivating a diverse, inclusive, and equitable work environment, OMA's diversity, equity, inclusion, and accessibility (DEIA) program launched two employee resource groups during this reporting period—one for veterans and the other for women. These employee-led communities play a vital role in fostering a sense of belonging, driving cultural change, and promoting DEIA across the office. In collaboration with the General Services Administration and a consulting firm, OMA also assessed the OIG's enterprise-wide real estate footprint to ensure its leased space is making efficient use of the budget and meets staff needs. OMA determined it was in the OIG's best interest to close the Arlington, Virginia, office and consolidate those operations into the Washington, DC, location. This office closure was effective at the end of FY 2023 and will result in annual rent savings of $340,000.

Personnel continued to provide reliable and prompt administrative services to promote organizational effectiveness and efficiency. In the second half of FY 2023, for example, staff were responsible for transitioning the OIG to VA's new Integrated Financial and Acquisition Management System (iFAMS). The system increases the transparency, accuracy, timeliness, and reliability of financial information, resulting in improved fiscal accountability and better use of resources. The transition to iFAMS was a complete overhaul to the OIG's business processes and its successful implementation was a considerable undertaking. OMA also took steps to deploy several IT initiatives to modernize the office's infrastructure and address evolving and complex technology needs.

In addition to providing these and other essential support services, OMA oversees Hotline Division operations. Hotline staff receive, screen, and respond to complaints regarding VA programs and services. The hotline director also serves as the whistleblower protection coordinator. She is responsible for educating agency employees about disclosing serious wrongdoing or gross mismanagement and the rights and remedies against retaliation associated with those disclosures. In addition to receiving and screening 18,031 contacts from complainants during this six-month reporting period, hotline staff conducted activities such as the following:

- Directed complaints to OIG offices and directorates to determine if cases should be opened or other dispositions taken

Highlighted Activities and Findings

- Referred 660 cases to and required a written response from applicable VA offices for OIG review, as appropriate, after determining that allegations pertained to higher-risk topics but insufficient resources were available for OIG staff to complete a prompt independent review at that time
- Made 782 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 564 cases for which nearly 38 percent of allegations were substantiated, 477 administrative sanctions and corrective actions were taken, and more than $1.5 million in monetary benefits were achieved
- Responded to 1,059 requests for senior personnel record reviews from VA staff offices prior to promotions, new jobs, and particular awards
- Issued 4,115 semicustom complaint responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope

FEATURED HOTLINE CASES

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

Listen as the hotline director discusses how she and her team triage healthcare-related inquiries on the *Veteran Oversight Now* **podcast**. (Season 2, Episode 5).

MEDICATION ERRORS AT THE PHOENIX VA MEDICAL CENTER CONTRIBUTED TO ONE PATIENT'S HARM AND ANOTHER'S DEATH

The OIG hotline received a complaint alleging deficiencies in pharmacy and nursing processes at the Carl T. Hayden VA Medical Center in Phoenix, Arizona, may have contributed to the harm of one patient and another's death. OIG hotline staff referred the allegation to the medical center for further review, which determined the emergency department mistakenly gave a patient cisatracurium, a drug used to relax muscles during surgery, instead of octreotide, a drug used to control diarrhea and flushing caused by some tumors, due to incorrect labeling by the pharmacy. The patient's health declined, leading to a transfer to the intensive care unit and intubation. Medication was stopped when staff noticed the incorrect labeling. The review also found that a second patient mistakenly received nicardipine, a drug used to treat high blood pressure, instead of norepinephrine, a drug used to treat abnormally low blood pressure. This occurred because the pharmacy incorrectly stocked an intravenous bag of nicardipine in the automated dispensing cabinet as norepinephrine. The patient rapidly declined following the error and ultimately died. The medical center's reported corrective actions being undertaken to prevent future occurrences included the following:

- Adding cisatracurium and norepinephrine to the high-alert medication list
- Changing storage processes and implementing standardized labeling of batched IV medications
- Requiring pharmacy staff to complete verification of both labels (front and back) on all batched IV medication

- Standardizing pharmacy handling processes to include physical separation of all medication during the pulling and filing process
- Requiring nurses to scan each individual medication when pulling medication from the automated dispensing cabinet
- Adding verbiage to a medication safety training module reinforcing the need to verify medication labels
- Implementing medication management tracers (a means for tracing the path of medications through the organization) in the intensive care unit
- Hosting a high-reliability organization forum on serious safety events within 60 days to anticipate risk, strive for zero harm, and support enhanced psychological safety

VETERAN'S FAILURE TO INFORM VA OF CHANGES IN DEPENDENTS RESULTED IN BENEFITS OVERPAYMENT

An allegation was made to the hotline that a veteran continued to receive additional dependency allowance for an ex-spouse and a stepchild following a divorce in 2018. The matter with supporting evidence was referred to the Nashville VA Regional Office for further review. The regional office mailed a notification letter to the veteran proposing to remove the ex-spouse and stepchild from the compensation award. The veteran was given 60 days to respond but failed to do so to dispute the evidence. VA subsequently removed the ex-spouse and stepchild from the veteran's compensation award, creating an overpayment of more than $21,000 to the veteran. In addition, a final decision notice was mailed to the veteran that summarized the evidence VA considered, laws and regulations applicable to the issue, and applicable review options the veteran may use to seek further review of the decision.

LACK OF A FORMAL PROCESS TO IDENTIFY INCOMPLETE CASES LED TO UNSIGNED ELECTROCARDIOGRAM REPORTS AT THE JONATHAN M. WAINWRIGHT MEMORIAL VA MEDICAL CENTER IN WALLA WALLA, WASHINGTON

Another complaint alleged that electrocardiogram (EKG) reports were not being read at the VA medical center in Walla Walla due to insufficient staffing. The matter was referred to the supervising regional network office (VISN 20) for review, which determined that 22 of 519 EKG reports dating back to September 2022 were in a completed but unsigned status. VISN 20 staff determined that this was due not to insufficient staffing but to the lack of a formal process that routinely identified incomplete cases that were marked complete yet left unsigned. Following this review, the 22 unsigned EKG reports were completed by medical center staff in Walla Walla by May 15, 2023. The VISN personnel further disclosed similar findings in Roseburg and White City, Oregon, from a review of additional EKG reports from medical centers within its region. Beginning in August 2023, the VISN's offices for Quality Management and Oversight and Chief Nursing created a plan to establish formal monthly reporting to the VISN's electronic health record modernization steering committee. The VISN team will maintain monitoring and follow-up processes to ensure progress is being made at Walla Walla and the other identified facilities. The formal report will continue on a monthly basis until the VISN team determines that oversight can be effectively managed at the facility level.

Highlighted Activities and Findings

THE VA GREATER LOS ANGELES HEALTH CARE SYSTEM DEVELOPS PLANS FOR A NEW GERIATRIC-PSYCHIATRIC WARD AFTER THE REVIEW OF A PATIENT'S FALL

The OIG Hotline received an allegation that an elderly patient of the VA Greater Los Angeles Health Care System sustained a ground-level fall during admission to the mental health inpatient unit in May 2022. The allegation was reviewed and substantiated by the medical center. The veteran was found to be at a high risk for a fall at the time of admission. As a result, standard fall precautions were implemented by the receiving mental health unit, to include conducting checks on the patient every 15 minutes. Despite these actions, an unwitnessed fall occurred when the veteran attempted to move to the bathroom without a nurse's assistance and without use of an available wheelchair. The fall resulted in a left hip fracture. A root cause analysis investigation revealed that a mental health treatment plan and safety plan were not completed for the veteran within VA-prescribed timelines. The root cause analysis also determined that the inpatient mental health unit faces challenges in meeting the needs of geriatric patients requiring inpatient psychiatric care. This includes accommodating the patient's mental health safety and the need for assistive mobility devices by geriatric patients. As a result of the medical center's responsive review to the OIG referral, eight corrective actions were identified to include chart audits, frequent reminders to patients on how to safely move within the ward, and mental health leaders' decision to create a new psychiatric ward for geriatric patients. The architectural designs are reported to be underway.

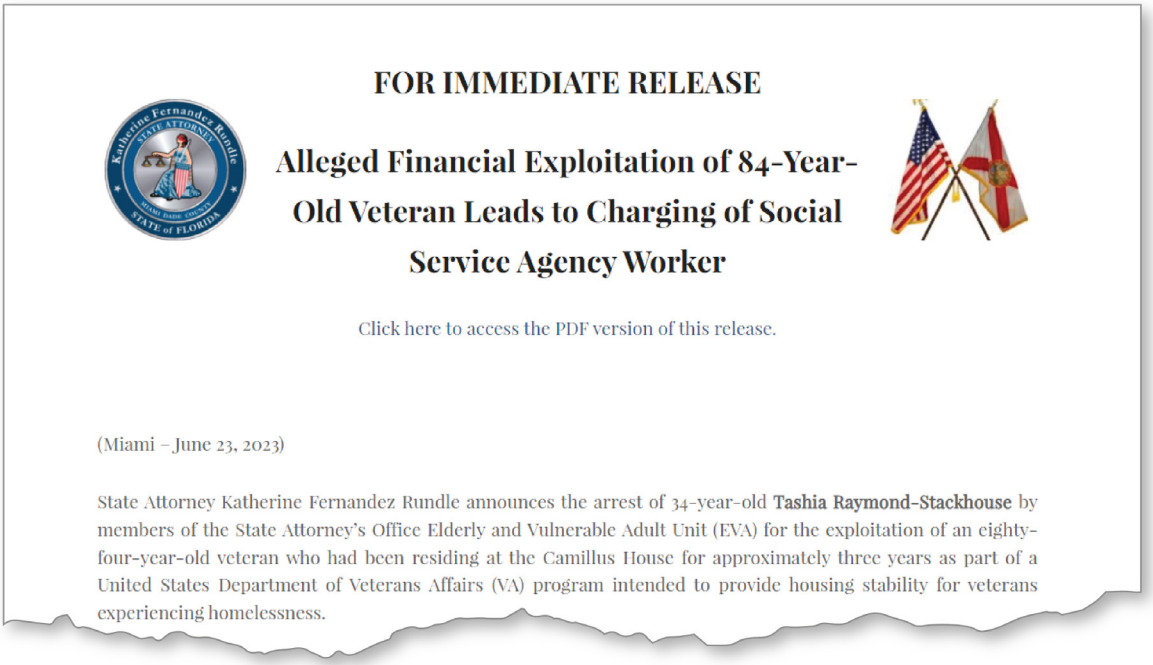
Statistical Performance

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	$306,053,726	$65,373,347	$371,427,073
Dollar Recoveries	$2,501,654	$4,926,630	$7,428,284
Fines, Penalties, Restitution, and Civil Judgments[15]	$365,684,787	$197,026,689	$562,711,476
Fugitive Felon Program	$50,191,551	$52,300,000	$102,491,551
Savings and Cost Avoidance	$114,551,430	$21,499,566	$136,050,996
Questioned Costs	$298,537,470	$60,727,761	$359,265,231
Total Dollar Impact	**$1,137,520,618**	**$401,853,993**	**$1,539,374,611**
Cost of OIG Operations[16]	$108,014,086	$109,474,143	$217,488,229
Return on Investment[17]	**$11:1**	**$4:1**	**$7:1**



FOR IMMEDIATE RELEASE

Alleged Financial Exploitation of 84-Year-Old Veteran Leads to Charging of Social Service Agency Worker

Click here to access the PDF version of this release.

(Miami – June 23, 2023)

State Attorney Katherine Fernandez Rundle announces the arrest of 34-year-old **Tashia Raymond-Stackhouse** by members of the State Attorney's Office Elderly and Vulnerable Adult Unit (EVA) for the exploitation of an eighty-four-year-old veteran who had been residing at the Camillus House for approximately three years as part of a United States Department of Veterans Affairs (VA) program intended to provide housing stability for veterans experiencing homelessness.

Read the **full press release** from Miami-Dade State Attorney Katherine Fernandez Rundle about this joint case investigated by the VA OIG and the Florida State Attorney's Office Elderly and Vulnerable Adult Unit.

15 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 $198,691,295.

16 The six-month operating cost for OHI ($28,485,914), 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.

17 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	0	1	1
Audits and Reviews	25	14	39
Care in the Community Inspections	0	2	2
Claim Reviews	0	0	0
Comprehensive Healthcare Inspection Program (National-Level)	1	4	5
Comprehensive Healthcare Inspection Program (VISN- and Facility-Level)	33	7	40
Financial Inspections	3	2	5
Healthcare Inspections	16	14	30
Information Security Inspections	6	2	8
Joint Reviews	1	1	2
National Healthcare Reviews	6	2	8
Postaward Contract Audits and Reviews*	10	14	24
Preaward Contract Audits and Reviews*	34	18	52
Special Reviews	0	0	0
Vet Center Inspections	2	2	4
Subtotal	**137**	**83**	**220**
OTHER PRODUCTS	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Budget Request	0	1	1
Congressional Testimonies	8	1	9
Crime Alerts	2	1	3
Internal Investigation Summaries	0	1	1
Issue Statements	1	0	1
Major Management Challenges	0	1	1
Management Advisory Memoranda	6	1	7
Monthly Highlights	6	6	12
Peer Reviews Completed of Other OIGs	0	0	0
Podcasts	8	7	15
Press Releases	0	0	0
Whistleblower Reprisal Investigation Memoranda*	1	1	2
Subtotal	**32**	**20**	**52**
Total	**169**	**103**	**272**

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

Table 3. Selected Office of Investigations Activities

TYPE[18]	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Arrests[19]	95	122	217
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	23	18	41
Indictments	73	114	187
Indictments and Informations Resulting from Prior Referrals to Authorities	35	44	79
Criminal Complaints	55	15	70
Convictions	99	96	195
Pretrial Diversions and Deferred Prosecutions	6	7	13
Case Referrals to Department of Justice for Criminal Prosecution[20]	132	129	261
Case Referrals to State and Local Authorities for Criminal Prosecution[21]	34	33	67
Administrative Sanctions and Corrective Actions	104	118	222
Cases Opened	230	222	452
Cases Closed	190	217	407

18 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**.

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

20 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.

21 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	94	114	208
Investigative Interviews	54	58	112
Reviews of Complaints Alleging Whistleblower Reprisal by VA Contractors or Grantees	2	4	6
Substantiated Instances of Contractor/ Grantee Whistleblower Reprisal	0	0	0

Table 5. Selected Office of Healthcare Inspections Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Clinical Consultations to Other VA OIG Offices	4	3	7
Clinical Consultations to Other Federal Entities	0	0	0
Hotline Referrals Reviewed	2,123	1,957	4,080

Table 6. Selected Hotline Division Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Contacts	18,031	15,526	33,557
Cases Opened	660	624	1,284
Cases Closed	564	528	1,092
Administrative Sanctions and Corrective Actions	477	477	954
Substantiation of Allegations Percentage Rate	38%	42%	40%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	26	27	53
Individuals Provided Office of Special Counsel Contact Information	63	39	102
Individuals Provided Merit Systems Protection Board Contact Information	6	0	6
Individuals Provided Office of Resolution Management Contact Information	121	100	221

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.va.gov/oig/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.[22] 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.[23] The tables that follow identify OIG investigations and reports by type and date and include hyperlinks to their respective publications (when available).

Table 7 lists significant investigations with judicial action this period, with hyperlinks that direct readers to the full case summary as published in the VA OIG's **Monthly Highlights**. Although the IG Act only requires that federal inspectors general provide information regarding significant *closed* investigations, table 7 includes judicial actions from significant closed *and open* criminal investigations to provide a more accurate representation of the VA OIG's efforts this reporting period. When applicable, investigations in the table marked with an asterisk (*) indicate those with substantiated allegations of misconduct involving a senior government employee or official; however, the VA OIG has no investigations responsive to this reporting requirement this period.[24]

Table 7. Significant Criminal Investigations with Judicial Actions This Period

DATE	TITLE
VHA INVESTIGATIONS	
CHAMPVA AND OTHER HEALTHCARE FRAUD	
6/7/2023	**Defendant Pleaded Guilty to Role in Healthcare Fraud Scheme**
6/8/2023	**Defendant Admitted to Fraudulent Receipt of VA Funds**
6/13/2023	**Pharmacy Owner and Marketing Manager Sentenced for Compounding Pharmacy Fraud Scheme**
7/11/2023	**Coconspirators Indicted for Healthcare Fraud Scheme**
8/4/2023	**Civil Complaint Filed against Two Debt Collection Agencies and Three Individuals**
8/16/2023	**Former VA Pharmacist Sentenced in Connection with Fraud Scheme**
8/23/2023	**Business Executive Sentenced in Connection with COVID-19 Fraud Scheme**

22 5 U.S.C. § 405(b)(2) and § 405(b)(3) (as amended by Pub. L. No. 117-263).

23 5 U.S.C. § 405(h) (as amended by Pub. L. No. 117-263).

24 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
THEFT OF GOVERNMENT PROPERTY, IDENTITY THEFT, BRIBERY, AND FALSE STATEMENTS	
6/2/2023	Non-VA Defendant Found Guilty for Role in Theft Scheme Involving Former VA Pharmacy Tech
8/23/2023	VA Psychiatrist Sentenced for Scheme to Sell Opioids to Patients
VBA INVESTIGATIONS	
EDUCATION BENEFITS FRAUD	
4/17/2023	Dive School Training Director Sentenced in Connection with Education Benefits Fraud Scheme
7/21/2023	School Owner Pleads Guilty in Connection with Education Benefits Fraud Scheme
THEFT OF GOVERNMENT FUNDS AND FIDUCIARY FRAUD	
4/4/2023	Veteran Indicted for Compensation Benefits Fraud Scheme
4/4/2023	Defendant Indicted for Another Survivor Benefits Fraud Scheme
4/26/2023	Deceased Veteran's Spouse Charged for Allegedly Defrauding VA of Survivor Benefits for Nearly 30 Years
5/17/2023	Inventory Management Specialist Pleaded Guilty to Theft of Government Funds
6/14/2023	Former VA Employee Pleaded Guilty to Theft of Government Funds
7/11/2023	Defendant Pleaded Guilty to Theft of Government Property
7/24/2023	Relative of Deceased Veteran Pleaded Guilty to Theft of Government Funds
7/25/2023	Former VA Employee Convicted of Compensation Benefits Fraud Scheme
8/1/2023	Veteran Indicted in Connection with Fraud Scheme
9/1/2023	Veteran Indicted in Connection with Compensation Benefits Fraud Scheme
9/14/2023	Veteran Indicted for False Statements about His Claimed Disability
BRIBERY AND KICKBACKS	
4/25/2023	Former Arkansas State Senator Sentenced for Role in Bribery Scheme
4/27/2023	Former VA Medical Center Supervisor Pleaded Guilty for Role in Bribery Scheme
5/16/2023	Former Procurement Supervisor and Business Executive Pleaded Guilty in Connection with Kickback Scheme
9/25/2023	Two Former VA Medical Center Employees Indicted in Connection with Bribery Scheme

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

DATE	TITLE
OTHER INVESTIGATIONS	
FRAUD RELATED TO COVID-19	
5/18/2023	Former Agent Cashier Indicted in Connection with COVID-19 Fraud Scheme
7/31/2023	VA Employee Pleaded Guilty in Connection with Paycheck Protection Act Loan Scheme
8/24/2023	Defendant Indicted in Connection with COVID-19 Fraud Scheme
8/29/2023	Business Executive Sentenced in Connection with COVID-19 Fraud Scheme
SEX-RELATED OFFENSES AND ASSAULT	
4/28/2023	Former Contract Supervisor Charged with Aggravated Sexual Abuse of Subordinate at the Palo Alto VA Medical Center in California
5/3/2023	Registered Nurse Charged with Assault and Elderly Abuse
SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD AND WORKERS' COMPENSATION PROGRAM FRAUD	
5/2/2023	Construction Company Owner Pleaded Guilty for Service-Disabled Veteran-Owned Small Business Fraud Scheme
6/23/2023	Former VA Nurse Sentenced in Connection with Workers' Compensation Fraud Scheme
9/20/2023	Two Defendants Pleaded Guilty in Connection with Workers' Compensation Fraud Scheme
9/26/2023	Physician and Two Pharmacists Indicted in Connection with Workers' Compensation Fraud Scheme
9/27/2023	Four Defendants Indicted in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme
THREATS AND ASSAULTS AGAINST VA EMPLOYEES	
5/22/2023	Veteran Sentenced for Making Threats
8/7/2023	Veteran Pleaded Guilty to Making Threats against a VA Employee and the Loma Linda VA Medical Center
8/8/2023	Veteran Pleaded Guilty to Firearm Possession at the Tulsa VA Outpatient Clinic
9/6/2023	Veteran Allegedly Threatened VA and VA OIG Employees and the White House

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.[25] Those marked with a dagger (†) indicate instances for which the VA OIG did not request or receive a VA management decision during the reporting period.[26] Reports marked with a double dagger (‡) indicate those with substantiated allegations of misconduct involving a senior government employee or official; however, the VA OIG has no investigations responsive to this reporting requirement this period.[27] A key to these symbols is included.

Table 8. Reports Issued This Period

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF AUDITS AND EVALUATIONS				
AUDITS AND REVIEWS				
4/6/2023	**Office of Emergency Management Has Not Deployed a Functional Last-Resort Emergency Communications System**	21-03133-48	—	—

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25 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 (FOIA), 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.

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

27 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
4/11/2023	**Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic**	22-02604-74	$2,500,000	—
4/12/2023	**A Summary of Preaward Reviews of VA Federal Supply Schedule Nonpharmaceutical Proposals Issued in Fiscal Year 2021**	22-02323-87	—	—
4/20/2023	**The Medical Disability Examination Office Needs to Better Monitor Mileage Requirements for Contract Exams**	22-02067-82	—	—
5/9/2023	**VHA Can Improve Controls Over Its Use of Supplemental Funds**	21-03101-73	—	$187,200,000
5/17/2023	**Federal Information Security Modernization Act Audit for Fiscal Year 2022**	22-01576-72	—	—
5/31/2023	**Goals Not Met for Implementation of the Beneficiary Travel Self-Service System**	21-03598-92	—	—
6/2/2023	**Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2022**	23-00237-124	—	—
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	—	—
7/19/2023	**Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff**	21-03544-111	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
8/15/2023	**Summary of Fiscal Year 2022 Preaward Reviews and Audits of Healthcare Resource Proposals from Affiliates**	23-01236-101	—	—
8/17/2023	**The Fiduciary Program Needs to Verify the Prompt Return of Deceased Beneficiaries' Funds to VA**	22-03543-151	—	—
8/23/2023	**Additional Measures Would Better Protect Borrowers from Risks Associated with Interest Rate Reduction Refinance Loans**	21-01295-149	—	—
8/30/2023	**VA Should Ensure Veterans' Records in the New Electronic Health System Are Reviewed before Deciding Benefits Claims**	22-03806-162	—	—
9/7/2023	**Nonadherence to Requirements for Processing Gulf War Illness Claims Led to Premature Decisions**	22-02194-152	—	$25,600,000 *($25,600,000 unsupported costs)*
9/7/2023	**VHA Faces Challenges Implementing the Appeals Modernization Act**	22-02064-155	—	—
9/12/2023	**Inconsistent Guidance and Limited Oversight Contributed to Inaccurate Community Care Wait-Time Eligibility Calculations at the C.W. Bill Young VA Medical Center in Bay Pines, Florida**	23-01011-148	—	—
9/14/2023	**Staff Did Not Limit the Use of Schools and Training Programs That Were Only Approved for the Veteran Readiness and Employment Program**	22-02293-188	—	$13,000,000 *($13,000,000 unsupported costs)*

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
9/19/2023	**A Summary of Preaward Reviews and Examinations of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2022**	23-00750-181	—	—
9/20/2023	**Manufacturers Failed to Make Some Drugs Available to Government Agencies at a Discount as Required**	22-01624-143	$28,100,000	—
9/21/2023	**VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement**	21-03718-189	—	—
9/22/2023	**VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2023**	22-00879-196	—	—
9/25/2023	**Improvements Needed for VBA's Claims Automation Project**	22-02936-175	—	—
9/26/2023	**Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans**	22-00414-113	—	—
9/27/2023	**VA Should Strengthen Enterprise Cloud Security and Privacy Controls**	22-03525-195	—	—
FINANCIAL INSPECTIONS				
6/14/2023	**Financial Efficiency Inspection of the VA New York Harbor Healthcare System**	22-02989-103	$48,500	$44,121,813
6/29/2023	**Financial Efficiency Inspection of the VA Philadelphia Healthcare System**	22-03503-131	$44,457	$16,000,000 *($15,600,000 unsupported costs)*

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
FINANCIAL INSPECTIONS (CONTINUED)				
8/28/2023	Financial Efficiency Inspection of the VA Milwaukee Healthcare System	22-03768-156	$1,900,000	$6,900,000
INFORMATION SECURITY INSPECTIONS				
6/7/2023	Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania	22-02960-70	—	—
6/8/2023	Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota	22-02961-71	—	—
7/11/2023	Inspection of Information Security at the Northern Arizona VA Healthcare System	22-04104-112	—	—
9/21/2023	Inspection of Information Security at the VA Beckley Healthcare System in West Virginia	23-00089-144	—	—
9/27/2023	Inspection of Information Security at the VA El Paso Healthcare System in Texas	23-01179-204	—	—
9/28/2023	Inspection of Information Security at the VA Dublin Healthcare System in Georgia	23-01138-203	—	—
ISSUE STATEMENT				
6/8/2023	Compensation and Pension Benefits Claims Backlog†	23-01362-130	—	—
MANAGEMENT ADVISORY MEMORANDA				
5/11/2023	VA Needs to Improve Testing Procedures to Assess Compliance with Mandatory Improper Payment Requirements	22-00576-55	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MANAGEMENT ADVISORY MEMORANDA (CONTINUED)				
8/24/2023	**Results of Consulting Engagement on Potential Risks Related to the Integrated Financial and Acquisition Management System and Future VA Financial Statement Audits**	23-00891-166	—	—
9/6/2023	**The Electronic Health Record Modernization Program Could Strengthen Its Process for Reviewing Task Order Progress Reports**	21-03290-159	—	—
9/6/2023	**Opportunities Exist to Improve the Accuracy of Veterans' Emergency Housing Assistance and Permanent Housing Placement Data**	21-02685-161	—	—
9/13/2023	**Inconsistent Disability Benefits Questionnaires May Lead to Inaccurate Mental Competency Determinations**	22-03543-193	—	—
POSTAWARD CONTRACT AUDITS AND REVIEWS*†				
4/4/2023	**Independent Audit Report on a Prime Contractor Proposal for a Change Order Request Submitted under a VA Contract**	22-02731-94	$1,244,956	—
4/13/2023	**Independent Audit Report on Request for Equitable Adjustment Proposal Submitted under a VA Contract**	22-03092-100	$950,048	—
4/25/2023	**Independent Audit Report on Subcontractor Proposal for Change Order Request under a VA Contract**	22-03027-104	$1,392,263	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS AND REVIEWS (CONTINUED)*†				
6/1/2023	**Independent Audit Report on a Termination Settlement Proposal under a VA Contract**	23-01200-134	$128,528	—
6/23/2023	**Independent Audit Report of a Voluntary Disclosure under a Federal Supply Schedule Contract**	23-00148-147	—	$1,631,915
6/28/2023	**Independent Audit Report of a Voluntary Disclosure under a Federal Supply Schedule Contract**	22-04034-150	—	$2,570,249
8/18/2023	**Review of Compliance with Public Law 102-585 Section 603 and Related Contract Provisions under a Federal Supply Schedule Contract**	21-02372-173	—	—
8/29/2023	**Independent Audit Report of a Contract Billing Compliance**	22-02161-199	—	—
9/21/2023	**Independent Audit Report of a Voluntary Disclosure Under Federal Supply Schedule Contract**	22-01490-219	—	$261,592
9/28/2023	**Review of Compliance with Public Law 102-585 Section 603 and Related Contract Provisions Submitted under Federal Supply Schedule Contracts**	20-00448-231	—	$1,251,901
PREAWARD CONTRACT AUDITS AND REVIEWS*†				
4/3/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03438-95	—	—
4/5/2023	**Independent Audit Report of a Proposal Submitted under a Contract**	22-03307-97	$4,347,270	—
4/6/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03734-90	$1,846,580	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS (CONTINUED)*†				
4/13/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00307-98	—	—
4/25/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03252-93	$109,980	—
4/25/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03958-85	—	—
4/25/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01321-99	$7,525,195	—
5/2/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00255-119	$130,070	—
6/7/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03305-129	—	—
6/12/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	22-03733-140	$47,520	—
6/12/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01691-128	$1,627,144	—
6/12/2026	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00551-135	$96,303,295	—
6/15/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01681-141	—	—
6/23/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02183-137	$566,819	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS (CONTINUED)*†				
6/23/2023	**Independent Audit Report of a Proposal Submitted under a Contract**	23-00503-145	$1,416,268	—
7/24/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00563-165	$886,140	—
7/27/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01126-170	$70,940,960	—
8/3/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-00019-164	$1,680,439	—
8/3/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01320-178	—	—
8/11/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01651-182	—	—
8/16/2023	**Independent Audit Report of the Request for Modification—Product Additions—Submitted under a Federal Supply Schedule Contract**	23-01834-154	—	—
8/17/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01329-167	—	—
8/17/2023	**Independent Audit Report of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract**	23-02210-187	—	—
8/18/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01838-180	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS AND REVIEWS (CONTINUED)*†				
8/28/2023	**Independent Audit Report of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract**	23-00604-192	—	—
9/5/2023	**Independent Audit Report of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract**	23-02211-194	—	—
9/11/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01034-206	$33,741,820	—
9/12/2023	**Independent Audit Report of a Federal Supply Schedule Proposal Submitted under a Solicitation**	23-02532-205	$1,627,178	—
9/12/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02233-207	$35,176,900	—
9/26/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-02521-202	$8,181,055	—
9/26/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-01403-228	—	—
9/27/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03050-229	—	—
9/28/2023	**Independent Audit Report of a Product Addition Proposal Submitted under a Federal Supply Schedule Contract**	23-01662-230	—	—
9/28/2023	**Independent Audit Report of a Proposal Submitted under a Solicitation**	23-03076-232	$3,590,341	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF HEALTHCARE INSPECTIONS				
COMPREHENSIVE HEALTHCARE INSPECTIONS (NATIONAL-LEVEL)				
9/22/2023	Comprehensive Healthcare Inspection Program Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities	23-01177-215	—	—
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL)				
4/19/2023	Veterans Integrated Service Network 9: VA MidSouth Healthcare Network in Nashville, Tennessee	21-03313-96	—	—
4/27/2023	VA Long Beach Healthcare System in California	22-00047-106	—	—
5/9/2023	Central Texas Veterans Health Care System in Temple	22-00041-105	—	—
5/11/2023	West Texas VA Health Care System in Big Spring	22-00037-117	—	—
5/16/2023	Tennessee Valley Healthcare System in Nashville	21-03312-114	—	—
5/17/2023	South Texas Veterans Health Care System in San Antonio	22-00040-115	—	—
5/23/2023	Northern Arizona VA Health Care System in Prescott	22-00052-121	—	—
5/24/2023	VA Loma Linda Healthcare System in California	22-00048-120	—	—
5/31/2023	VA San Diego Healthcare System in California	22-00053-116	—	—
6/6/2023	VA North Texas Health Care System in Dallas	22-00038-125	—	—
6/7/2023	New Mexico VA Health Care System in Albuquerque	22-00046-126	—	—
6/8/2023	Manila VA Clinic in Pasay City, Philippines	22-00228-127	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL) (CONTINUED)				
6/27/2023	Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network in Arlington	22-00044-142	—	—
6/28/2023	VA Southern Nevada Healthcare System in North Las Vegas	22-00062-139	—	—
6/29/2023	Phoenix VA Health Care System in Arizona	22-00051-136	—	—
7/20/2023	VA Central California Health Care System in Fresno	22-00059-157	—	—
8/1/2023	VA NY Harbor Healthcare System in New York	22-04133-163	—	—
8/2/2023	Southern Arizona VA Health Care System in Tucson	22-00054-158	—	—
8/3/2023	San Francisco VA Health Care System in California	22-00231-176	—	—
8/9/2023	VA Palo Alto Health Care System in California	22-00064-172	—	—
8/10/2023	Butler VA Health Care System in Pennsylvania	22-00068-171	—	—
8/15/2023	Lebanon VA Medical Center in Pennsylvania	22-00069-177	—	—
8/24/2023	VA Greater Los Angeles Healthcare System in California	22-00055-184	—	—
9/13/2023	Erie VA Medical Center in Pennsylvania	22-00234-200	—	—
9/14/2023	VA Sierra Nevada Health Care System in Reno	22-00230-190	—	—
9/19/2023	Wilkes-Barre VA Medical Center in Pennsylvania	22-00236-212	—	—
9/19/2023	St. Cloud VA Health Care System in Minnesota	22-02666-214	—	—
9/22/2023	Michael E. DeBakey VA Medical Center in Houston, Texas	22-00238-213	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
COMPREHENSIVE HEALTHCARE INSPECTIONS (VISN- OR FACILITY-LEVEL) (CONTINUED)				
9/26/2023	Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania	22-00071-216	—	—
9/27/2023	VA Northern California Health Care System in Mather	22-00063-220	—	—
9/29/2023	Gulf Coast Veterans Health Care System in Biloxi, Mississippi	22-00074-218	—	—
9/29/2023	Central Arkansas Veterans Healthcare System in Little Rock	22-00076-222	—	—
9/29/2023	Alexandria VA Health Care System in Pineville, Louisiana	22-00073-223	—	—
HEALTHCARE INSPECTIONS				
5/2/2023	Issues Related to an Administrative Investigation Board at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota	22-00540-107	—	—
5/2/2023	Failure of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota	22-00514-108	—	—
5/3/2023	Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California	22-02188-109	—	—
5/10/2023	Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia	22-01116-110	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
6/13/2023	**Inadequate Community Living Center Processes and Training at the West Texas VA Health Care System in Big Spring**	22-03483-133	—	—
6/28/2023	**Quality of Care Concerns and the Facility Response Following a Medical Emergency at the VA Southern Nevada Health Care System in Las Vegas**	22-02725-132	—	—
6/29/2023	**Deficiencies in Emergency Department Care for a Patient Who Died by Suicide at the John Cochran Division of the VA St. Louis Health Care System in Missouri**	22-01540-146	—	—
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	—	—
7/27/2023	**Facility Leaders' Failures in Communications, Construction Oversight, Emergency Preparedness, and Response to an Oxygen Disruption at the West Haven VA Medical Center in Connecticut**	22-01696-160	—	—
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	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
8/9/2023	**Deficiencies in Communication for a Patient with a Spinal Cord Injury at the Charlie Norwood VA Medical Center in Augusta, Georgia**	22-02485-168	—	—
8/23/2023	**Leaders' Failure to Resolve Cardiology Department Challenges at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana**	22-00029-183	—	—
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	—	—
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	—	—
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	—	—
9/29/2023	**Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia**	22-02800-225	—	—
MANAGEMENT ADVISORY MEMORANDUM				
5/4/2023	**Outdated Mental Health Policies Should be Published Expeditiously**	23-00739-118	—	—

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Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
NATIONAL HEALTHCARE REVIEWS				
4/26/2023	Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic	21-02805-102	—	—
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	—	—
8/16/2023	Concern with Veterans Health Administration's Lung Cancer Screening Program Requirements	22-01511-174	—	—
8/22/2023	OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages	23-00659-186	—	—
9/28/2023	Review of Veterans Health Administration's Multi-Tiered Patient Safety Program	22-02377-217	—	—
9/28/2023	Review of Veterans Health Administration Reproductive Health Services	22-03931-226	—	—
VET CENTER INSPECTIONS				
5/25/2023	Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers	21-03233-122	—	—
5/25/2023	Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers	21-03269-123	—	—
JOINT REVIEW WITH OTHER FEDERAL OIGS				
9/21/2023	Review of Personnel Shortages in Federal Health Care Programs During the COVID-19 Pandemic	22-03080-221	—	—

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

Table 8. Reports Issued This Period (Continued)

DATE	TITLE	NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF SPECIAL REVIEWS				
WHISTLEBLOWER REPRISAL INVESTIGATION (CONTRACTORS AND GRANTEES)*				
8/24/2023	**Report of Investigation of Whistleblower Retaliation Claim Under 41 U.S.C. § 4712**	22-03419-191	—	—
Total			**$306,053,726**	**$298,537,470** *($54,200,000 unsupported costs)*

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

Note: Dollar figures may not sum due to rounding.

Unimplemented Recommendations

The IG Act requires federal inspectors general to identify each recommendation made during a prior reporting period for which corrective action has not been completed by the Department, including any potential cost savings associated with the recommendation.[28] Table 9 identifies recommendations made prior to this reporting period that are open (unimplemented) as of September 30, 2023.

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

Table 9. Open Recommendations from Prior Reporting Periods

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/28/2018	VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016	18-00474-300	1	—
12/13/2018	Inadequate Governance of the VA Police Program at Medical Facilities	17-01007-01	1, 4	—
10/10/2019	Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018	19-07040-243	9	—
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	—

28 5 U.S.C. § 405(b)(2) (as amended by Pub. L. 117-263).

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
5/19/2020	Delays in Diagnosis and Treatment and Concerns of Medical Management and Transfer of Patients at the Fayetteville VA Medical Center, North Carolina	19-08256-124	3	—
9/2/2020	Financial Management Practices Can Be Improved to Promote the Efficient Use of Financial Resources	18-03800-232	1	—
2/10/2021	Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi	20-01036-70	2	—
2/25/2021	Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement	19-07053-51	6, 9–11	—
3/3/2021	VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors	20-00421-63	1–2, 4–6	—
3/4/2021	Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing	19-06147-50	1–2, 4, 10	$3,700,000
5/19/2021	Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio	20-01276-131	5, 9	—
5/25/2021	Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03178-116	5	—
6/10/2021	Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency	20-00541-133	1–4	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/15/2021	Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs	20-01487-142	1–2	$129,709,810
6/16/2021	Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System	19-07719-113	1, 6	$5,400,000
6/24/2021	Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards	20-00176-125	5, 10	—
6/29/2021	Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk	20-00345-77	1–3, 5–10	—
7/1/2021	VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules	20-01646-139	1–7	$16,600,000
7/7/2021	Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03185-151	2–6	—
7/13/2021	Adaptive Sports Grants Management Needs Improvement	20-01807-173	1, 3–7	$247,000
8/2/2021	Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020	21-00519-192	3	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
8/4/2021	Opportunities Exist to Improve Management of Noninstitutional Care through the Veteran-Directed Care Program	20-02828-174	7	—
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	—
9/9/2021	Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans' Hospital in Bedford, Massachusetts	21-00260-232	2–4, 6	—
9/14/2021	Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds	21-00263-246	4	—
9/15/2021	Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont	21-00258-230	2	—
9/23/2021	Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors	20-01802-234	2, 4	$20,000,000
9/24/2021	Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts	21-00261-266	6–8	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/27/2021	Contracting Officer Warranting Program Meets Federal Requirements but Could Be Strengthened	20-01910-244	1–3	—
9/27/2021	Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina	21-01304-275	5	—
9/29/2021	VA's Management of Land Use under the West Los Angeles Leasing Act of 2016: Five-Year Report	20-03407-253	1	—
9/29/2021	Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven	21-00266-281	8	—
9/30/2021	Comprehensive Healthcare Inspection of the Miami VA Healthcare System in Florida	21-00268-273	5	—
10/21/2021	Veterans Integrated Service Network 21's Management of Medical Facilities' Nonrecurring Maintenance	19-06004-225	7	—
10/26/2021	Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico	21-00270-04	7, 10	—
11/8/2021	Audit of VA's Compliance under the DATA Act of 2014	20-04237-09	1, 3–4, 9, 11	—
11/10/2021	Deficiencies in Select Community Care Consult (Stat) Processes during the COVID-19 Pandemic	20-03437-26	5	—
11/10/2021	New Patient Scheduling System Needs Improvement as VA Expands Its Implementation	21-00434-233	3, 7	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
11/23/2021	Delayed Cancer Diagnosis of a Veteran Who Died at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico	20-03700-35	2	—
12/2/2021	VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements	20-00426-02	1	—
12/8/2021	VHA Risks Overpaying Community Care Providers for Evaluation and Management Services	21-01807-251	1	$59,600,000
12/8/2021	VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services	20-01099-249	3	$341,700,000
12/9/2021	Comprehensive Healthcare Inspection of the Fayetteville VA Coastal Health Care System in North Carolina	21-00277-41	3, 6	—
12/15/2021	Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains	19-09592-262	3	—
12/15/2021	Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits	20-04219-07	6	$136,000,000
12/20/2021	Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers	21-01804-56	4, 6	—
12/20/2021	MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data	20-03351-08	1	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/11/2022	Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina	21-00279-54	2	—
1/13/2022	VA's Use of the Defense Logistics Agency's Electronic Catalog for Medical Items	20-00552-30	4–5	—
1/20/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020	21-01507-61	1–4, 6–7	—
2/3/2022	Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina	21-00276-67	8	—
2/17/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020	21-01506-76	3	—
2/17/2022	First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions	20-03086-70	1–3	—
3/9/2022	Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened	21-02750-63	5	$88,700

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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	—
3/17/2022	Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-00656-110	1	—
3/23/2022	Comprehensive Healthcare Inspection of the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina	21-00282-111	4	—
3/24/2022	Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints	21-00510-105	1, 3	—
3/28/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020	21-01503-112	2–5	—
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	1–4	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
4/25/2022	The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule	21-02889-134	1–5	—
5/4/2022	Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System in Bath, New York	21-00291-136	5	—
5/24/2022	VHA Continues to Face Challenges with Billing Private Insurers for Community Care	21-00846-104	1–3	$805,200,000
5/25/2022	Comprehensive Healthcare Inspection of the Samuel S. Stratton VA Medical Center in Albany, New York	21-00295-161	10	—
5/26/2022	Comprehensive Healthcare Inspection of the VA NY Harbor Healthcare System in New York	21-00299-162	5, 8	—
6/1/2022	Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-03020-168	1–2	—
6/1/2022	Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Dallas, Texas	21-03305-139	5	—
6/2/2022	Comprehensive Healthcare Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia	21-00293-170	5–6	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/14/2022	Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore	21-00283-173	7–8	—
6/16/2022	Comprehensive Healthcare Inspection of the Washington DC VA Medical Center	21-00288-175	9	—
6/22/2022	Mission Accountability Support Tracker Lacked Sufficient Security Controls	21-03080-142	3	—
6/28/2022	Multiple Failures in Test Results Follow-Up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia	21-03349-186	2	—
7/13/2022	Comprehensive Healthcare Inspection of the Martinsburg VA Medical Center in West Virginia	21-00287-194	9	—
7/21/2022	Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure	21-02704-135	2–3	—
7/21/2022	Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement	21-02732-153	1	—
7/28/2022	VBA Improperly Created Debts When Reducing Veterans' Disability Levels	21-01351-151	1–2, 4	—
8/3/2022	The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring	21-02401-190	3	—
8/3/2022	VA Needs to Improve Governance of Identity, Credential, and Access Management Processes	22-00210-191	2–4	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
8/4/2022	Digital Divide Consults and Devices for VA Video Connect Appointments	21-02668-182	1–2, 4–8, 10	$14,478,000
8/9/2022	The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing	21-01361-192	6	—
9/7/2022	VBA Could Improve the Accuracy and Completeness of Medical Opinion Requests for Veterans' Disability Benefits Claims	22-00404-207	1, 3	—
9/15/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2021	22-00815-232	1–4	—
9/22/2022	Home Improvements and Structural Alterations Program Needs Greater Oversight	21-03906-226	1, 5	$12,676,084
9/22/2022	Inspection of Information Technology Security at the Alexandria VA Medical Center in Louisiana	22-00971-217	4	—
9/27/2022	Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina	21-03203-239	1	—
9/27/2022	Inspection of Information Technology Security at the Harlingen VA Health Care Center in Texas	22-00973-215	5	—
9/28/2022	Buy American Act Compliance Deficiencies at Regional Procurement Office Central	21-02641-229	1–2	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/28/2022	**Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance**	21-00797-248	1–7	—
10/20/2022	**Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2021**	22-00811-07	1, 3	—
10/25/2022	**Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2021**	22-00818-03	2-3	—
10/27/2022	**Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative**	21-03924-234	1–4	—
10/31/2022	**Review of VA's Staffing and Vacancy Reporting under the MISSION Act of 2018**	22-01440-254	2	—
11/3/2022	**VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics**	21-03777-218	1–2	—
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	1–4, 6	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
12/8/2022	Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services	21-03630-250	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	2–5	—
1/12/2023	Care in the Community Healthcare Inspection of VA Southeast Network (VISN 7)	21-01823-31	2	—
1/12/2023	Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers	21-03232-37	2–3, 5–11	—
1/12/2023	Comprehensive Healthcare Inspection of the El Paso VA Health Care System in Texas	22-00043-39	1	—
1/17/2023	Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	22-00029-40	3–4	—
1/18/2023	Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama	22-01854-13	7	—
1/18/2023	Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics	22-01836-12	2, 4, 8	—
1/19/2023	Vet Center Inspection of Midwest District 3 Zone 1 and Selected Vet Centers	21-03231-38	3–6, 8–11, 14–15, 17–18, 21	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/19/2023	Deficiencies in Suicide Risk Assessments, Continuity of Care, and Leadership at the South Bend Vet Center in Indiana	21-02511-28	1–3	—
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	1, 3–6	—
1/25/2023	Physician's Falsification of VA Video Connect Blood Pressures at the North Las Vegas VA Medical Center in Nevada	22-00707-44	4–5	—
1/25/2023	Poor Emergency Department Care of a Patient at the Baltimore VA Medical Center in Maryland	22-01668-45	1, 4	—
1/26/2023	Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison	22-01341-43	1–5, 7	—
1/31/2023	Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System	21-03864-34	3	—
1/31/2023	Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs	21-01711-50	1–3	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
2/1/2023	Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana	21-02612-53	1–3	—
2/2/2023	Financial Efficiency Inspection of the VA Palo Alto Health Care System in California	22-01565-29	7–10	—
2/8/2023	Financial Efficiency Inspection of the Northern Arizona VA Health Care System	22-01721-35	1, 3, 5–7	$136,600
2/14/2023	Comprehensive Healthcare Inspection of the Memphis VA Medical Center in Tennessee	21-03310-54	3	—
2/22/2023	Security and Incident Preparedness at VA Medical Facilities	22-03770-49	1–6	—
2/23/2023	Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia	21-03718-47	1–3	—
2/27/2023	Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama	22-00031-67	9, 11	—
3/9/2023	VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff	22-01814-36	2–4	—
3/14/2023	Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA	22-02721-77	2–3	—
3/15/2023	Comprehensive Healthcare Inspection of the Amarillo VA Health Care System in Texas	22-00036-68	1–3	—

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

DATE	TITLE	NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
3/16/2023	**Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits**	22-01503-65	1–3	—
3/28/2023	**Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met**	21-01997-69	1–2, 4–5	—
3/29/2023	**Deficiencies in Emergent and Outpatient Care of a Patient with Alcohol Use Disorder at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana**	21-03680-80	3–4, 6	—
3/30/2023	**Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida**	22-01594-86	1–3	—
Total				**$1,545,536,194**

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

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.[29] 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 reporting period, or in which follow-up efforts for recommendations issued in a prior reporting period have reached an impasse. Additional context for each instance is provided below the table.

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

INSPECTION OF INFORMATION SECURITY AT THE JAMES E. VAN ZANDT VA MEDICAL CENTER IN ALTOONA, PENNSYLVANIA

During this information security inspection, VA concurred with three of the OIG's recommendations but did not concur with recommendation 1, which was to verify and make necessary corrections to the systems' component inventory in VA's Enterprise Mission Assurance Support Service (eMASS). In his comments to the OIG draft report, the assistant secretary for information and technology and chief information officer reported that the Office of Information and Technology (OIT) has an automated assignment process to ensure assets are identified by the correct boundaries. Further, the OIG identified approximately 2,500 devices on the facility's network as compared to approximately only 1,450 devices identified by the component inventory in VA's eMASS. The assistant secretary noted in his comments that the discrepancy in numbers is a direct result of OIT's interpretation of language used in the OIG request process. The assistant secretary committed to seeking "clarifying evidence request language" going forward, but did not identify the specific language that resulted in interpretation questions or how it raised interpretation questions. OIT also did not submit additional evidence to resolve this discrepancy. Beginning on page 27 of the report, appendix D includes the full text of OIT's comments, and the VA OIG's response is on page 9. The OIG stands by this recommendation and considers it open.

INSPECTION OF INFORMATION SECURITY AT THE ST. CLOUD VA MEDICAL CENTER IN MINNESOTA

In this report, OIT concurred with nine of the VA OIG's 10 recommendations but did not concur with recommendation 2, which was to implement a more effective inventory process to identify network devices. The assistant secretary for information and technology and chief information officer reported that both the trusted agent and the vulnerability scanning service team looked for the devices identified in the OIG's scan data but could not find them on the network or in any of the past 12 months of vulnerability scans. VA's position is that the devices were not identified properly during the OIG scan. The OIG evaluated OIT's scan results and agreed that the network segments and devices were not identified by OIT using their standard vulnerability management processes. The OIG was able to identify

29 5 U.S.C. § 405(b)(6) (as amended by Pub. L. 117-263).

the devices by performing scans that did not rely on VA's standard network vulnerability identification methods. The OIG shared with OIT that the devices did not respond to network management protocols, which could have contributed to the lack of visibility. The OIG ran the scans again in May 2023 and confirmed that the devices were no longer on the network. The OIG shared its results with VA so it could seek to understand why OIT did not have similar results. It should be noted, however, that the OIG did not identify any critical or high-risk vulnerabilities on these devices and does not consider the security issues associated with this network segment to be a significant risk to VA systems or data. Beginning on page 31 of the report, appendix D includes the full text of OIT's comments, and the VA OIG's response is on page 11. The OIG considers this recommendation closed.

MANUFACTURERS FAILED TO MAKE SOME DRUGS AVAILABLE TO GOVERNMENT AGENCIES AT A DISCOUNT AS REQUIRED

The Office of Acquisition, Logistics, and Construction (OALC), in conjunction with VHA, concurred with five of the VA OIG's eight recommendations in this report but did not concur with recommendations 4, 5, and 7. Recommendation 4 was to continue monitoring any covered drugs identified in the review that are not commercially sold; recommendation 5 was to monitor newly launched covered drugs identified in the review and ensure they have an established ceiling price and are made available on the Federal Supply Schedule (FSS) at the end of the 75-day period; and recommendation 7 was to work with the US Food and Drug Administration (FDA) to ensure that when manufacturers request new national drug codes, the manufacturers are made aware of the public law requirements. For recommendations 4 and 5, the principal executive director and chief acquisition officer stated that the OALC's National Acquisition Center (NAC) is not resourced to police the supply chain of all covered drugs or to perform federal oversight of newly launched covered drugs if the drugs are not under a master agreement and existing FSS contract. He further noted the NAC takes steps to monitor existing FSS contractors. However, the OIG is not asking the NAC to police or monitor the supply chain of all covered drugs that are not under a master agreement or an existing FSS contract. The OIG is recommending the NAC specifically monitor the 3,057 covered drugs that were found to be not commercially sold and the 90 newly launched drugs referred to in this report—not all covered drugs that exist. The 90 newly launched drugs are manufactured by FSS contractors with existing master agreements, and these drugs should be added to their FSS contracts. For the 3,057 drugs identified as not commercially sold, only 553 drugs belong to manufacturers with no master agreement. For recommendation 7, the principal executive director and chief acquisition officer disagreed with the OIG, and VHA asked to strike this recommendation, which focuses on efforts to communicate with the FDA (notwithstanding the roles played by the Office of Federal Procurement Policy, federal comptrollers, and acquisition officials). However, the recommendation does not require VA to monitor or track manufacturers, nor does it mandate that the FDA provide information to manufacturers. The goal of the recommendation is to initiate collaboration between government agencies so that manufacturers are more aware of the public law requirements. Beginning on page 32 of the report, appendix C includes the full text of OALC's and VHA's comments, and the VA OIG's response is on page 24. The OIG stands by these recommendations and considers them open.

INSPECTION OF INFORMATION SECURITY AT THE VA BECKLEY HEALTHCARE SYSTEM IN WEST VIRGINIA

In this inspection, OIT concurred with nine of the VA OIG's 10 recommendations but did not concur with recommendation 2, which was to improve vulnerability management processes to ensure system changes occur within organization timelines. The assistant secretary for information and technology

and chief information officer responded that VA could provide evidence of remediation for vulnerabilities persisting beyond established remediation time frames. Although VA has implemented a new process to address vulnerability remediation at the facility, VA did not provide evidence illustrating that those efforts have been successful. The OIG will continue to monitor VA's progress toward implementation and will close recommendation 2 when VA can demonstrate that the plan of action and milestones process can effectively mitigate security risks for unremedied security vulnerabilities. Beginning on page 31 of the report, appendix D includes the full text of OIT's comments, and the VA OIG's response is on page 9. The OIG considers this recommendation open.

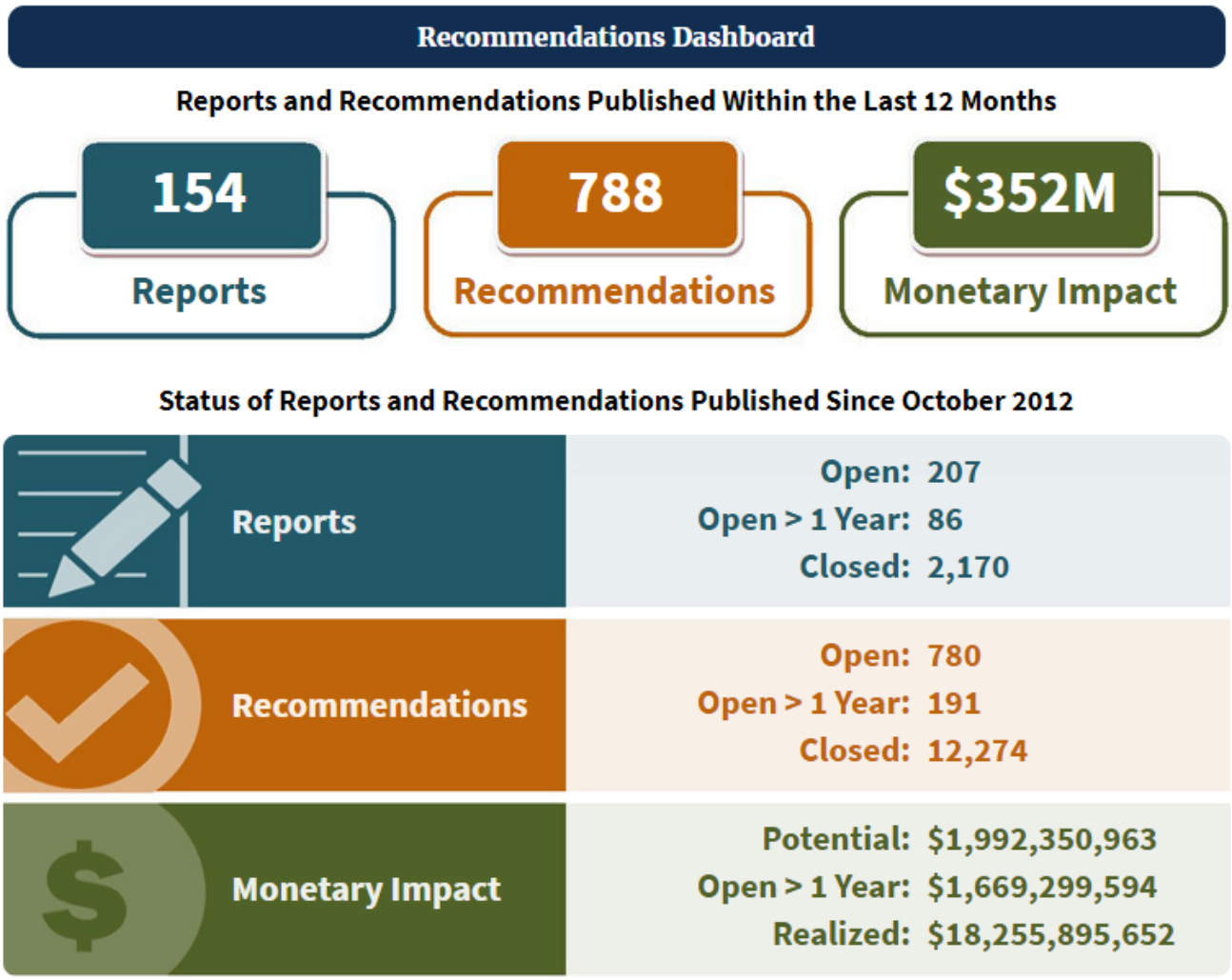
REVIEW OF VHA'S OVERSIGHT OF COMMUNITY CARE PROVIDERS' OPIOID PRESCRIBING AT THE EASTERN KANSAS HEALTH CARE SYSTEM IN TOPEKA AND LEAVENWORTH

VHA concurred or concurred in principle with 12 of the VA OIG's 13 recommendations but did not concur with recommendation 5, which was to consider issuing formal guidance to all VHA pharmacy staff regarding best practices for conducting state prescription drug monitoring program (PDMP) queries upon receipt of controlled substance prescriptions from community care network providers. VHA asserted that the OIG's recommendation is based on a review of one state, and state requirements for private sector prescriber PDMP reporting vary significantly. In addition, specific geographical nuances do not indicate a perpetual challenge across the enterprise. VHA also noted the Eastern Kansas Healthcare System has instituted local policies to address identified concerns, and that the responsibility for querying PDMPs rests with the prescriber rather than pharmacy staff. However, the OIG maintains that this report highlights significant risk to veterans prescribed controlled substances by community providers that are then filled and dispensed by VHA pharmacists who often do not have evidence that the community care network provider queried the PDMP. An Eastern Kansas Health Care System practice detailed in this report may provide an option for VHA staff to better ensure the safety of veterans participating in community care until VHA can make certain that community care network providers are compliant with querying PDMPs. Assuming a position that refuses to consider all options, and supporting that position with a directive that is not applicable to community care network providers, fails to mitigate the significant risk to patients when evidence of a PDMP query is lacking. Beginning on page 60 of the report, appendix D includes the full text of VHA's comments and the VA OIG's response. The OIG stands by this recommendation and considers it open.

Instances in Which Follow-Up Efforts for Recommendations Issued in a Prior Reporting Period Have Reached an Impasse

VETERANS DATA INTEGRATION AND FEDERATION (VDIF) ENTERPRISE PLATFORM LACKS SUFFICIENT SECURITY CONTROLS

In this report, OIT concurred with recommendation 3 but nonconcurred with recommendations 1 and 2, which were related to categorizing VDIF at a high-risk level and reestablishing VDIF in eMASS at the high-risk level. Appendix D of the report includes the full text of OIT's comments and the OIG's response is on page 13. As a result of the report, OIT implemented additional protection mechanisms and security controls in VDIF; however, the assistant secretary and chief information officer indicated during the follow-up process that OIT had no plans to recategorize the system risk level as "high." As such, the OIG closed the recommendations as unimplemented due to this impasse.



The VA OIG **Recommendations Dashboard** tracks all report recommendations for corrective action made during the reporting period. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012. The statistics depicted are current as of October 23, 2023.

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.[30] During this reporting period, the OIG reviewed 12 legislative or regulatory proposals and made three comments. The OIG also reviewed 18 internal VA directives and handbooks that guide the work of VA employees and provided one comment. The OIG also testified in support of H.R. 2733, the *Department of Veterans Affairs Office of Inspector General Training Act of 2023,* a bill that, if enacted, would help VA employees understand their role and responsibilities to report fraud, waste, abuse of authority, and other wrongdoing to the VA OIG and how to properly engage with oversight staff.

Refusals to Provide Information or Assistance to the OIG

The IG Act authorizes federal inspectors general to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the Act. OIGs are required by the IG Act to provide a summary of instances when such information or assistance is refused.[31] The VA OIG reports no such instances occurring during this reporting period.

Instances of the OIG Exercising Testimonial Subpoena Authority

The VA OIG is authorized by the Strengthening Oversight for Veterans Act of 2021 to require by subpoena the attendance and testimony of witnesses as necessary in the performance of its functions.[32] The act also requires the VA OIG to disclose certain information in its semiannual report to Congress about its use of this authority. With respect to the use of its testimonial subpoena authority during this reporting period, Inspector General Missal issued one testimonial subpoena, and testimony in that matter remained pending as of the end of the reporting period. OIG staff interviewed one individual pursuant to a subpoena issued in a prior SAR period. The US Attorney General did not object to any proposed subpoenas during this SAR period. As of the prior reporting period, an action to enforce a subpoena issued in September 2022 was pending before a federal district court for the District of Montana. In April 2023, the court granted the petition for summary enforcement and (as reported above) the former employee was interviewed in June 2023. There are no other matters to report.

30 5 U.S.C. § 405(a)(2) (as amended by Pub. L. No. 117-263).

31 5 U.S.C. § 405(b)(15)(B) (as amended by Pub. L. No. 117-263).

32 Pub. L. No. 117-136 § 2(a).

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

The IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information.[33] The VA OIG reports no such instances occurring during this reporting period.

Instances of Whistleblower Retaliation

Inspectors general are required by the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers as well as any consequences imposed by the Department to hold those officials accountable.[34] 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.[35] 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 two complaints of alleged whistleblower reprisal by VA contractors or grantees during this reporting period, and did not substantiate any of the allegations. Consistent with the statutory requirements for these cases, the OIG refers the findings of completed investigations to the VA Secretary, who is responsible for granting or denying relief to the complainant.[36]

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 VA OIG received eight allegations involving suspected violations related to human trafficking. The VA OIG closed three investigations pertaining to this reporting requirement:

- The OIG received an allegation that a former VA registered nurse received kickbacks for referring patients to home health agencies. The OIG received additional allegations that one of these home health agencies fraudulently received funds through the Small Business Administration's

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

34 5 U.S.C. § 405(b)(14)(A) and §405(b)(14)(B) (as amended by Pub. L. No. 117-263).

35 41 U.S.C. § 4712 (b)(2).

36 41 U.S.C. § 4712(c).

Paycheck Protection Program and the Economic Injury Disaster Loan program and created false background clearance documents for employees that were smuggled from a foreign country. The OIG did not find any evidence that substantiated these allegations. This case was declined by the U.S. Attorney's Office for the Central District of California due to lack of evidence.

- A complaint was made that a VA employee allegedly told his supervisor he traveled to a foreign country to engage in sexual contact with underage girls and purportedly showed photos and videos stored on his personal cell phone that depicted underage girls. The complainant learned about the alleged conversation through multiple layers of hearsay. The OIG interviewed the supervisor, who denied that the employee showed any questionable photos of females that would indicate they were underage. Further, the supervisor indicated that when discussing his foreign travels, the VA employee only spoke about his girlfriend who lived outside the United States. Having found no evidence in the investigation to substantiate the allegations, the OIG did not refer this matter to the Department of Justice.
- OIG hotline staff received an allegation that several individuals were engaging in a human trafficking ring that was targeting veterans and their families through chat bots and brain-computer interfaces. The OIG found that the hotline complaint did not contain a nexus to VA but referred the matter to Homeland Security Investigations.

The VA OIG made no recommendations to improve VA programs and operations pursuant to this information.

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.[37] 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 Office of Special Counsel, the OIG may close its own investigation. During this reporting period, OI closed one criminal investigation with unsubstantiated allegations against senior government employees:

- The OIG received a hotline allegation that a medical center director was engaging in a dual compensation scheme, receiving salaries from VA and a nonprofit organization for which he served as a board member. The complainant further alleged that the director was embezzling grant funds from the nonprofit. The OIG's investigative efforts found no evidence to support these allegations. This matter was not referred to the Department of Justice because no criminal conduct was identified.

37 5 U.S.C. § 405(b)(16)(A) and § 405(b)(16)(B) (as amended by Pub. L. No. 117-263).

Peer and Qualitative Assessment Reviews

The IG Act, as amended by the Dodd–Frank Wall Street Reform and Consumer Protection Act, requires inspectors general to report the results of any peer review of its operations conducted by another office of inspector general during the reporting period or identify the date of the last peer review conducted by another office of inspector general, in addition to any outstanding recommendations that have not been fully implemented.[38] This information is presented in table 10. The VA OIG's offices of Investigations, Special Reviews, Audits and Evaluations, and Healthcare Inspections are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by these offices meets the applicable requirements and standards.

The IG Act also requires inspectors general to report the results of any peer review they completed of another office of inspector general's audit operations during the reporting period, as well as any outstanding recommendations that have not been fully implemented from any peer review completed during or prior to the reporting period.[39] 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 OIG	Pass	None
9/22/2023	Inspections and Evaluations	Department of Interior OIG	Pass	None
12/10/2018*	Investigations	NASA OIG	Pass	None

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

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

DATE COMPLETED	TYPE	REVIEWING OIG	RATING	OUTSTANDING RECOMMENDATIONS
8/8/2018	Audits	Social Security Administration OIG	Pass	None
9/14/2021	Inspections and Evaluations	DoD OIG	Pass	None
12/13/2018	Investigations	Department of Education OIG	Pass	None

38 5 U.S.C. § 405(b)(8)(A), § 405(b)(8)(B), and § 405(b)(9) (as amended by Pub. L. No. 117-263).

39 5 U.S.C. § 405(b)(10) (as amended by Pub. L. No. 117-263).

Awards and Recognition

Employee Recognition of Military Personnel

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

- Amber Clark, a criminal investigator in Denver, Colorado, was activated by the US Air Force Reserves in July 2023 and returned in August 2023.
- 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 May 2022 and returned in July 2023.
- George Kurtzer, an IT specialist in Hines, Illinois, was activated by the US Air Force in May 2023 and returned in August 2023.
- Jennifer Siegel, a management and program analyst in Bay Pines, Florida, was activated by the US Army in July 2023.

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 Alexander Hamilton Award—the highest recognition awarded by CIGIE for outstanding achievements in improving the integrity, efficiency, or effectiveness of agency operations—was given to the OHI review team that published *Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm*, which made seven recommendations that facilitate actions to prevent suicide by enhancing oversight, provider training, lethal means assessment and intervention, and reducing barriers to firearms access discussions.

Dr. Terri Julian discusses the VA OIG's report on lethal means safety training for the annual CIGIE awards ceremony.

Awards and Recognition

- The Glenn/Roth Award for Exemplary Service was awarded to two OAE teams responsible for the reports, *Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure* and *Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement*. The teams' evaluation of persistent errors in processing benefit claims and their analysis of the broken registry exam process provided legislators with crucial data to bolster their efforts to enact the PACT Act, which will help millions of affected veterans.

Michael Stack discusses the VA OIG's reports related to burn pits for the annual CIGIE awards ceremony.

- The Barry R. Snyder Joint Award recognized several OAE and OHI staff who participated on the Pandemic Response Accountability Committee's (PRAC) report, *Insights on Telehealth Use and Program Integrity Risks Across Selected Health Care Programs During the Pandemic*, which provided key insights into telehealth services and related program integrity risks in federal healthcare programs.
- An Award for Excellence in Audit was presented to an OAE team that identified significant weaknesses in the master schedule for VA's multibillion-dollar electronic health record system and noncompliance with the Federal Acquisition Regulations (FAR) that could lead to schedule overruns that cost $2 billion annually in *The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule*.
- An Award for Excellence in Audit was awarded to the OAE team for *VHA Continues to Face Challenges with Billing Private Insurers for Community Care*. The OIG found an estimated $805.2 million was lost from billing delays and missed deadlines, and the findings also prompted Congress to require VA to report on its progress in implementing the OIG's recommendations.
- An Award for Excellence in Evaluations was earned by the team that produced *Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune.* The OIG found that VBA staff, in recent years, incorrectly processed about 21,000 of 57,500 Camp Lejeune claims (about 37 percent), resulting in $13.8 million in unpaid benefits for veterans. The team's work resulted in VBA centralizing processing for these claims to improve accuracy.
- An Award for Excellence in Investigation was given to VA OIG's Post-9/11 GI Bill Nationwide Fraud Initiative. In this case, four schools submitted fraudulent claims to VA in order to obtain millions of dollars in payments in Post-9/11 GI Bill benefits. The OIG investigation resulted in 12 guilty pleas, $20.9 million in cost savings to VA, $113.9 million in restitution, and $1.9 million in forfeiture. One of the four cases was the largest Post-9/11 GI Bill investigation ever prosecuted by the Department of Justice.
- An Award for Excellence in Investigation recognized the OIG's work to unravel a complex fraud scheme went to the core of systemic weaknesses and control issues within VA's service and construction contracts and its over $5 billion-a-year purchase card program. Results included

one pretrial diversion, 18 guilty pleas, 208 months of imprisonment, 606 months of probation, $15,000 in fines, and $9.7 million in restitution to VA.

- An Award for Excellence in Investigation was presented to the Zieson Construction Multiagency Investigative Team. The team included thirteen agencies including five OIGs that partnered to investigate one of the largest ever set-aside fraud conspiracies. The defendants falsely claimed their firms were owned by minorities, veterans, and service-disabled veterans and defrauded the government of $346 million across 201 construction contracts at seven federal agencies. The investigative teamwork resulted in significant judicial actions.
- An Award for Excellence in Multiple Disciplines went to the OAE teams that published Security and Incident Preparedness at VA Facilities, which identified police staffing shortages that put VA staff, patients, and visitors at risk at these facilities.
- An Award for Excellence in Special Acts was given to Jeffrey Ferris an OIG criminal investigator who investigated allegations of price gouging and an attempt to sell counterfeit goods to VA at the onset of the COVID-19 pandemic. At the risk of exposing himself and his family to the virus at a time when much was still unknown, Special Agent Ferris placed himself in harm's way to aggressively pursue this investigation, working long hours and driving over 5,000 miles to conduct interviews and surveillance and to execute search and arrest warrants. Ultimately, the suspect was sentenced to 244 months' imprisonment and ordered to pay restitution of $108 million after pleading guilty to two fraud schemes.
- An Award for Excellence in Special Acts acknowledged the efforts of the Little Rock, Arkansas, Tornado Search and Rescue Response Team. On March 31, 2023, a half-mile-wide tornado touched down in Little Rock, Arkansas, and remained on the ground for 31 miles. VA OIG South Central Field Office staff responded to support search and rescue operations. The agents evacuated numerous tornado victims and assisted with providing immediate first aid. Throughout the weekend, the agents continued to help with recovery efforts.

OIG Investigations Recognized by FBI and US Attorney's Offices

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

Resident Agents in Charge (RAC) Josh Lollar and Doug Williams both received Outstanding Law Enforcement Officer of the Year awards from U.S. Attorney Roger B. Handberg, Middle District of Florida, for their efforts on two separate cases. RAC Lollar was recognized for his work on a joint civil case involving a medical practice and 10 physicians that allegedly violated the False Claims Act.

The defendants agreed to pay $2 million to resolve allegations. RAC Williams was recognized for his investigative efforts that led to a civil settlement in which a physician medical group agreed to pay $24.5 million to resolve False Claims Act allegations.

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)[40];

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

40 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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Strategic Plan

VA's Major Management Challenges

The faces featured on the covers of this report are some of the many VA OIG employees and their family members who have served in the military. We honor all veterans by working together to improve the services, benefits, and care they receive.

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