US DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT to Congress

Issue 94 | April 1–September 30, 2025

250 YEARS OF VALOR:

HONORING THE LEGACY OF THE ARMY, NAVY, AND MARINE CORPS

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

MISSION VISION VALUES

MISSION

To conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

VISION

To perform audits, inspections, investigations, and reviews that enhance the efficiency, effectiveness, and integrity of VA and its services to the veteran community.

The Office of Inspector General (OIG) will

- issue accurate, timely, and evidence-driven reports with recommendations that help VA deliver high-quality health care, benefits, and services to eligible veterans and other beneficiaries;
- work to deter and address VA-related fraud and other crimes, waste, and abuse, as well as advance efforts to hold individuals responsible for their misconduct; and
- maintain transparency of its oversight work by disclosing to veterans, the public, VA, and Congress identified risks and opportunities to make better use of taxpayer dollars.

VALUES

- Honor veterans by putting their interests first and continually striving for excellence
- Uphold the highest standards of integrity, professionalism, and accountability
- Safeguard the OIG's independence and objectivity
- Protect individuals alleging wrongdoing and treat them with respect and dignity
- Promote a culture that attracts and retains skilled and dedicated staff

A MESSAGE FROM THE INSPECTOR GENERAL

I am honored to serve as the inspector general for the Department of Veterans Affairs (VA), continuing my three decades of service to veterans, their families, survivors, and caregivers. My first semiannual report to Congress sets out the work completed by the VA Office of Inspector General (OIG) during the six-month reporting period from April 1 through September 30, 2025, and includes enhancements to the OIG's mission, vision, and values—reaffirming our commitment to veterans and their families, survivors, and caregivers while ensuring VA is a strong steward of taxpayer dollars. During this period, VA OIG experienced departures due to some staff electing the deferred resignation and early retirement programs and routine attrition. Staff adjusted, implementing efficiencies to successfully meet our mission. Late in this period, the Office of Personnel Management approved multiple hiring freeze exemptions across VA OIG, and we are moving forward with recruitment and hiring to fill these positions.

As this report demonstrates, our independent oversight resulted in 507 recommendations during the reporting period (849 for the full fiscal year) to improve and support VA programs, operations, services, and benefits.

My priorities convey both our internal and external actions and will shape the OIG's approach and define our success:

- ***Accountability*** is the cornerstone of trust. It starts with each one of us individually, to the OIG, and to the department meeting our mission to support and serve veterans, their families, survivors, and caregivers. At the OIG, we must be committed to holding the department and ourselves to the highest standards of integrity, quality, transparency, and excellence.
- ***Collaboration*** empowers our oversight. While our independence is crucial, collaboration requires communication within VA OIG, and with the department, Congress, veterans, and all our stakeholders. If we are not listening and working across and through the OIG and the department, we will not have all the information to ensure our reports are accurate, unbiased, and precise so that they identify risks and promote best practices that lead to better outcomes.
- ***Efficiency*** is what VA OIG is about. If we are not operating efficiently and effectively, how can we hold the department to that standard? Efficiency maximizes resources and minimizes waste requiring assessment of our internal operations, functions, and programs. This is not a one-time occurrence; this is ongoing because change is constant. It is what is expected of us and it is what we owe to veterans and taxpayers.

- ***Resolution*** focuses improvements. We are leveraging the expertise across VA OIG to ensure our work impacts VA policies, practices, and processes. Resolution means following through on our recommendations with the department, acknowledging when they act in response to these recommendations. Promoting advancement in the second largest department in the federal government is a monumental undertaking. Each impact matters.

These priorities reflect our deep sense of responsibility and our unwavering dedication to the veteran community. Our work is grounded in purpose, guided by integrity, and focused on delivering value and impact across the VA enterprise.

VA OIG's oversight work is intended to encourage efforts by VA personnel to make continuous improvements. For this six-month reporting period, we published 138 reports. However, the true metric for success is the impact of the efforts noted in the reports. As we move forward in fiscal year 2026, VA OIG will also begin measuring our impacts on VA and the veterans we all serve.

We also continued to expand our outreach with monthly highlights of criminal investigations and other activities, fraud alerts, and additional communications, as showcased by this report. VA OIG identified nearly $3.8 billion in monetary impact, for a return on investment of $32 for every dollar spent on oversight for the reporting period (and $30:1 for fiscal year 2025). The OIG hotline received 24,781 contacts in this reporting period alone (41,979 for the year) that identify potential wrongdoing and address concerns with VA activities. For the last six months of the fiscal year, our special agents opened 624 investigations and closed 431, with efforts leading to 205 arrests (349 for the year). Collectively, VA OIG's work this reporting period also resulted in 512 administrative sanctions and corrective actions.

VA OIG is working to become even more agile in responding to emerging issues and identified concerns, particularly considering VA's ongoing transformation. We are also committed to producing more timely reports with measured impacts that motivate real changes in how VA conducts business and ensures veterans and other beneficiaries are provided with the care, compensation, and services they deserve.

OIG leaders and staff appreciate the many VA personnel who engaged candidly and cooperatively with us. I also want to thank members of Congress, veterans service organizations, and the greater veteran community for their support that is so crucial to our work.

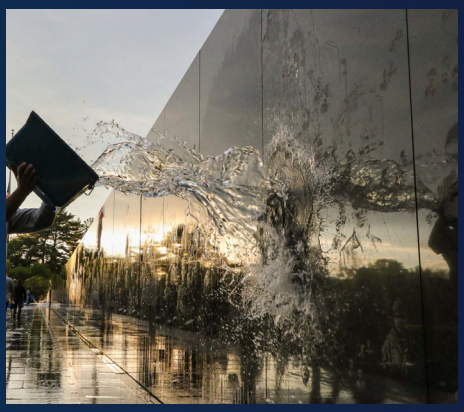
CHERYL L. MASON
Inspector General

CONTENTS

HONORING SACRIFICE

Approximately 30 percent of VA OIG employees are veterans. Another large percentage are spouses or other family members of those who have served. All staff are deeply committed to serving veterans, their families, survivors, and caregivers through effective independent oversight.

Shown here are VA OIG employees volunteering on several occasions to wash the Korean War and Vietnam Veterans Memorials in Washington, DC, to honor all who gave their lives in service to their country.



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) 2025, VA operated under a $396 billion budget with approximately 458,000 employees serving an estimated 18 million veterans. VA maintains facilities in every state, the District of Columbia, American Samoa, the Commonwealth of Puerto Rico, Guam, 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 OIG is to conduct independent oversight of VA that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

HISTORY AND STATUTORY AUTHORITY

The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (the IG Act), as amended.[1] This act states that the inspector general is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of—and to prevent and detect criminal activity, waste, abuse, and mismanagement in—VA programs and operations; and (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The inspector general has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements with the department. In addition, the Veterans Benefits and Services Act of 1988

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

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

STRATEGIC FOCUS AREAS

VA manages a vast and complex portfolio, including the nation's largest integrated public healthcare system. VA leaders and personnel, the veteran community, Congress, and taxpayers look to the OIG to root out potential crimes, waste, and abuse of authority while suggesting significant improvements to VA through data- and evidence-driven recommendations and findings. The OIG's five-year strategic plan for 2022–2026 outlines its goals and objectives in promoting the efficiency, effectiveness, and integrity of VA's operations. The OIG's oversight efforts focus on five core areas:

VA OIG Strategic Plan, 2022–2026

01 Help ensure veterans receive prompt access to exemplary health care

02 Make recommendations that facilitate the swift delivery of benefits and superior services to eligible veterans and other beneficiaries

03 Identify and implement how VA can make the most responsible use of its appropriated funds

04 Address failures in governance and leadership that cut across VA programs and operations

05 Encourage innovation and recommend enhancements to VA's infrastructure and systems, such as those that affect all IT, predictive analysis, and financial or other management systems

When determining whether to undertake a specific matter, the OIG considers a variety of factors, including the number of veterans impacted, the actual or risk of imminent harm to veterans as individuals or groups, the potential effect on taxpayers, the pervasiveness of the problem, the level of stakeholder interest, alignment with OIG strategic focus areas and prior related work, and whether other avenues of redress may be more appropriate. Because the OIG can act on only a limited number of matters brought to its attention, these considerations help guide decisions on where to focus resources.

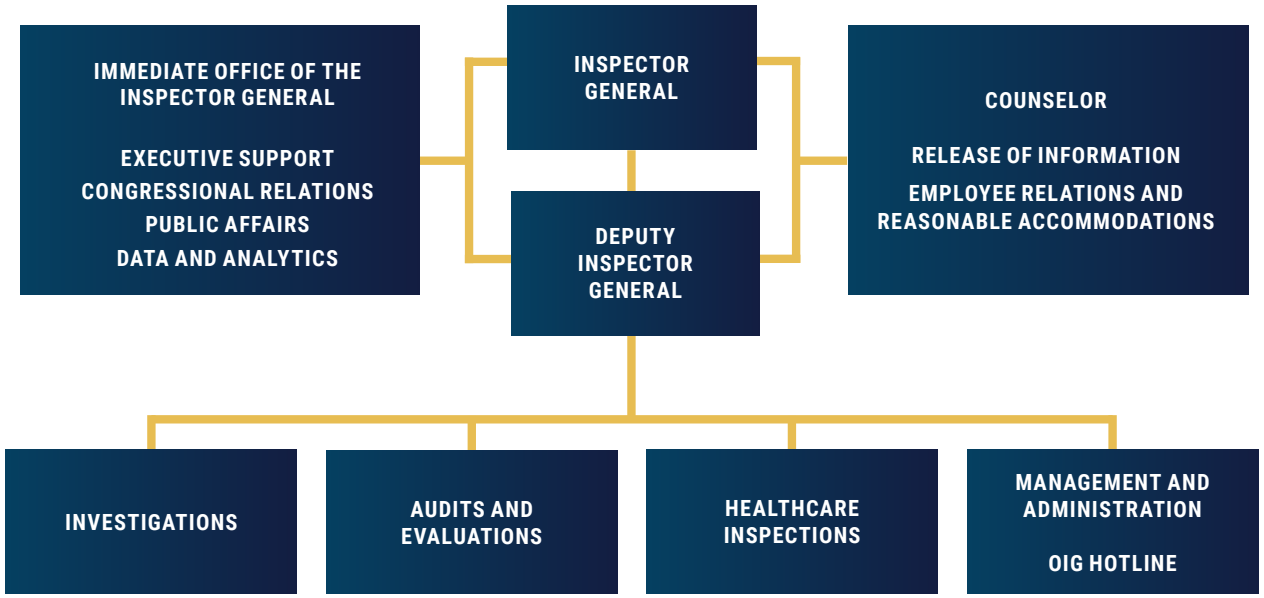
[2] Veterans Benefits and Services Act of 1988, Pub. L. No. 100-322, 102 Stat. 487.

STRUCTURE AND FUNDING

The VA OIG has more than 1,000 staff organized into four primary directorates: the Offices of Investigations, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline).[3] 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 2025 funding from ongoing appropriations provided $296 million for OIG operations. The OIG predicts similar funding for FY 2026, though no budget has been passed as of the time of this drafting.

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



[3] Pursuant to its Agency Reduction in Force and Reorganization Plan, the OIG consolidated some supporting functions across the enterprise in FY 2025, such as healthcare data analytics, and discontinued the Office of Special Reviews as a standalone office. Remaining staff were assigned to other directorates with a smaller cohort of administrative investigators aligned under the Office of Investigations.

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 advanced analytics, software engineering solutions, data requests, and systems access to inform enterprise-wide oversight on emerging issues and to help detect fraud and waste. 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.

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. Its attorneys provide legal support for investigations, audits, and inspections; advise OIG's management officials on contracting and administrative law matters; represent the office in employment litigation and personnel matters; and inform legislative proposals and congressional briefings. Attorneys serve as liaisons to the inspector general legal community, the Department of Justice, the Office of Special Counsel, and other agencies. Investigative attorneys within the office also review allegations of whistleblower reprisal made by employees of VA contractors or grantees pursuant to 41 U.S.C. § 4712. The counselor's office oversees the work of the Release of Information Office and staff responsible for handling reasonable accommodation requests as well.

THE OFFICE OF INVESTIGATIONS

This office investigates potential crimes and other violations of law and policy involving VA programs and operations committed by VA employees, contractors, beneficiaries, and other individuals or entities. These investigations focus on a wide range of fraudulent matters related to healthcare, contracting and procurement, benefits, and construction; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. OI also conducts administrative investigations and other reviews involving allegations of misconduct or gross mismanagement that implicate senior VA officials or significantly affect VA programs and offices. The office is staffed by special agents, forensic accountants, attorneys, and other professionals with a broad range of expertise. 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 office's investigations promote integrity, patient safety, efficiency, and accountability within VA.

THE OFFICE OF AUDITS AND EVALUATIONS

The Office of Audits and Evaluations provides independent audits, inspections, and reviews of VA's activities to improve the integrity of its programs and operations. Personnel assess VA's compliance with laws, regulations, and other governing requirements for areas of concern to the veteran community and taxpayers. These include healthcare delivery, financial efficiencies, the administration of benefits, cemetery services, resource utilization, acquisitions, construction, physical security, staffing, and information technology modernization and security. This work helps VA improve its program results, strengthens controls over the delivery of benefits, identifies potential fraud, improves veteran care and support, and promotes stewardship of taxpayer dollars and efficiency. The office also reviews VA's contracts with outside entities, 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 identify overcharges for recovery.

THE OFFICE OF HEALTHCARE INSPECTIONS

Healthcare Inspections personnel are committed to ensuring veterans have access to timely and high-quality health care that meets their unique needs and experiences. Leveraging broad clinical expertise, staff conduct for-cause inspections to assess allegations pertaining to poor VA medical care that are prompted by complaints to the OIG hotline, congressional requests, and other leads. The office also performs proactive cyclical evaluations of vet centers, inpatient mental health units, individual medical centers, healthcare systems, regional networks, and community providers, as well as performance reviews of nationwide clinical programs. Collectively, these efforts advance comprehensive oversight of the nation's largest integrated public healthcare system and help VA improve patient outcomes, mitigate risk, and deliver caring service. Staff also provide clinical consultations to OIG criminal investigators and audit staff and other federal entities as needed.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

The Office of Management and Administration provides comprehensive and critical support services across the OIG. Staff promote organizational effectiveness and efficiency by providing reliable and timely support from its many divisions, including operations, human resources, finance and budgeting, information technology and security, space and facilities management, and training. The office also oversees the OIG hotline, which screens all contacts that make allegations or submit complaints of wrongdoing for either additional action or referral to a more appropriate entity. Staff triage matters for further OIG action, prioritizing those that pose the most risk to veterans and VA programs and operations, or those for which the OIG may be the only avenue of redress.

Pursuant to the IG Act, this *Semiannual Report to Congress* presents the OIG's accomplishments during the reporting period April 1–September 30, 2025. Highlighted below are some of the priorities set, activities conducted, and oversight report findings issued during these 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 other reporting requirements of the IG Act. 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

The congressional relations team actively engages with Congress to promptly inform members and their staff of critical issues affecting VA programs and operations. During the six-month reporting period, OIG leaders were expert witnesses in four congressional hearings on VA's provision of mental health services; improper payments found in VA's compensation and pension programs; abuses in how VHA used incentive payments for staff recruitment, retention, and relocations; and VA's program integrity tool designed to detect fraud and to bill veterans or insurers for community care. The OIG also provided a statement for the record on a hearing related to VA's Veterans Readiness and Employment program.

The OIG conducted 100 briefings on oversight reports and activities with members and their staff. Some of the topics addressed included the following:

- VHA's lack of planning, request processes, and oversight of nonexpendable equipment
- Continuing issues in military sexual trauma claims processing
- Review of the governance of a major VA medical facility construction project
- Review of a program serving veterans who are experiencing homelessness related to intake, suicide risk assessments, and care coordination
- Review of scheduling patients with community care providers and conveying records back from them to VA to provide seamless care

- Quality of care reviews at the VA Western New York Healthcare System in Buffalo; the New Mexico Healthcare System in Albuquerque; and VA Atlanta Healthcare System in Decatur, Georgia
- Training on processing of claims in compliance with the PACT Act
- Costs and patients' length of stay issues, as well as quality of care, for residential substance use disorder treatment provided under community care contracts

The congressional relations team also responded to 83 inquiries from House and Senate offices including several that resulted in OIG projects that are still in process, such as a healthcare inspection related to VA oncology care and another healthcare inspection related to procedures inside a mental health unit.

The team also handles the OIG's liaison with other oversight bodies such as the Government Accountability Office (GAO) and the Council of Inspectors General on Integrity and Efficiency's Legislation Committee. The 42 engagements with GAO are invaluable to both offices to ensure oversight efforts are not duplicated. In some instances, GAO has also referred investigative matters to the OIG for follow-up based on the findings of their work.

DATA AND ANALYTICS

The Office of Data and Analytics (ODA) provides advanced analyses, software engineering solutions, and comprehensive data services to empower OIG personnel to conduct proactive oversight of VA programs and operations. ODA develops intuitive, self-service applications and dashboards that use near real-time information to enable directorate teams across the OIG to identify areas of greatest risk to veterans and their families, deficiencies in VA programs, and misuse of taxpayer dollars.

During the reporting period, ODA continued work on 87 projects, developed 16 new internal data-monitoring tools, and made significant enhancements to several others. These efforts addressed a wide array of subjects, including VA's contract management, opioid use treatment, community care utilization and pricing, education benefits, benefit awards and appeals, use of artificial intelligence (AI) in reviewing benefit applications, compensation and pension payments, the modernization of electronic health records, and suicide prevention initiatives.

ODA is actively developing tools that identify new opportunities for oversight that consolidate related products and triangulate fraud indicators to identify individuals or entities potentially engaged in wrongdoing. These tools have shortened staff's learning curves; expedited the discovery of leads for audits, inspections, reviews, and investigations; and increased overall efficiency and productivity.

To prepare for the transition to a cloud-based infrastructure, ODA is expanding its collection of curated datasets in critical topical areas such as community care, benefits eligibility, benefits awards, and veteran population profiles. The availability of these datasets will streamline data analysis workflows, reduce redundancy in generating datasets, and standardize data preparation and documentation across the OIG. ODA is also using AI and machine-learning technologies to advance the timeliness and impact of oversight through collaboration with directorate teams. These technologies have been used to assist with

transcribing interviews, summarizing oversight documents, categorizing recurring themes, detecting fraud, and optimizing OIG hotline triage processes.

The office also fulfilled 244 internal data requests and 587 requests to access VA data systems for oversight work during this period. These responses contributed to OIG examinations of VA healthcare and benefits services involving compensation and pensions, employment, education, housing assistance, and veterans' burials. ODA also conducted formal trainings for OIG staff to build their competency in using data monitoring and content search tools. ODA regularly coordinates with leaders and staff from VA's Office of Integrated Veteran Care to monitor the progress of restoring the Program Integrity Tool and works with the Office of Information and Technology, as well as data stewards from program offices across VA, to ensure access to IT resources and source data essential for OIG analytics needs.

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 reports, news releases, podcasts, and other products to keep stakeholders informed of the OIG's oversight work. Staff also worked with US Attorneys' public affairs offices and other law enforcement partners to release public statements and respond to requests for information on criminal investigations.

Among the press releases and external messages released during this reporting period, the OIG announced the confirmation of Cheryl L. Mason as its new inspector general. The release detailed her distinguished career in federal service and her role as a champion for suicide prevention and military spouse employment. Her first **public message** focused on National Suicide Prevention Month and the need for greater awareness, support, and actions that can save veterans' lives.

Personnel within the communications office also have responsibility for following up on the implementation of OIG report recommendations. In this six-month reporting period, those efforts included sending 431 requests for status updates to various offices within VA tasked with taking action. These efforts facilitated the closing of 421 recommendations. These recommendations addressed topics including the evaluation of patient safety reporting, improved PACT Act training for VA staff, and opioid safety and veterans' mental health clinic scheduling—among others.

During the reporting period, the public affairs team continued its social media growth on LinkedIn and X to nearly 105,000 followers, posting 284 updates on reports, investigations, congressional hearings, and other news—leading to approximately 809,000 impressions. OIG content was viewed more than 17,300 times on its YouTube channel (@VetAffairsOIG). Additionally, the team

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released 131 email bulletins through GovDelivery. The number of bulletin subscribers increased by about 31,500 since the previous reporting period, bringing the total to nearly 215,000.

Staff also made enhancements to the OIG's website. During the reporting period, nearly 369,600 visitors accessed the site to view reports, contact the hotline, review the data dashboard on report recommendations and monetary impact, and to learn more about OIG oversight.

The OIG responded to 160 media inquiries and was referenced 375 times by local and national media outlets—helping to inform the national debate on issues of concern to the veteran community. National and local media frequently featured OIG healthcare facility inspection findings, updates on criminal investigations, and recommendations on how to improve VA programs and services. The OIG also published numerous investigative updates noting the OIG's collaborative work with the Department of Justice and highlighted its collaboration on multiagency operations (see the section on the Office of Investigations for more information).

The Office of the Counselor to the Inspector General

The counselor's office provides legal and employee relations support to every OIG component. During this reporting period, staff focused on implementing executive orders that changed federal personnel rules. The office also experienced a significant increase in administrative litigation challenging OIG decisions on some employees' reasonable accommodation requests. These requests continued to grow, ending FY 2025 with a 400 percent increase over FY 2024, with the responsible team processing 180 requests for reasonable accommodations and 81 Family and Medical Leave Act and other approved absences. The Employee Relations team also assisted management officials in addressing 172 disciplinary and performance matters. In addition, they worked with attorneys from the Administrative Law division to advise managers on seven fact-finding inquiries.

Administrative Law attorneys advised OIG managers on employee performance and misconduct matters, supported four internal investigations, and provided live trainings for new staff and supervisors. Attorneys in the division also represented the OIG in addressing 25 equal employment opportunity (EEO) complaints and three appeals before the Merit Systems Protection Board. During the review period, the team received a favorable summary judgment ruling from the EEO Commission in a case involving an applicant's nonselection and prevailed in a hearing in a disability discrimination case.

Oversight and Procurement division attorneys continued to provide high-quality legal advice to OIG directorates on all oversight matters and investigations. Attorneys reviewed 354 subpoenas to support criminal investigations, worked with US Attorneys' Offices, reviewed policy updates, and provided required training. They made significant contributions to audit and healthcare inspection reports on matters such as PACT Act benefit payments and leadership challenges at the Augusta VA medical center. They also continue to represent the OIG in litigation before the Civilian Board of Contract Appeals.

Through a restructuring to increase efficiency, the office now has attorneys assigned to assess possible whistleblower retaliation under 41 U.S.C. § 4712, which protects employees of contractors, grantees, subcontractors, and subgrantees from retaliation for making protected disclosures. They examined 12 new allegations and continued to investigate four pending matters. During the reporting period,

the VA Secretary issued an order related to a prior § 4712 report, finding insufficient evidence that the complainant had experienced prohibited reprisal.[4]

The Release of Information office worked with the Department of Justice to resolve a long-running Freedom of Information Act (FOIA) case. The team responded to 309 FOIA requests and appeals and addressed myriad other requests, including 17 Giglio requests and one Touhy request.[5] They routinely ensure compliance with privacy mandates for OIG oversight and investigations.

[4] Federal law prohibits OIGs from disclosing "any information from or about any person alleging the reprisal" except as needed to conduct its investigation, which exempts § 4712 investigation reports from public release.

[5] *Giglio v. United States*, 405 U.S. 150 (1972), requires federal prosecutors to provide the defense information that could challenge the credibility of a government witness, such as a law enforcement officer. *United States ex rel. Touhy v. Ragen*, 340 U.S. 462 (1951) provides a means for litigants to request official information from a government agency or agency employee in a legal proceeding in which the government is not a party.

The Office of Investigations

Personnel from this office investigate potential criminal activity and civil violations of law, including fraud related to VA benefits, construction, education, procurement, and health care, as well as drug offenses, crimes of violence, threats against VA employees or facilities, and cyberthreats to VA information systems. Personnel also conduct administrative investigations and other reviews involving allegations of misconduct or gross mismanagement that implicate senior VA officials or significantly affect VA programs and offices. During this six-month reporting period, investigative efforts resulted in 205 arrests, 116 convictions, and more than $553 million in monetary benefits for VA and non-VA entities.

The Office of Investigations (OI) coordinates with other OIG directorates, external law enforcement partners, and the Department of Justice on high-impact cases to ensure that veterans, VA employees, and VA assets are protected, and wrongdoers are held accountable. In June 2025, OI participated in a strategically coordinated, three-week nationwide law enforcement action led by the Department of Justice. This effort resulted in criminal charges against more than 300 defendants for their alleged participation in various healthcare fraud and opioid diversion schemes. These schemes, if not thwarted, were expected to result in over $14.6 billion in losses to federal, state, and private insurers. As part of this effort, OI conducted 12 investigations that resulted in charges against 17 defendants—including five licensed medical professionals—for fraud schemes involving purchases of durable medical equipment, genetic testing, wound care products, and massage therapy that were expected to result in approximately $26.7 million in losses to VA's Community Care and CHAMPVA programs.

In August 2025, the VA OIG, VA, and Homeland Security Investigations signed a charter for Operation Genuine Valor, which is an initiative protecting the VA supply chain against the infiltration of counterfeit, unapproved, substandard, and noncompliant medical devices, equipment, and pharmaceuticals. This initiative will help safeguard the health and safety of veterans by leveraging the combined expertise and authority of these agencies in investigation, enforcement, and regulatory compliance. Operation Genuine Valor uses a holistic approach to ensuring the integrity of VA's medical supply chain, drawing on data analytics, proactive investigations, strategic partnerships, and educational outreach to VA staff.

OI issued two fraud alerts during this reporting period. The first alert focused on "pension poaching," in which criminals target benefits available to wartime veterans or their surviving spouses who meet certain age or disability requirements and have limited income and net worth. This alert cautioned veterans to be aware of a wide range of schemes. For example, scammers may charge large fees to represent

veterans in pursuing pension benefits for which they do not qualify. They also may try to sell in-home care to eligible pension recipients that may be overpriced or never provided. The second alert is directed to VA personnel to help them spot and report VA purchase card fraud and related theft. This type of crime involves the misuse or theft of government-issued purchase cards for personal gain or other unauthorized procurements. VA spends billions of dollars each year on contracted services, supplies, and medications alone, with a significant amount obtained through purchase cards. Among indicators of potential fraud are increases in large purchases from the same vendor by a single or small number of purchase cardholders; orders made just below the authorized ceiling amount; missing documentation; and required controls not being met (such as ensuring that the individual requesting a purchase is not the same person approving it).

In addition to OI's extensive prevention and proactive collaborations, the office conducted many successful investigations resulting in arrests, indictments, and sentencing. The investigations summarized below illustrate OI's emphasis on a broad range of cases that have led to monetary recoveries for VA that can be reinvested in its programs, services, and benefits. These efforts address fraud, waste, and abuse by bad actors and VA employees in positions of trust and help ensure benefits and services meant for veterans and other eligible beneficiaries are being delivered timely and accurately.

VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

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

CHARITY FOUNDER AND FOUR EMPLOYEES INDICTED FOR DEFRAUDING VA OF APPROXIMATELY $20 MILLION IN VA PENSION BENEFITS

The founder of a purported charitable organization and four of its employees allegedly defrauded both VA and veterans in connection with a pension benefits application assistance scheme. These defendants misled veterans by advising them that they were eligible for pension benefits to which they were not actually entitled. On their behalf, the charity submitted falsified documentation to VA in support

of their pension applications. Once the applications were approved, the defendants either demanded direct payment or a large percentage of the resulting benefits before releasing the remainder to the veteran. VA allegedly paid more than $20 million as a result of this scheme. The charity, its founder, and four employees were indicted in the Cuyahoga County (Ohio) Court of Common Pleas on various criminal charges in connection with this fraud scheme. This investigation was conducted by the VA OIG, the Ohio Attorney General's Office, and the Ohio Department of Commerce.

MASSAGE SCHOOL OWNER PLEADED GUILTY IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

An owner of a for-profit, non-college-degree school is alleged to have offered comprehensive massage training to veterans. Though the school was prohibited from offering distance learning, a VA OIG investigation revealed that most veterans lived far away; received very few, if any, hours of instruction; and did not obtain their state-issued massage licenses. From 2012 to 2022, the massage school owner falsely represented veteran enrollments, which resulted in VA education benefits payments totaling $9.8 million. The owner pleaded guilty in the District of Hawaii to conspiracy to commit wire fraud.

SAN JUAN VA REGIONAL OFFICE SUPERVISOR, SEVEN VETERANS, AND TWO OTHERS INDICTED IN CONNECTION WITH DISABILITY BENEFITS FRAUD SCHEME

An investigation by the VA OIG and FBI, which was responsive to a complaint to the OIG hotline, resulted in charges alleging that 10 defendants participated in a scheme to arrange for fraudulent disability claims to be submitted to VA and approved based on faked medical conditions. A VA supervisor communicated to a facilitator which fictitious or exaggerated medical conditions veterans could claim to obtain higher disability benefits. The facilitator identified veterans without a 100 percent disability rating and offered to help them obtain that top rating for an up-front cash fee plus a percentage of any back pay the veteran received if successful. The facilitator instructed seven veterans on the false information to provide when attending medical evaluations and completing their disability application paperwork. Another defendant, a nonveteran related to some of the veterans involved, also helped facilitate this scheme on their behalf. The veterans knowingly received fraudulent disability ratings based on their participation in this scheme. All 10 defendants were indicted in the District of Puerto Rico on various charges to include conspiracy to commit wire and mail fraud.

VETERAN PLEADED GUILTY TO VA DISABILITY COMPENSATION BENEFITS FRAUD

After medically retiring from the Army in 1983 due to an eye condition, a veteran received VA disability compensation benefits with a 100 percent service-connected rating for legal blindness while maintaining a Florida driver's license since 1993. The VA OIG proactive investigation revealed the veteran misrepresented his true visual acuity during VA examinations in order to fraudulently receive the higher disability benefits for blindness. Despite his claims to VA, the veteran passed multiple driver's license vision examinations with the Florida Department of Motor Vehicles. By pleading guilty, the veteran acknowledged that he fraudulently led VA to believe that he was blind when he could operate a motor vehicle. The loss to VA was approximately $1.1 million. The veteran pleaded guilty in the Middle District of Florida to theft of government funds.

FOUR INDIVIDUALS CONNECTED TO A HOUSE OF PRAYER AFFILIATE INDICTED IN CONNECTION WITH EDUCATION BENEFITS FRAUD SCHEME

A multiagency investigation resulted in charges alleging that from at least 2011 through 2022, four leaders of Georgia affiliates of the House of Prayer Christian Churches of America conspired to defraud VA and veterans of millions of dollars in education benefits. According to the indictment, these leaders fraudulently obtained a religious exemption from state regulators in Georgia to operate two of five locations in Georgia as the affiliate called the House of Prayer Bible Seminary (HOPBS). This exemption required that Georgia seminaries not receive federal funds. Yet the four defendants applied for and accepted VA education benefits, making the seminary ineligible for the exemption. The defendants recruited military personnel to the church, directed them to enroll in HOPBS, and then used VA benefits for personal gain. HOPBS received more than $3 million in education benefits for its two Georgia locations and more than $23.5 million for all five locations. From 2013 through 2021, the four leaders fraudulently submitted false certifications to Georgia regulators that claimed the seminary did not receive federal funds. The scheme channeled funding from VA education benefits to seminary accounts, which the defendants in turn siphoned off for their own use. The impact was that some veterans' benefits were exhausted, often without completing their programs. The four defendants were indicted in the Southern District of Georgia on multiple criminal charges. Two of the four defendants, along with two additional individuals, were also indicted in connection with a long-running mortgage fraud conspiracy that was partially tied to VA home loans. In total, eight defendants were indicted for both the education and mortgage fraud schemes. This investigation was conducted by the VA OIG, FBI, Internal Revenue Service Criminal Investigation, Federal Housing Finance Authority OIG, Army Criminal Investigation Division, U.S. Citizenship and Immigration Services, and U.S. Postal Inspection Service.

VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, 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 the **Investigations and Reports** section.

DRUG AND ALCOHOL REHABILITATION CENTER AGREED TO PAY $19.75 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

The VA OIG has intensified its efforts to stop fraud associated with residential substance use disorder treatment facilities that overbill VA using a variety of schemes, including billing for treatments not provided, while failing to provide high-quality care to veterans by qualified clinicians. This multiagency investigation resolved allegations that a drug and alcohol rehabilitation facility, Seabrook House, submitted claims to VA's Community Care program and New Jersey's Medicaid program for short-term residential treatment and partial hospitalization care for which it was not properly licensed or contracted and misled state inspectors. Specifically, from January 2022 through December 2024, Seabrook provided services for

which it had no license, sought to conceal improperly performed services from state inspectors, and failed to employ a sufficient number of properly credentialed caregivers (including those credentialed in treating patients with both mental health and addiction issues).

Seabrook also allegedly provided the same care to veterans as other patients, while claiming to provide specialized care, and maintained false, inconsistent, and inadequate records of care. In a civil settlement, Seabrook agreed to pay $19.75 million to resolve False Claims Act allegations. Of this amount, VA will receive $19.15 million. This investigation was conducted by the VA OIG and Department of Health and Human Services OIG. The case was handled by the US Attorney's Office for the District of New Jersey. It was the first such case involving VA substance use disorder programs resolved with assistance from the VA OIG's Office of Investigations.

MEDICAL DEVICE COMPANY AGREED TO PAY $4.3 MILLION TO RESOLVE ALLEGATIONS OF OVERBILLING FOR PRODUCTS

A VA OIG investigation resolved allegations that a medical device company fraudulently overcharged VA and other federal agencies for hardware and software products. The company held a federal contract to sell and lease products to VA and other federal agencies at a set price or a negotiated discounted price. Due to pricing issues in their internal software, the company sometimes sold and leased products to federal agencies at a price higher than the applicable contract price. When becoming aware of certain overpricing issues related to specific individual orders, the company at times issued credits or otherwise corrected prices charged to VA and the other federal agencies. However, the company did not correct the underlying causes of their sales and pricing system errors. The company also did not analyze whether these federal agencies may have been previously overcharged due to the pricing problems and should have received refunds. The company entered a civil settlement in the Eastern District of Washington under which it agreed to pay more than $4.3 million to resolve allegations that it violated the False Claims Act. Of this amount, VA will receive more than $2.1 million.

FORMER INVENTORY MANAGEMENT SPECIALIST AT TENNESSEE VA MEDICAL CENTER SENTENCED FOR STEALING DENTAL EQUIPMENT

A VA OIG and VA Police Service investigation revealed that a former inventory specialist at the Mountain Home VA Medical Center in Tennessee stole dental equipment, including various high-speed handpieces and other dental tools, from the facility and sold the items online. The former VA employee was sentenced in the Eastern District of Tennessee to six months' imprisonment, 36 months' supervised release, and ordered to pay restitution to VA of approximately $385,000 after previously pleading guilty to theft of government property.

FORMER NURSE AT TEXAS VA MEDICAL CENTER PLEADED GUILTY TO FALSELY CLAIMING SHE HAD CHECKED ON PATIENT WHO ULTIMATELY DIED

Another VA OIG investigation found a former nurse at the Michael E. DeBakey VA Medical Center in Houston made false entries in the VA's Computerized Patient Record System, in which she claimed to have observed a male patient on several occasions during her shift on July 26–27, 2024. Contrary to these entries, the former nurse did not have any contact with the patient at those times. In the early

morning hours of July 27, medical personnel found the patient unresponsive and ultimately pronounced him deceased. The former nurse pleaded guilty in the Southern District of Texas to making or using false writings or documents.

OTHER INVESTIGATIONS

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

DEFENDANT SENTENCED FOR FRAUDULENTLY OBTAINING CARES ACT FUNDS

A multiagency investigation exposed that a husband and wife improperly used $2 million in Coronavirus Aid, Relief, and Economic Security (CARES) Act funds to purchase their home and engaged in a scheme to avoid paying workers' compensation insurance premiums. The husband was sentenced in the District of Massachusetts to 12 months' imprisonment, 24 months' supervised release with the first six months on home confinement, and ordered to pay restitution of over $627,000 after previously pleading guilty to conspiracy to commit mail, wire, and bank fraud. The husband was further ordered to jointly pay additional restitution of over $1.6 million with his wife, who was previously sentenced to 27 months' supervised release with the first three months on home confinement. This investigation was conducted in connection with the Pandemic Response Accountability Committee (PRAC) Fraud Task Force by the VA OIG, Insurance Fraud Bureau of Massachusetts, Internal Revenue Service Criminal Investigation, and FBI. As a PRAC member, the VA OIG has assisted federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

Spot and Report Purchase Card Fraud

VA spends billions of dollars each year on contracted services, supplies, and medications alone, with a significant amount obtained through these cards.

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

FORMER PHILADELPHIA VA MEDICAL CENTER ENGINEER SENTENCED FOR USING FICTITIOUS COMPANY TO DEFRAUD VA

A VA OIG and FBI investigation established that a former engineer at the Philadelphia VA Medical Center submitted false invoices to VA on behalf of a fictitious heating, ventilation, and air conditioning company that he established with his girlfriend. Using his VA position, the former engineer identified fake work to be performed at the facility by this company. After falsely confirming that the work had been

completed, he authorized an unsuspecting VA purchase cardholder to pay the fictitious company. After receiving payment from VA, the girlfriend returned the payment to the former engineer, either by check or envelopes containing cash. In total, he defrauded VA of more than $500,000. The former engineer was sentenced in the Eastern District of Pennsylvania to 64 months' imprisonment and 36 months' supervised release, and he was ordered to pay restitution of approximately $565,000 to VA after having been previously found guilty following a jury trial on charges of wire fraud. The girlfriend was previously sentenced to three months' probation and ordered to pay restitution of more than $41,000 to VA after pleading guilty to bankruptcy fraud related to the fictitious company.

TWELVE EMPLOYEES AT THE LOUIS STOKES CLEVELAND VA MEDICAL CENTER PLEADED GUILTY TO A COVID-19 FRAUD SCHEME

A multiagency investigation resulted in charges alleging that in 2020 and 2021, 13 employees of the Louis Stokes Cleveland VA Medical Center fraudulently received more than $396,000 in Pandemic Unemployment Assistance benefits by falsifying their applications and failing to disclose their employment and wages earned at VA. The Ohio Department of Job and Family Services paid these benefits, which were funded through the CARES Act. Nine former and three current employees pleaded guilty in Cuyahoga County (Ohio) Court to theft after previously being indicted on charges of theft and tampering with government records, and another former employee entered into a pretrial diversion agreement. The three current VA employees mentioned above retained their VA employment after pleading guilty to a misdemeanor theft charge and serving work suspensions between 15 and 30 days. The VA OIG, DOL OIG, and US Postal Inspection Service conducted this investigation.

BEDFORD VA MEDICAL CENTER PHYSICIAN ARRESTED FOR CHILD PORNOGRAPHY OFFENSES

An investigation by the VA OIG, VA Police Service, and FBI resulted in charges alleging that a physician at the Bedford VA Medical Center in Massachusetts uploaded and stored child pornography on several devices, including a cellular telephone that he kept in his VA office. The physician was arrested and charged in the District of Massachusetts with the receipt and possession of child pornography.

ADMINISTRATIVE INVESTIGATIONS

OI conducts administrative investigations and other reviews involving allegations of misconduct or gross mismanagement that implicate senior VA officials or significantly affect VA programs and offices. Such work may also examine issues of ethics, egregious waste of funds, and the effectiveness of VA programs and operations. The IG Act requires disclosure of any investigation involving substantiated allegations of misconduct by senior government employees or officials.[6] The summaries that follow discuss the results of two such administrative investigations completed this period.

[6] 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

FORMER ORLANDO VA MEDICAL CENTER EXECUTIVE VIOLATED ETHICS RULES

An OIG administrative investigation of alleged ethics violations by the former deputy director of the Orlando VA Medical Center in Florida found that Tracy Skala violated federal government ethics rules. On multiple occasions, she used her public office to promote VA procurement of navigation software from her son's employer (without disclosing their relationship) for veterans to use at her facility and VISN-wide, knowing her son could receive bonus pay for a new contract. Her conduct reflected an apparent conflict of interest. The OIG also noted that although Ms. Skala informed VA she received a critical skills incentive payment of more than $32,000, VA had not initiated the process to recover any debt from her retirement in April 2024—before her term of service had been completed. Because Ms. Skala retired, the OIG made no recommendations regarding her conduct. Three recommendations involved addressing potential conflicts before vendor presentations and recovering critical skill incentive debts. The OIG referred the allegations to the US Attorney's Office for the Middle District of Florida on April 19, 2023, and the office declined to pursue a criminal investigation on the same date.

FORMER ACQUISITION ACADEMY EXECUTIVE VIOLATED ETHICAL STANDARDS AND VA POLICY

The VA OIG investigated allegations that Judith Dawson, the chancellor of the VA Acquisition Academy, engaged in misconduct in connection with an August 2023 training symposium held at a conference center hotel in Aurora, Colorado. The VA OIG found that Ms. Dawson accepted gifts from the conference center and failed to disclose them on her 2023 public financial disclosure as required. She also directed VA staff to solicit and accept sponsorships for social events held during the symposium and discouraged her executive assistant from asking questions or seeking guidance regarding possible ethics violations. The VA OIG recommended that VA consider whether additional training is necessary regarding sponsorships for VA events, acceptance of free meals, and whether VA ethics officials need to take additional steps regarding the then chancellor's 2023 public financial disclosure. VA concurred and provided acceptable responses to the VA OIG's recommendations. The OIG referred the allegations to the US Attorney's Office for the District of Maryland on October 23, 2024, and the office declined to pursue a criminal investigation on the same date.

Read more criminal investigative updates on the OIG website.

The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) released 41 publications summarizing results from its oversight work during this reporting period. These reports included 152 recommendations for corrective actions and identified a potential monetary impact of more than $2.5 billion for VA.

In addition, OAE teams conducted 54 preaward and postaward contract audits to help VA obtain fair and reasonable pricing on products and services, as well as ensure that contractors comply with the terms of their contracts.[7] These audits resulted in 73 recommendations, identified nearly $698 million in potential cost savings, and positioned VA to recover more than $1.5 million in overcharges. Altogether, the total monetary impact of OAE's work this period exceeded $3.2 billion.

In support of OAE's efforts to improve the well-being of veterans and their families, staff conducted audits and reviews to recommend improvements in the following areas:

- Veterans' access to health care and how it is coordinated between VA and community care providers
- Veterans' receipt of benefits and services to which they are entitled
- VA's financial stewardship of taxpayer dollars and its supporting systems and infrastructure

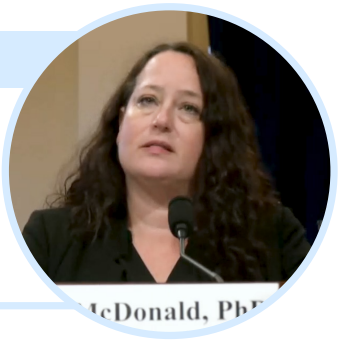
OAE's ongoing oversight of community care has helped VA improve program management and the continuity of care for veterans. For example, the Veterans Health Administration (VHA) has developed a process that is responsive to OIG recommendations to improve the accuracy of Community Care Network provider information. It has also delivered training for staff to more accurately and consistently determine veterans' eligibility for requested mental health care in the community. OAE's community care oversight work continues to inform the veteran community and Congress of systems issues that put the program's integrity at risk. In June, the director of OAE's community care division testified before a House subcommittee on the impact of VA's pause of the Program Integrity Tool, an IT system critical for billing veterans and insurers as well as detecting fraud, waste, and abuse in community care. The

[7] Preaward and postaward reports are submitted only to VA. They 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. The reports are also exempt from mandatory public disclosure under the Freedom of Information Act, 5 U.S.C. § 552. Information on contractor proposals are also protected from disclosure by 41 U.S.C. § 4702. To improve transparency, the OIG does publish summaries of these reports.

pause resulted in some veterans receiving bills more than a year old and approximately $665.5 million in Revenue Operations collections was in arrears. VHA has since restored the tool's revenue collection functionality and is rebuilding its fraud-detection capabilities while upgrading servers and data logic.

CONGRESSIONAL TESTIMONY

Legislative Hearing | Jennifer McDonald, Director, Community Care Division, Office of Audits and Evaluations testifies before the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations on June 11, 2025.



OAE has also continued its oversight of a broad range of services to help eligible veterans receive timely and accurate benefits. For example, one report found that pension automation did not always identify transportation costs related to burial expenses.[8] The automation system did not include the proper rules to identify and process those costs. The Veterans Benefits Administration (VBA) has since taken corrective action to make certain that automation of transportation reimbursements follows established procedures. Another report focused on fiduciaries assigned to protect those unable to manage their own VA benefits.[9] In response, VBA updated its written procedures and quality review process to ensure staff flag individuals and entities barred from serving as a VA fiduciary.

OAE work also focused on addressing system-wide deficiencies to position VA to spend taxpayer dollars judiciously. The OIG provided statements to Congress on how to reduce VA's improper compensation and pension payments and tighten controls over the Veteran Readiness and Employment (VR&E) program, which was found to be at risk for fraudulent activities.[10] In other areas, OAE reports examined VHA's use of incentives to help recruit for hard-to-fill positions and retain high-quality staff who may otherwise leave.[11] The director of OAE's human capital and operations division testified before Congress on VHA's insufficient governance and controls of the incentive payments.[12] VHA has begun correcting these issues, including

[8] VA OIG, *Delays in Pension Automation Updates Led to Some Burial Transportation Benefits Being Incorrectly Processed*, Report No. 24-02430-152, July 15, 2025.

[9] VA OIG, *Failure to Flag Fiduciaries Who Were Removed Results in Risk to Vulnerable Beneficiaries*, Report No. 24-01322-103, May 29, 2025.

[10] Waste & Delays: Examining VA's Improper Payments in its Compensation and Pension Programs, Before the House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs, 119th Cong. (May 14, 2025) (statement of Brent Arronte, Deputy Assistant Inspector General for the Office of Audits and Evaluations, VA Office of Inspector General); Hearing on Path of Purpose: Restoring the VA VR&E Program to Effectively Serve Veterans, Before the House Committee on Veterans' Affairs Subcommittee on Economic Opportunity Committee, 119th Cong. (July 16, 2025) (statement of the VA Office of Inspector General).

[11] See, e.g., VA OIG, *Recruitment, Relocation, and Retention Incentives for VHA Positions Need Improved Oversight*, Report No. 23-01695-94, June 12, 2025; VA OIG, *VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives*, Report No. 23-03773-169, May 9, 2024.

[12] Counting the Money: Preventing Fraud and Abuse in VA's Bonus Payment Practices for VA Employees, Before the House Committee on Veterans' Affairs (HVAC) Subcommittee on Oversight and Investigations, 119th Cong. (July 22, 2025) (statement of Shawn Steele, Director of Human Capital and Operations, Office of Audits and Evaluations, VA Office of Inspector General).

monitoring incentives through internal audits and working to terminate and recoup funds paid after the incentive expired.

During this reporting period, VA has taken adequate measures to close over 100 OIG recommendations. These include enhancements to funds management controls and reporting, communications on annual fund management, oversight of contractor performance, inventory management practices, protections for veterans' sensitive information, oversight of special-authorization drug prescriptions, and guidance to improve the accuracy of claims processing. OAE met regularly with VA leaders to discuss issues such as community care, electronic health record modernization, benefits delivery, supply chain management, and VA's financial statements.

CONGRESSIONAL TESTIMONY

Counting the Money: Preventing Fraud and Abuse in VA's Bonus Payment Practices for VA Employees | Shawn Steele, Director, Human Capital and Operations, testifies before the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations on July 22, 2025.

To increase efficiency and ensure OIG recommendations drive positive change, OAE works across OIG directorates to share information and leverage in-house expertise. During the six-month reporting period, audit staff worked closely with OIG healthcare personnel on a report detailing the risks for drug diversion posed by automated pharmacy dispensing cabinets and calling for better monitoring.[13] An Office of Healthcare Inspections pharmacist and a physician were embedded with the audit team to ensure the report's accuracy and provide clinical expertise. OAE staff also assist the Office of Investigations by sharing their knowledge of systems and programs at risk of fraud, as well as offering their technical expertise on contracts and benefit claims. Most of OAE's projects rely on partnerships with the OIG's Office of Data Analytics to ensure teams have the necessary data to effectively analyze programs and to develop tools and dashboards that promote efficiencies.

These and other OAE oversight efforts result in changes in VA that improve the lives of veterans and their families. The following publications exemplify OAE's efforts to help VA improve its operations and services to the veteran community. All published OAE reports and other products are listed in **Investigations and Reports** section and OIG website.

FEATURED REPORTS

CONCERNS ABOUT THE COST, DURATION, AND QUALITY OF COMMUNITY RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT FOR VETERANS

The OIG issued this memorandum to help VHA determine whether additional actions are needed to address significant cost concerns and potential issues about patients' length of stay, as well as the quality

[13] VA OIG, *Pharmacy Automated Dispensing Cabinets Need Improved Monitoring for Accountability over High-Risk Medications*, Report No. 24-00765-184, August 20, 2025.

of care for residential substance use disorder treatment provided under community care contracts with two third-party administrators (TPAs). The OIG found the contracts do not require community providers to use designated billing codes, which could lead to VHA overpaying providers for these services. Though VHA has amended the contract for one TPA, negotiations are ongoing with the other; until changes are made, overpayments will continue to the second TPA—which were over $268 million for FYs 2023 and 2024 combined. The OIG also noted that lax oversight of the TPAs could lead to VHA also paying too much for these clinical services because TPAs may bill for unnecessary treatment that could lengthen the time a veteran receives care. Further, the OIG expressed concern about the quality of residential substance use disorder treatment veterans receive in the community and suggested greater oversight could safeguard the care veterans receive while mitigating financial risk. While VHA has taken steps to create a new payment policy and has completed a contract modification with the first TPA to clarify the use of billing codes, VHA should apply those changes to current and future contracts and monitor whether these changes control costs. The OIG also suggested VHA consider consulting with mental health staff at authorizing VA facilities for feedback on improving the care veterans receive in the community for these services.

BETTER CONTROLS NEEDED TO ACCURATELY DETERMINE DECISIONS FOR VETERANS' NONPRESUMPTIVE CONDITIONS INVOLVING TOXIC EXPOSURE UNDER THE PACT ACT

In August 2022, the PACT Act significantly expanded veterans' eligibility for benefits and services for conditions related to toxic exposure. The expansion added further complexity to VBA's claims determination process, particularly given the voluminous guidance issued for nonpresumptive conditions—those conditions for which service connection cannot be granted on a presumptive basis. Notably, the law opened a new path for service connection for veterans with nonpresumptive conditions related to toxic exposure risk activity (TERA). The VA OIG conducted this review from October 2023 through May 2025 to determine whether VBA staff processed decisions in compliance with TERA procedures under the PACT Act that denied nonpresumptive conditions. The OIG focused on denials because of the potential impact of incorrect decisions on benefits received by veterans.

CONGRESSIONAL TESTIMONY

Waste & Delays: Examining VA's Improper Payments in its Compensation and Pension Programs | Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testifies before the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs on May 14, 2025.

The review found VBA's oversight lagged in ensuring accurate processing of nonpresumptive conditions under the PACT Act. While VBA took steps to improve PACT Act claims processing, these efforts have not remedied the problem of various inaccuracies related to nonpresumptive conditions. An OIG statistical analysis estimated 61 percent of all nonpresumptive, TERA-related decisions under the PACT Act that VBA denied from May 1 through August 31, 2023, had processing errors—some of which could have affected veterans' benefits . For example, some errors showed that claims processors did not accurately identify toxic exposure claims, research and verify veterans' participation in a TERA, request a medical exam and opinion regarding toxic exposure, or appropriately include key information in decisions for nonpresumptive conditions. Furthermore, PACT

Act guidance is difficult for staff to navigate because it is frequently updated and spread among several different sources. VBA needs to improve its oversight to mitigate and prevent inconsistencies and errors. VBA concurred with the OIG's three recommendations to correct processing errors, consolidate guidance, and evaluate controls.

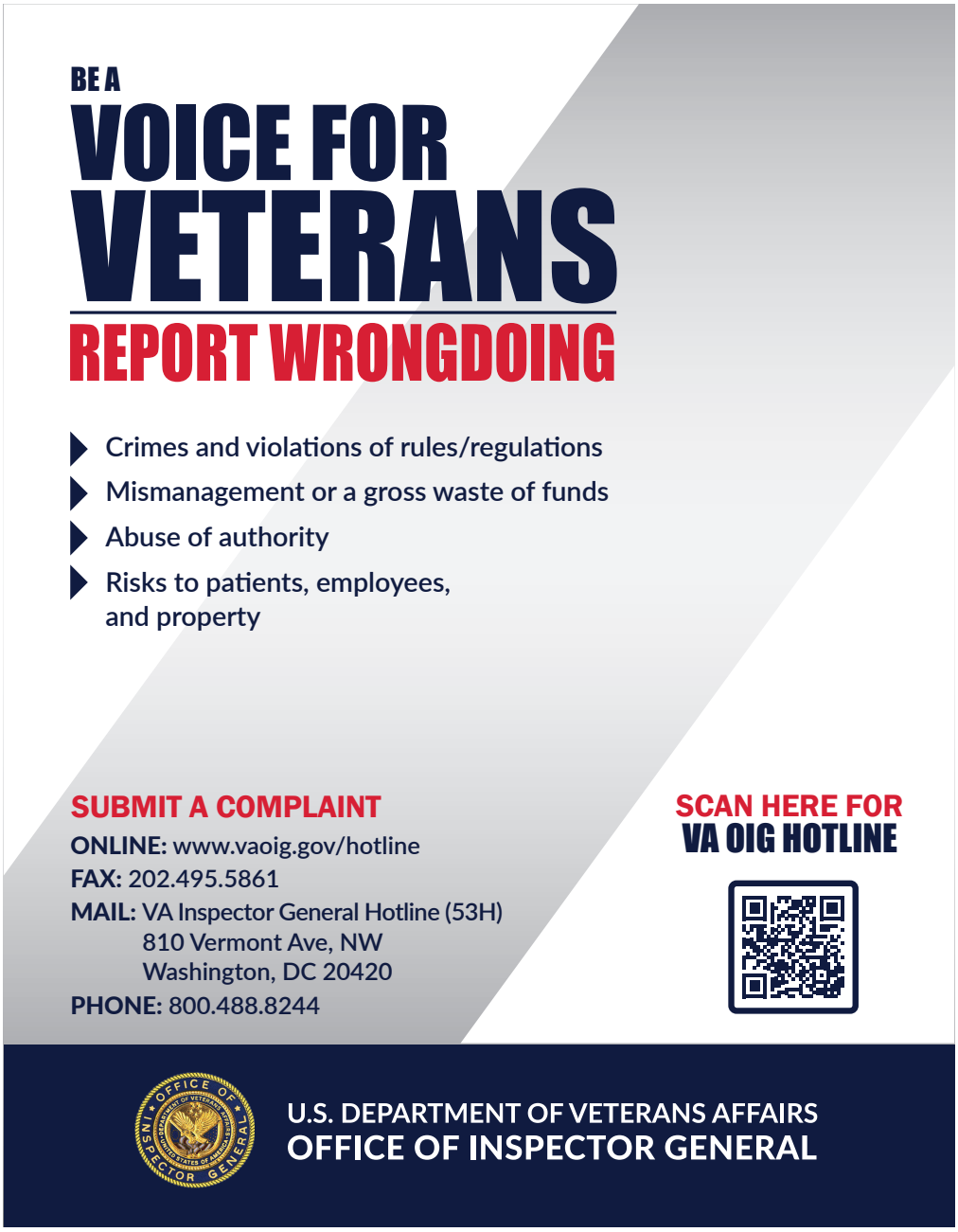
VA NEEDS TO PRIORITIZE ACCESSIBILITY FOR INDIVIDUALS WITH DISABILITIES WHEN PROCURING INFORMATION TECHNOLOGY SYSTEMS

To comply with Section 508 of the Rehabilitation Act of 1973, VA must make the information and communication technology it uses accessible to veterans with disabilities and anyone else seeking VA information. The OIG conducted this audit to follow up on a 2024 report on areas where VA's implementation and monitoring of Section 508 requirements could be improved and to evaluate whether the procurement process for information and communication technology meets Section 508 standards. The OIG team sampled 30 critical information technology and communications systems for review. The team did not independently verify compliance with Section 508 standards and relied on self-reporting by VA to assess progress and deficiencies. Of the 30 systems, VA's Office of 508 Compliance classified only four as compliant. The OIG concluded that VA officials did not ensure the sampled information technology systems they procured would meet the accessibility standards required by law. The team also reviewed contract documentation for the 30 systems and found contracting officers and the designated officials for VA program offices did market research on vendors that could meet business requirements, but they took no additional action to verify that sampled systems were accessible to individuals with disabilities. The OIG made four recommendations, including that the assistant secretary for information and technology ensure staff receive training and updated guidance on their roles and responsibilities. VA should also ensure the Office of 508 Compliance receives complete market research showing the technology VA seeks to procure is the most compliant under Section 508. The OIG also recommended the deputy assistant secretary for acquisition and logistics develop policies for ensuring information and communications technology procurements comply with Section 508.

WEAK GOVERNANCE THREATENS THE VIABILITY OF A MAJOR CONSTRUCTION PROJECT AT THE PALO ALTO VA MEDICAL CENTER IN CALIFORNIA

In its FY 2009 budget request, VA identified the need for the Palo Alto major construction project to improve seismic safety at the Palo Alto Health Care System. The planned construction project would also provide ambulatory and polytrauma care. Over the next 15 years, the project's cost and timeline increased. The review team evaluated the significant events that led to cost increases, schedule slippages, and scope changes for the major construction project. The OIG found VA still has not achieved two of its three critical project objectives and is more than 21 years behind its original schedule. As of February 2025, about $458.8 million had been spent on the project. Furthermore, because VA did not provide adequate justification for a significant scope increase proposed in the FY 2012 budget, the OIG questioned the expenditure of about $716.6 million. To proceed with the project, VA will need about $1.6 billion. Cost increases and delays occurred because VA did not have adequate formal procedures for governing major construction projects from 2009 to 2017. The OIG could not obtain evidence that the Palo Alto project was ever added to the Acquisition Program Management Framework, as required. VA must consider whether

it is worth continuing the project or canceling efforts to complete it. Should VA be unable to justify the business need to continue funding the project, the OIG determined taxpayers could save about $907.8 million. VA concurred with all four of the OIG's recommendations, which included revising VA's FY 2025 Agency Capital Plan to show the Palo Alto project's total estimated cost and progress (which is closed as of mid-September).



The Office of Healthcare Inspections

Drawing on the expertise of physicians, nurses, social workers, pharmacists, and other healthcare professionals, the Office of Healthcare Inspections (OHI) continues to play a vital role in providing oversight and increasing accountability across VA's diverse healthcare programs. Through a variety of inspection tools and products, OHI equips VA leaders and stakeholders with a thorough understanding of the challenges that can impede the Veterans Health Administration (VHA) mission to deliver high-quality patient care.

OHI conducts planned cyclical inspections of VA medical facilities, vet centers, and inpatient mental health programs to assess the quality and safety of patient care, the environment of care, staffing, and administrative operations. Staff also perform for-cause inspections in response to reported allegations or concerns about practices that put patients at risk, violate policy, or undermine program integrity. Both types of inspections often uncover deficiencies in patient care and operational processes that VA agrees to address by implementing OIG recommendations for corrective action. Although focused on a specific site, inspection findings can be broadly applied by other facilities looking to proactively identify and address potential vulnerabilities.

The office's healthcare specialists also complete national reviews and special projects that focus on system-wide initiatives and high-risk areas affecting vulnerable veteran populations. These focused reviews often lead to system-level changes across VA. In addition to the homeless program publication highlighted on page 30, other national reviews published this reporting period included examinations of VHA's oncology program, medical facility staffing, and suicide risk screening.[14]

Through their work, OHI inspectors investigate the underlying causes of identified problems. Their findings are used to generate actionable recommendations to enhance healthcare delivery and patient safety. OHI's work serves as a catalyst for sustained improvements. OHI recommendations have consistently informed action plans developed by facility, regional, and national leaders to address a wide range of challenges—from community care coordination to quality assurance, executive decision-making, infrastructure, and resources.

[14] VA OIG, *Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight*, Report No. 24-01618-198, August 14, 2025; VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages, Fiscal Year 2025*, Report No. 25-01135-196, August 12, 2025; VA OIG, *Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes*, Report No. 23-02507-210, September 11, 2025.

This reporting period, several OHI reports highlighted knowledge and training gaps, including suicide prevention training, that could negatively affect patient care.[15] In some cases, these lapses have left patients without care when they needed it most. In one case, staff unfamiliar with crisis management protocols failed to intervene when a patient posed a danger to themselves and others, resulting in a risk of harm. In response, the district director committed to delivering appropriate training for both leaders and staff.[16] In another instance, administrative and clinical staff provided incorrect information about a patient's eligibility to receive VA care, resulting in the veteran, who was eligible for care, having needed treatment withheld and being prematurely discharged.[17] The facility director pledged to properly train staff on eligibility criteria and processes.

OHI has also reported on the difficulties of integrating community care with VA services. The shortcomings have led to patients receiving fragmented and delayed care. These findings prompted Veterans Integrated Service Network (VISN) interventions to ensure facility leaders assess community care staffing needs, and their staff seek documentation from community providers, track adverse patient safety events, and facilitate the continuity of veterans' care.[18]

Following a team's identification of noncompliance with VHA's provider privileging and evaluation policies, facility leaders agreed to review and align practices with policies to prevent the types of mistakes disclosed in the teams' oversight reports. In one case, a physician delivered intensive care services without appropriate privileges.[19] In another, facility leaders did not thoroughly investigate reported concerns about a provider's deficient practices and did not take follow-up actions.[20]

Some OHI findings at individual facilities have led to national changes. For instance, after a finding that a provider did not receive timely diagnostic results from a community provider, the Under Secretary for Health committed to establishing and monitoring a process to make certain that urgent abnormal

[15] VA OIG, *Inspection of Select Vet Centers in Midwest District 3 Zone 2*, Report No. 24-00394-122, May 27, 2025; VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, Report No. 24-01862-151, June 26, 2025.

[16] VA OIG, *Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington*, Report No. 24-02690-167, July 17, 2025.

[17] VA OIG, *Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque*, Report No. 24-02059-177, July 31, 2025.

[18] VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 4: VA Healthcare*, Report No. 2400825-176, July 30, 2025; VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan*, Report No. 24-00824-174, July 29, 2025.

[19] VA OIG, *Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, Report No. 24-01566-100, April 24, 2025.

[20] VA OIG, *Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas*, Report No. 24-00193-186, August 6, 2025; VA OIG, *Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, Report No. 25-00400-189, August 20, 2025.

test results are promptly communicated to ordering VA providers.[21] The Under Secretary has directly intervened in response to other OHI-identified problems as well. After a cyclical inspection revealed numerous issues at one facility, the Under Secretary for Health agreed to review the facility and VISN leaders' actions and directed the VHA Office of Quality and Patient Safety to assess the facility's quality management.[22] Following a national review on VHA oncology programs, the Under Secretary also agreed to ensure the establishment of VISN- and facility-level multidisciplinary cancer committees, as well as requiring oversight of oncology program implementation.[23]

OHI continues to be a driving force in strengthening the quality, safety, and accountability of VA health care. Through its comprehensive inspections, targeted reviews, and in-depth analyses, OHI not only identifies deficiencies but also fosters meaningful, system-wide advancements. This reporting period, OHI closed more than 150 recommendations after VA submitted evidence of sustained improvements. OHI's recommendations have led to enhanced training, better integration of community care, stronger oversight mechanisms, and national process changes—all aimed at securing safe, timely, and high-quality care for veterans.

NATIONAL HEALTHCARE REVIEWS

The three national healthcare reviews published during this reporting period address key issues, including deficiencies in homeless program intake documentation, suicide risk assessment, and care coordination processes; inconsistent implementation of oncology program requirements due to insufficient oversight; and an annual evaluation of VHA's top occupational staffing challenges. One example follows:

DEFICIENCIES IN VA HOMELESS PROGRAM INTAKE DOCUMENTATION, SUICIDE RISK ASSESSMENT, AND CARE COORDINATION PROCESSES

OHI completed a national review to examine the alignment of information on mental health, substance use disorder (SUD), and suicide risk treatment needs found in VHA's Homeless Operations Management and

[21] VA OIG, *Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth*, Report No. 24-00990-99, April 17, 2025.

[22] VA OIG, *Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00617-118, May 22, 2025.

[23] VA OIG, *Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight*, Report No. 24-01618-198, August 14, 2025.

Evaluation System (HOMES) with the related electronic health record (EHR). The OIG also assessed the homeless program staff's adherence to suicide risk screening procedures and care coordination. The OIG determined that staff for the homeless program did not document the HOMES Assessment in 42 percent of patients' EHRs, which limited access to important clinical information by clinicians outside of VA homeless programs. In contrast, the OIG found that 85 percent of patient EHRs did include a suicide risk screening at the time of the HOMES Assessment or in the 30 days prior, as required. VHA had not implemented processes, however, to ensure that staff completed the required suicide risk procedures, including risk mitigation, in response to HOMES-identified risk of self-harm. Program staff also did not document care coordination as outlined in policy. The OIG found that only 35 percent of patients with HOMES-identified treatment needs, who were interested in participating in treatment, had EHR documentation of care coordination related to those needs. VHA homeless program strategic goals include coordinating care to address veterans' mental health and SUD needs, yet VHA had not delineated responsibility for ensuring care coordination, resulting in a lack of oversight and increased risk of patients not having those treatment needs met. VA submitted action plans to implement the September 2025 report's four recommendations. The recommendations address consistent EHR documentation of HOMES clinical information, suicide risk screening at intake, suicide risk screening in response to danger of self-harm identified in the HOMES Assessment, and documentation of mental health and SUD care coordination.

HEALTHCARE INSPECTIONS

These for-cause inspections (including those referred to as "hotline inspections" in previous semiannual reports to Congress) assess allegations pertaining to VA medical care that are made by patients or their families, VA employees, members of Congress, and other stakeholders. Of the 12 inspections published during the second half of FY 2025, the two summaries below highlight weaknesses in VHA oversight, systems, and processes.

DEFICIENCIES IN CARE AT THE BATAVIA COMMUNITY LIVING CENTER CONTRIBUTED TO A RESIDENT'S DEATH AT THE VA WESTERN NEW YORK HEALTHCARE SYSTEM IN BUFFALO

An OHI team conducted a healthcare inspection related to the care of a resident at the Batavia community living center (CLC), which is part of the VA Western New York Healthcare System (system). In late winter 2024, Resident A was admitted to the Buffalo VA Medical Center for combativeness, agitation, and confusion. After the resident's dementia-related behaviors were controlled, the resident was admitted to the Batavia CLC and received 21 doses of injectable antipsychotic medications throughout the 23-day stay. On CLC day 20, the resident's elevated fingerstick blood sugar level was not reported to a physician for treatment and on CLC day 23, the level was more than four times the system's upper limit of normal. The resident was admitted to a community hospital, then hospice at the Buffalo VA Medical Center, and died shortly thereafter.

The OIG substantiated that ongoing and cumulative deficiencies may have contributed to the resident's preventable decline in health, which necessitated end-of-life care. These lapses included (1) physician and nursing staff mismanagement of Resident A's dementia and diabetes and (2) inadequate nursing

documentation of medication administration and nutritional intake. The team also discovered similar deficiencies in care for a second resident.

CLC leaders did not submit patient safety reports, provide oversight of nursing care, or consider disclosure upon awareness of adverse events in Resident A's care. However, system leaders identified the need for and conducted an institutional disclosure; temporarily removed the chief geriatric physician from providing care; and initiated clinical and administrative investigations once aware of concerns with Resident A's care. Additional identified shortcomings relate to provider staffing and nurse education, which increase risks to patient safety and may have contributed to Resident A's functional decline. VA concurred with the OIG's 10 recommendations to the System Director regarding dementia and diabetes care, quality assurance performance improvement, and a focused review of the chief geriatric physician's care.

DELAYED DIAGNOSIS AND TREATMENT FOR A PATIENT'S LUNG CANCER AND DEFICIENCIES IN THE LUNG CANCER SCREENING PROGRAM AT THE VA EASTERN KANSAS HEALTHCARE SYSTEM IN TOPEKA AND LEAVENWORTH

This healthcare inspection evaluated allegations related to a patient's care and the lung cancer screening (LCS) program at the VA Eastern Kansas Healthcare System (system) in Topeka and Leavenworth. The OIG substantiated that the patient experienced a delay in the diagnosis of and treatment for lung cancer. Neither the patient aligned care team provider nor the system pulmonologist took the necessary steps to ensure a bronchoscopy was ordered and completed. The patient aligned care team provider ordered, but did not track, a positron emission tomography (PET) scan completed by a community provider. The provider also did not communicate the abnormal results to the patient and initiate clinical actions as indicated. System leaders conducted an institutional disclosure to the patient, but without the required details documented.

The April 2025 report details concerns related to the absence of an established process for community care providers to communicate abnormal test results directly to the system's ordering providers. Community care staff did not make timely, sufficient efforts to retrieve the patient's PET scan results. The OIG found pervasive failures regarding community care staff not making three attempts to retrieve patient records within 90 days of completed appointments, which leaders partially attributed to metrics that prioritized staff receiving and scheduling community care appointments. System and program leaders did not develop the LCS infrastructure prior to implementation. The LCS program lacked oversight, multidisciplinary engagement, policies, and adequate primary care training. Consequently, the OIG made one recommendation to the Under Secretary for Health on communicating patients' abnormal test results and one to the VISN director regarding the system's LCS program. The remaining four recommendations directed to the System Director related to test results, institutional disclosures, and community care records. VA agreed with the OIG recommendations and provided action plans for corrective action.

PROACTIVE, CYCLICAL INSPECTION PROGRAMS

CARE IN THE COMMUNITY HEALTHCARE INSPECTION PROGRAM

This program examines key clinical and administrative processes that are associated with providing quality VA and community care in the following domains: leadership and administration, diagnostic imaging results, administratively closed consults, provider requests for additional services, and care coordination (scheduling and communication with patients). The OIG published two care in the community healthcare inspection reports this period that evaluated VISNs 4 and 10. As VHA contends with expanding community care services, OHI's inspection program will continue to provide feedback to VISN leaders on indicators critical to the provision of safe, seamless, and coordinated care. Going forward, community care reviews will be added as a separate domain in all Healthcare Facility Inspection Program reports to allow for more frequent reporting.

MENTAL HEALTH INSPECTION PROGRAM

The Mental Health Inspection Program evaluates acute inpatient mental health care across six topic domains: leadership and organizational culture, high-reliability principles, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. During the reporting period, the OIG published two mental health inspection publications that evaluated the VA healthcare systems in Philadelphia, Pennsylvania, and Salem, Virginia.

CONGRESSIONAL TESTIMONY

Answering the Call: Examining VA's Mental Health Policies | Julie Kroviak, MD, Principal Deputy Assistant Inspector General, in the role of Acting Assistant Inspector General for Healthcare Inspections, testifies before the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations on April 30, 2025.

VET CENTER INSPECTION PROGRAM

Vet Center Inspection Program 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.

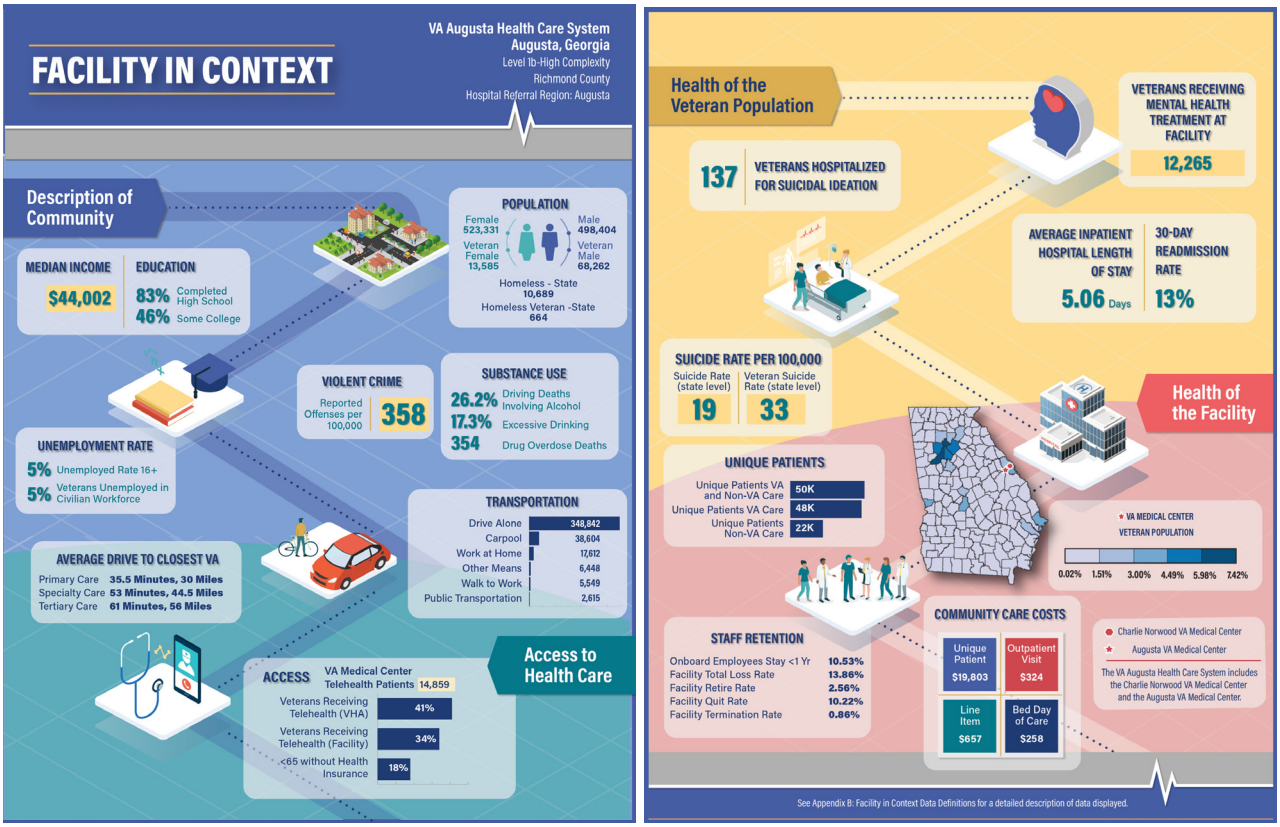
HEALTHCARE FACILITY INSPECTION PROGRAM

Healthcare Facility Inspection Program reports are based on inspections of VHA medical facilities on an approximately three-year cycle. They measure and assess the quality of care provided using five content domains: (1) culture, (2) environment of care, (3) patient safety, (4) primary care, and (5) veteran-

centered safety net (for vulnerable populations such as those served by homeless programs). The inspections incorporate VHA's high-reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff. The OIG published 23 healthcare facility inspection reports during the second half of FY 2025. One example follows:

HEALTHCARE FACILITY INSPECTION OF THE VA AUGUSTA HEALTH CARE SYSTEM IN GEORGIA

This report, released in May 2025, presents findings from interviews and a facility-wide questionnaire, through which the OIG learned of a threatening and abusive communication style among facility leaders, retaliation against employees who raised concerns, and a toxic workplace that led to a culture of fear and employees feeling psychologically unsafe. There were also continued supply chain management concerns, which were repeat findings from two prior OIG reports. In addition, there were inconsistent and low compliance rates for providers' communication of test results to patients, and leaders had not developed action plans to address the deficiencies. Based on the inspection team's findings, the OIG issued five recommendations for improvement in three domains to which VA concurred. The culture



Facility in Context (from *Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia*, May 22, 2025).

domain recommendations call on the Under Secretary for Health to evaluate facility leaders for appropriate supervisory behavior and professional communication, and to take needed actions. The Under Secretary also is asked to determine whether the VISN director and other leaders were aware of facility leaders' unprofessional behavior and communication, and to take any appropriate actions. The environment of care recommendation is to ensure the VISN and facility directors oversee the inventory management system and resolve medical supply deficiencies, as well as monitor actions for sustained improvement. Finally, for patient safety, the OIG recommended that facility leaders develop action plans to make certain that providers timely communicate test results to patients and that the under secretary directs the national VHA Quality and Patient Safety Program staff to review the facility's quality management program and determine whether actions by facility and VISN leaders addressed the system's patient safety issues, including nursing leaders' lack of access to safety reports, and missed opportunities for institutional disclosures, and to again take action as needed.

The Office of Management and Administration

The Office of Management and Administration (OMA) provides the structure and support needed to advance OIG operations and promote organizational effectiveness and efficiencies. In FY 2025, OMA delivered timely and reliable services to the OIG workforce of more than 1,000 employees and executed a budget of $296 million.

Throughout this reporting period and fiscal year, OMA remained committed to the timely implementation of new federal regulations as well as Executive and Presidential Orders, including ensuring compliance with new reporting requirements. These mandates cover a broad range of administrative programs and processes, such as return to in-person work, deferred resignation or early retirement, merit hiring, and space occupancy and utilization.

In implementing these changes along with an ongoing OIG reorganization to achieve greater efficiency, human resources (HR) personnel worked with offices across OIG to reconfigure staffing and transition remote staff to offices.[24] They also out-processed staff who opted to participate in the deferred resignation or early retirement programs as well as routine staff separations from the OIG. In addition, space and facilities staff worked with leaders to assess the OIG's real estate footprint and to ensure leased space makes the most effective use of resources while fostering productivity and collaboration. Numerous offices were redesigned to increase seating capacity and functionality. To accurately account for space utilization and occupancy, PIV (Personal Identity Verification) card readers were installed at applicable sites. The data will help drive future decisions related to office space as well.

This reporting period was marked with meaningful accomplishments from OMA's many other divisions and groups, including operations, procurement, information technology (IT) and security, and budget and finance. For example, during this reporting period staff completed OIG's inaugural IT strategic plan, which guides technological investments and initiatives for the next four years. An artificial intelligence (AI)

[24] Pursuant to its Agency Reduction in Force and Reorganization Plan, the OIG consolidated some supporting functions across the enterprise in FY 2025, such as healthcare data analytics, and discontinued the Office of Special Reviews as a standalone office. Remaining staff were assigned to other directorates with a smaller cohort of administrative investigators aligned under the Office of Investigations.

subcommittee was created that oversees the development of OIG-wide AI strategies and the compliance plan.

The hotline division continued to receive a high volume of complaints regarding VA programs, operations, and services. During this six-month reporting period, hotline staff screened 24,781 contacts from complainants and conducted a wide range of activities, such as the following:

- Directed complaints to OIG offices and directorates to determine if cases should be opened or other dispositions taken
- Referred 624 cases to appropriate VA offices or officials and required their written responses for OIG experts to review, after determining the allegations pertained to higher-risk topics but insufficient resources were available for OIG staff to complete a prompt independent review at that time
- Made 1,089 non-case referrals to the proper VA offices after concluding that the allegations related to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated
- Closed 431 cases for which 35 percent of allegations were substantiated, 342 administrative sanctions and corrective actions were taken, and $535,470 in monetary benefits were achieved
- Responded to 625 requests for senior personnel record reviews from VA staff offices prior to promotions, new jobs, and awards
- Issued 439 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

The OIG Hotline Division receives, triages, and coordinates action on complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse of authority, and major mismanagement of VA programs and operations. Matters not selected for immediate OIG review may be referred to VA to investigate and report back on its findings. VA has written policy to receive, review, document, and respond to OIG hotline case referrals.[25] OIG subject matter experts then assess VA's response for adequacy before either closing the case as sufficiently addressed or escalating it for possible OIG further action (especially if responses indicate there may be a systems-level problem) by one of the OIG's directorates.

This collaborative process between the OIG and VA enables a broader review of reported concerns, helping to ensure that as many critical issues as possible receive appropriate attention. It is a vital function that supports accountability, responsiveness, and the protection of veterans and other stakeholders who rely

[25] VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*, December 16, 2020.

on VA services. Highlighted below are three cases opened by the OIG's hotline that were not included in inspections, audits, investigations, or reviews by other directorates and did not result in a formal report.

VETERAN'S DEATH BY SUICIDE ALLEGEDLY TIED TO INADEQUATE MENTAL HEALTH CARE

Hotline staff received allegations that inadequate mental health care at the VA outpatient clinic in Pueblo, Colorado, contributed to a discharged veteran's death by suicide. They asked officials at the VA Eastern Colorado Health Care System in Aurora, Colorado, to review the matter and provide information back to the OIG. The VA medical center review substantiated the allegations and found the veteran's care team failed to review his available health history and there were significant delays in scheduling the veteran's mental health consult (referral). To address these failings, several actions were or are being taken: (1) facility medical providers were reeducated on requirements for reviewing the medical history for new patients and initiating or adjusting psychiatric medications; (2) mental health schedulers are being trained to document at least three outreach attempts and send a follow-up letter within 28 days of consult placement; and (3) facility administrators will regularly monitor processes for open consults to verify outreach attempts occurred, with regular audits for compliance.

LACK OF CLINICAL OVERSIGHT IN PALO ALTO VA MEDICAL CENTER'S HOME OXYGEN PROGRAM ALLEGEDLY POSES PATIENT RISK

The OIG hotline received allegations that the Palo Alto VA Medical Center's Home Oxygen Program lacked clinical oversight, posing a risk that the 197 enrolled patients would not have continued eligibility for prescriptions. The matter was referred to VISN 21 officials for review, who substantiated the allegations and found that the program did not comply with VHA directives. The VISN implemented 10 corrective actions, including assigning program clinical leaders, tasking the medical center's chief of prosthetics with reviewing and monitoring all FY 2025 audits, and initiating provider training.[26] The VISN also coordinated with facility clinical and prosthetics staff to create a proactive prescription-monitoring process.

ALLEGED DELAYS IN APPROVING COMMUNITY CARE REFERRALS

A complainant alleged that a veteran was not obtaining timely approvals for community care consults (referrals) at the Dallas VA Medical Center in Texas. Between October and November 2024, the veteran's Patient Aligned Care Team reportedly submitted multiple consults across several disciplines to community care providers in VA's network. The Mission Act of 2018 (a law designed to improve VA health care for veterans by expanding access to community care) requires primary and specialty care consults to be scheduled within 21 and 28 days, respectively. By December, the veteran had not yet received an appointment confirmation. The veteran contacted the medical center to resolve the scheduling delays and was unable to reach a community care representative by phone. The OIG hotline team referred the matter to higher-level leaders at to the Dallas VA Medical Center for further examination. Medical center officials substantiated the allegations and identified prevalent scheduling delays due to an increased number of referrals to community care providers. To address these delays, medical center officials implemented additional oversight measures, provided more training to current staff, and received approval to hire new

[26] VA Prosthetic and Sensory Aids Service provides home oxygen services.

staff. Through February 3, 2025, 31 community care consult schedulers were hired. The matter was closed in June 2025.

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	$1,816,234,521	$1,150,164,125	$2,966,398,646
Dollar Recoveries	$5,214,506	$2,229,514	$7,444,020
Fines, Penalties, Restitution, and Civil Judgments[27]	$489,026,137	$1,770,927,052	$2,259,953,189
Fugitive Felon Program	$40,759,851	$46,750,836	$87,510,687
Savings and Cost Avoidance	$18,775,358	$30,668,603	$49,443,961
Questioned Costs	$1,399,494,795	$253,951,245	$1,653,446,040
Total Dollar Impact	**$3,769,505,167**	**$3,254,691,375**	**$7,024,196,542**
Cost of OIG Operations[28]	$117,796,164	$117,936,539	$235,732,703
Return on Investment[29]	**$32:1**	**$28:1**	**$30:1**

[27] 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 date and amounts payable to all government entities, nongovernment entities, and private individuals as a result of these investigations. Of the total amount reported for this period and fiscal year, the monetary impact to VA is $72,303,617 and $983,682,377, respectively. This amount includes forfeited funds for which VA could submit a petition for remission.

[28] The six-month and fiscal year operating costs for OHI ($30,203,836 and $60,267,297, respecitvely), 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.

[29] 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	2	1	3
Audits and Reviews	36	14	50
Care in the Community Inspections	2	3	5
Financial Inspections	0	1	1
Healthcare Facility Inspections	23	14	37
Healthcare Inspections	12	10	22
Information Security Inspections	1	1	2
Mental Health Inspections	2	1	3
National Healthcare Reviews	3	7	10
Postaward Contract Audits*	27	2	29
Preaward Contract Audits*	27	28	55
Vet Center Inspections	3	1	4
Subtotal	**138**	**83**	**221**
OTHER PRODUCTS	**THIS PERIOD**	**LAST PERIOD**	**FISCAL YEAR**
Budget Request	0	1	1
Congressional Testimonies	5	4	9
Crime Alerts	2	2	4
Major Management Challenges	0	1	1
Management Advisory Memoranda	4	1	5
Monthly Highlights	6	6	12
Podcasts	7	4	11
Press Releases	2	0	2
Whistleblower Reprisal Investigation Memoranda*	0	1	1
Subtotal	**26**	**20**	**46**
Total	**164**	**103**	**267**

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

Table 3. Selected Office of Investigations Activities

TYPE[30]	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Arrests[31]	205	144	349
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	20	7	27
Indictments	149	104	253
Indictments and Informations Resulting from Prior Referrals to Authorities	91	42	133
Criminal Complaints	45	31	76
Convictions	116	137	253
Pretrial Diversions and Deferred Prosecutions	13	9	22
Case Referrals to the Department of Justice for Criminal Prosecution[32]	368	178	546
Case Referrals to State and Local Authorities for Criminal Prosecution[33]	80	52	132
Administrative Sanctions and Corrective Actions	170	196	366
Cases Opened	230	256	486
Cases Closed	301	213	514

[30] 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.

[31] During this reporting period, VA OIG agents apprehended 31 fugitive felons, bringing the fiscal year total to 41. This total does not include fugitive felon arrests made by other agencies with VA OIG assistance.

[32] 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.

[33] 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 Healthcare Inspections Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Clinical Consultations to Other VA OIG Offices	6	4	10
Clinical Consultations to Other Federal Entities	0	0	0
Hotline Referrals Reviewed	2,672	2,529	5,201

Table 5. Selected Hotline Division Activities

TYPE	THIS PERIOD	LAST PERIOD	FISCAL YEAR
Contacts	24,781	17,198	41,979
Cases Opened	624	649	1,273
Cases Closed	431	420	851
Administrative Sanctions and Corrective Actions	342	402	744
Substantiation of Allegations Percentage Rate	35%	42%	39%
Individuals Claiming Retaliation/ Seeking Whistleblower Protection	33	27	60
Individuals Provided Office of Special Counsel Contact Information	37	34	71
Individuals Provided Merit Systems Protection Board Contact Information	6	14	20
Individuals Provided Office of Resolution Management Contact Information	69	66	135

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MONTHLY HIGHLIGHTS

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

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.[34] 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.[35] The tables that follow identify OIG investigations and reports by type and date and include hyperlinks to their respective publications (when available).

Significant Criminal Investigations with Judicial Actions

Table 6 lists significant investigations that resulted in judicial action this reoprting period, with hyperlinks directing readers to the full case summaries as published in the VA OIG's Monthly Highlights. While the IG Act requires that federal inspectors general to report only on significant *closed* investigations, this table includes judicial actions from both *open and closed* criminal investigations to more accurately reflect the scope of the VA OIG's efforts during the period.

The IG Act also requires disclosure of any investigation involving *substantiated* allegations of misconduct by senior government employees or officials.[36] While the OIG has no such criminal investigations to report for this period, any future reports meeting this criterion will be marked with an asterisk (*) in the table. Two administrative investigations with substantiated allegations are detailed in OI's Highlighted Activities and Findings.

Additionally, the OIG closed one investigation with *unsubstantiated* allegations against a senior government employee, which is detailed in the Other Disclosures section under **Closed Work Not Disclosed to the Public**.

TABLE 6. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD

DATE	TITLE
VHA INVESTIGATIONS	
CHAMPVA, DRUG DIVERSION, AND OTHER HEALTHCARE FRAUD	
4/2/2025	National Sales Director for a Mobile Diagnostic Company Pleaded Guilty to Kickback Scheme
4/3/2025	Home Healthcare Company Owner Sentenced to Four Years in Prison for Healthcare Fraud and Tax Crimes

[34] 5 U.S.C. § 405(b)(2) and § 405(b)(3) (as amended by Pub. L. No. 117-263).

[35] 5 U.S.C. § 405(h) (as amended by Pub. L. No. 117-263).

[36] 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

TABLE 6. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
CHAMPVA, DRUG DIVERSION, AND OTHER HEALTHCARE FRAUD (CONTINUED)	
4/18/2025	National Chain Pharmacy Agrees to Pay Up to $350 Million for Illegally Filling Unlawful Opioid Prescriptions and for Submitting False Claims to the Federal Government
4/30/2025	Drug and Alcohol Rehabilitation Center Agreed to Pay $19.75 Million to Resolve False Claims Act Allegations
5/8/2025	Four Defendants Sentenced for Roles in $110 Million Healthcare Kickback Scheme
5/12/2025	Former Nurse at Texas VA Medical Center Indicted for Falsely Claiming She Had Checked on Patient that Ultimately Died
5/22/2025	Former Consulting Firm Senior Partner Sentenced for Obstruction of Justice
6/3/2025	Healthcare Software Company Chief Executive Officer Convicted of Billion-Dollar Fraud Conspiracy
6/5/2025	Medical Device Company Agreed to Pay $4.3 Million to Resolve Allegations of Overbilling for Products
6/10/2025	Regional Sales Director for a Mobile Diagnostic Company Pleaded Guilty to Kickback Scheme
6/16/2025	Doctor Pleads Guilty for Role in $445 Million Healthcare Fraud Scheme
6/25/2025	Former VA Subcontractor's Employee Sentenced for Illegally Accessing a Veteran's Medical Record
6/30/2025	Eleven Members of a Transnational Criminal Organization Indicted in Multi-Billion Dollar Healthcare Fraud and Money Laundering Scheme
7/14/2025	Former Home Health Aide Sentenced for Theft Scheme
8/8/2025	Physical Therapy Practice Employee Sentenced for Healthcare Fraud Conspiracy
8/14/2025	Former Nurse at Texas VA Medical Center Pleaded Guilty to Falsely Claiming She Had Checked on Patient that Ultimately Died
9/3/2025	Muskogee VA Medical Center Nurse Sentenced for Drug Diversion
BRIBERY, KICKBACKS, AND THEFT OF GOVERNMENT PROPERTY	
5/14/2025	Former Inventory Management Specialist at Tennessee VA Medical Center Sentenced for Stealing Dental Equipment

TABLE 6. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
BRIBERY, KICKBACKS, AND THEFT OF GOVERNMENT PROPERTY (CONTINUED)	
6/25/2025	Former Inventory Management Specialist at the Cleveland VA Medical Center and Coconspirator Indicted for Purchase Card Theft Scheme
8/5/2025	Two Former VA Employees and Two Surgical Sales Representatives Sentenced for Bribery Scheme
VBA INVESTIGATIONS	
THEFT OF GOVERNMENT FUNDS, FIDUCIARY FRAUD, AND LOAN GUARANTY FRAUD	
4/2/2025	Brother of Deceased Veteran Indicted for Theft of Government Benefits
5/7/2025	Disabled Veteran's Nephew Accused of Concealing Veteran's Death to Steal VA and Social Security Benefits
5/7/2025	Veteran Indicted for Alleged Compensation Benefits Fraud Scheme
5/13/2025	Former VA Fiduciary Indicted for False Statements
5/21/2025	San Juan VA Regional Office Supervisor, Seven Veterans, and Two Others Indicted in Connection with Disability Benefits Fraud Scheme
6/2/2025	Former Spouse of Veteran Sentenced to Prison for Improperly Claiming Surviving VA Spouse Benefits
6/10/2025	Charity Founder and Four Employees Indicted for Defrauding VA of Approximately $20 Million in VA Pension Benefits
6/18/2025	Veteran Sentenced for Fabricating Military Service to Receive VA Compensation Benefits
6/23/2025	Veteran Pleaded Guilty to VA Disability Compensation Benefits Fraud
7/11/2025	Family Members of Veteran Pleaded Guilty in Connection with Caregiving Services Fraud Scheme
7/14/2025	Brother of Deceased Veteran Pleaded Guilty to Theft of Government Benefits
7/24/2025	Veteran and Spouse Indicted in Connection with Compensation Benefits Fraud Scheme
8/11/2025	Former VA Fiduciary Charged with Stealing from Elderly Veterans
8/12/2025	Veteran Indicted on Theft and Fraud Charges Relating to Veterans Benefits and Federal Student Loans
8/20/2025	Son of Deceased VA Beneficiary Charged with Wire Fraud

TABLE 6. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
THEFT OF GOVERNMENT FUNDS, FIDUCIARY FRAUD, AND LOAN GUARANTY FRAUD (CONTINUED)	
8/21/2025	Veteran Indicted in Connection with a Compensation Benefits Fraud Scheme Was Arrested After Evading Law Enforcement for More than a Year
9/5/2025	Veteran Pleaded Guilty to Compensation Benefits Fraud Scheme
9/8/2025	Veteran Found Guilty at Trial of Aggravated Identity Theft
9/24/2025	Former VA Fiduciary and Spouse Indicted in Connection with Theft Scheme
9/25/2025	Son of Deceased VA Beneficiary Pleaded Guilty to Theft of Government Funds
9/26/2025	Defendant Arrested for the Murder of a Veteran and Subsequent Theft of Their VA Compensation Benefits
ILLEGAL RECEIPT OF GRATUITIES AND EDUCATION BENEFITS FRAUD	
4/4/2025	Former Scuba Diving School Owner Charged for Education Benefits Fraud
4/23/2025	Massage School Owner Pleaded Guilty in Connection with Education Benefits Fraud Scheme
4/30/2025	School Official Pleaded Guilty to $2.9 Million Scheme to Defraud VA's Education Programs
6/17/2025	School Official Sentenced for Defrauding VA's Post-9/11 GI Bill Program
6/18/2025	Former Scuba Diving School Owner Pleaded Guilty to Education Benefits Fraud
7/8/2025	Former VA Veterans Service Representative Pleaded Guilty to Federal Extortion, Bribery, and Witness Tampering Charges
7/14/2025	Another Former VA Veterans Service Representative Pleaded Guilty to Unlawfully Receiving Gratuities
7/17/2025	Six Charged in Conspiracy to Defraud Veterans and VA of Nearly $20 Million in GI Bill Benefits
8/18/2025	Owner of Dog Training School Pleaded Guilty to VA Post-9/11 GI Bill Program Fraud
9/10/2025	Four Individuals Connected to a House of Prayer Affiliate Indicted in Connection with Education Benefits Fraud Scheme
9/17/2025	School Official Sentenced in Connection with $2.9 Million Scheme to Defraud VA's Education Programs

TABLE 6. SIGNIFICANT CRIMINAL INVESTIGATIONS WITH JUDICIAL ACTIONS THIS PERIOD (CONTINUED)

DATE	TITLE
OTHER INVESTIGATIONS	
SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD, WORKERS' COMPENSATION BENEFITS FRAUD, AND FALSE CLAIMS	
7/15/2025	Former Philadelphia VA Medical Center Engineer Sentenced For Using Fictitious Company to Defraud VA
8/22/2025	Government Contractor Agreed to Pay $3.1 Million to Resolve False Claims Act Allegations
9/5/2025	Former CEO and Executive Director of a Nonprofit Corporation Serving as a Veterans' Homeless Shelter and Service Facility Pleaded Guilty to Federal Program Theft
FRAUD RELATED TO COVID-19	
4/21/2025	Twelve Employees at the Louis Stokes Cleveland VA Medical Center Pleaded Guilty to COVID-19 Fraud Scheme
5/14/2025	Defendant Pleaded Guilty for Role in Unemployment Insurance Fraud Scheme
5/23/2024	Defendant Sentenced for Fraudulently Obtaining Federal Pandemic Relief Loans for Multiple Businesses
5/29/2025	Another Owner of Defunct Business Sentenced for Fraudulently Obtaining Federal Pandemic Relief Loans
7/28/2025	Married Couple Sentenced for Fraudulently Obtaining CARES Act Funds
7/30/2025	Orlando VA Medical Center Employee Pleaded Guilty to COVID-19 Fraud Scheme
SEX-RELATED OFFENSES	
4/23/2025	Bedford VA Medical Center Physician Arrested for Child Pornography Offenses
THREATS AND ASSAULTS AGAINST VA EMPLOYEES	
5/3/2025	Veteran Charged for Threats Against a West Los Angeles VA Medical Center Employee
7/28/2025	Veteran Sentenced for Threatening a Mass Casualty Event

Reports and Other Products Issued This Reporting Period

Table 7 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.[37] 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.

Some OIG reports are precluded from public release pursuant to federal law.[38] Within table 7, these reports are marked with an asterisk (*). The IG Act also requires that semiannual reports disclose any reports involving substantiated allegations of misconduct by senior government employees or officials.[39] While the OIG has no such criminal investigations to report for this period, any future reports meeting this criterion will be marked with a dagger (†) in table 7.

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

[38] Preaward and postaward reports are submitted only to VA. They 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. The reports are also exempt from mandatory public disclosure under the Freedom of Information Act, 5 U.S.C. § 552. Information on contractor proposals are also protected from disclosure by 41 U.S.C. § 4702. To improve transparency, the OIG does publish summaries of these reports. Federal law prohibits OIGs from disclosing "any information from or about any person alleging the reprisal" except as needed to conduct its investigation, which exempts § 4712 investigation reports from public release.

[39] 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF AUDITS AND EVALUATIONS				
AUDITS AND REVIEWS				
4/3/2025	VHA Should Improve Monitoring of Underground Storage Tanks to Minimize Environmental and Health Risks at VA Medical Facilities	24-00295-49	–	–
4/8/2025	Independent Audit Report on a Transportation Company's Billing Practices Under a VA Healthcare System Contract	22-02369-48	–	$1,811,694
4/10/2025	A Prohibited Default in the Clinically Indicated Date Field Limited Some Veterans' Eligibility for Community Care at the Omaha VA Medical Center in Nebraska	24-02356-58	–	–
4/15/2025	Hiring of Claims Processors Generally Met Requirements and the Attrition Rate Remained Steady	23-02778-51	–	–
4/15/2025	The PACT Act Has Complicated Determining When Veterans' Benefits Payments Should Take Effect	24-01153-52	–	$20,400,000

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

TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
4/22/2025	Improper Sharing of Sensitive Information on Cloud-Based Collaborative Applications	24-01330-29	–	–
4/24/2025	Integrated Financial and Acquisition Management System Interface Development Process Needs Improvement	24-00645-84	–	–
5/21/2025	Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2024	24-03777-113	–	–
5/28/2025	Better Communication and Oversight Could Improve How the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program Manages Funds	24-00524-104	–	–
5/29/2025	Failure to Flag Fiduciaries Who Were Removed Results in Risk to Vulnerable Beneficiaries	24-01322-103	–	–
5/29/2025	VBA's Special Monthly Compensation Calculator in the Veterans Benefits Management System for Rating Did Not Always Produce Accurate Results	24-01083-112	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
6/12/2025	Recruitment, Relocation, and Retention Incentives for VHA Positions Need Improved Oversight	23-01695-94	–	$345,532,795 *($345,532,795 unsupported costs)*
6/18/2025	Federal Information Security Modernization Act Audit for Fiscal Year 2024	24-01233-90	–	–
7/1/2025	VA Needs to Prioritize Accessibility for Individuals with Disabilities When Procuring Information Technology Systems	24-02142-105	–	–
7/2/2025	A Summary of OIG Postaward Contract Reports Issued in Fiscal Years 2023 and 2024 on Vendors' Noncompliance with VA Federal Supply Schedule Contracts	25-00170-115	–	–
7/15/2025	Delays in Pension Automation Updates Led to Some Burial Transportation Benefits Being Incorrectly Processed	24-02430-152	–	$1,900,000
7/17/2025	A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2024 on VA Federal Supply Schedule Pharmaceutical Proposals	25-00295-134	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
7/22/2025	A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2024 on VA Federal Supply Schedule Nonpharmaceutical Proposals	25-00183-133	–	–
7/30/2025	Implementation of a Military Sexual Trauma Operations Center Resulted in Minimal Change Despite Planned Intent to Improve Claims-Processing Accuracy	24-01429-145	–	–
8/7/2025	Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records	24-02154-154	–	–
8/13/2025	VA Can Strengthen Appeals Processing and Tracking by Improving Caseflow Program Management	24-01457-114	–	–
8/20/2025	Pharmacy Automated Dispensing Cabinets Need Improved Monitoring for Accountability of High-Risk Medications	24-00765-184	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
8/21/2025	Independent Audit Report on Invoices Submitted by a Graduate Medical Education Affiliate to the VA Nebraska–Western Iowa Health Care System	23-02423-135	–	–
8/27/2025	VISN 12 Needs to Improve How It Administers the Veterans Community Care Program	24-01757-146	–	–
9/3/2025	Not All VA Disability Compensation Examiners Completed Training Before Providing PACT Act Medical Opinions	24-00758-138	–	–
9/4/2025	Improved Oversight of VHA's Nonexpendable Equipment Is Needed	24-01676-153	$210,900,000	–
9/4/2025	Facilities Need to Fully Implement VHA's Strategic Planning and Request Process for Nonexpendable Medical Equipment	24-02295-155	–	–
9/10/2025	Weak Governance Threatens the Viability of a Major Construction Project at the Palo Alto VA Medical Center in California	23-03189-148	$907,811,962	$716,600,000 *($716,600,000 unsupported costs)*

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
9/10/2025	The Emergency Department Construction Project at the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Texas, Did Not Follow VA and Industry Equipment Design Standards	24-00982-147	–	–
9/16/2025	Summary of Fiscal Year 2024 Preaward Audits for Healthcare Resource Proposals from Affiliates	25-00335-183	–	–
9/24/2025	Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians	24-03319-213	–	–
9/25/2025	Loma Linda Healthcare System's Oversight of Community-Based Outpatient Clinic Contracts Needs Strengthening	23-00324-170	–	–
9/26/2025	VHA Did Not Effectively Oversee the Use of Manual Journal Vouchers	25-00451-200	–	–
9/29/2025	Inadequate Oversight Allowed a Senior Benefits Representative to Inaccurately Authorize Thousands of Decisions	24-03608-203	–	$2,200,000

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
9/30/2025	Better Controls Needed to Accurately Determine Decisions for Veterans' Nonpresumptive Conditions Involving Toxic Exposure Under the PACT Act	23-03357-156	–	–
9/30/2025	The Accuracy of Veteran Readiness and Employment Claims Cannot Be Assessed Because of Insufficient Documentation	23-03328-197	–	$309,500,000 *($309,500,000 unsupported costs)*
INFORMATION SECURITY INSPECTION				
5/1/2025	Inspection of Information Security at the Battle Creek Healthcare System in Michigan	24-02575-50	–	–
MANAGEMENT ADVISORY MEMORANDUMS				
7/10/2025	VBA Did Not Take All Corrective Actions for Veterans Prematurely Denied Service Connection for Conditions That Could Be Associated with Burn Pit Exposure	24-03642-132	–	–
8/5/2025	VA's Compliance with the Statutory Transfer of Funds Authority and Change of Program Requirements During the Presidential Transition	25-01482-165	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MANAGEMENT ADVISORY MEMORANDUMS (CONTINUED)				
9/3/2025	Documentation Deficiencies for Electronic Health Record Interface Testing at the Lovell Federal Health Care Center in North Chicago	24-00682-187	—	—
9/17/2025	Concerns About the Cost, Duration, and Quality of Community Residential Substance Use Disorder Treatment for Veterans	25-00261-169	—	—
POSTAWARD CONTRACT AUDITS*				
4/1/2025	Independent Audit Report of Compliance Submitted Under a Contract	24-02842-85	—	$603,327
4/30/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01379-111	—	$9,690
5/9/2025	Independent Audit Report of Compliance Submitted Under a Contract	24-02748-108	—	$350,528
5/14/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01381-126	—	—
5/15/2025	Independent Audit Report of Compliance Submitted Under a Contract	24-03591-125	—	$15,831
5/19/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01377-130	—	$12,629

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS* (CONTINUED)				
5/21/2025	Independent Audit Report of Compliance Submitted Under a Contract	24-02610-116	–	$105,095
6/9/2025	Independent Audit Report of Compliance Submitted Under a Contract	24-01969-143	$1,209,805	–
6/10/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01029-140	$3,004,876	–
6/20/2025	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	24-03771-149	–	$132,835
6/20/2025	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	25-00032-120	–	–
6/24/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01369-158	–	–
6/27/2025	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	24-03772-159	–	$215,617
7/1/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01378-160	–	–
7/29/2025	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	25-00456-172	–	$14,035

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS* (CONTINUED)				
8/5/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02376-194	—	—
8/13/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02695-193	—	—
8/15/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02367-191	—	—
8/22/2025	Independent Audit Report of Compliance with Public Law Under a Contract	25-00035-190	—	$60
8/22/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02368-192	—	—
8/28/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02366-206	—	—
9/2/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02678-216	—	—
9/9/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02365-221	$854,776	—
9/12/2025	Independent Audit Report of Compliance Submitted Under a Contract	20-02374-220	—	—
9/18/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-00852-223	$2,095,792	—

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS* (CONTINUED)				
9/19/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-02750-233	–	–
9/25/2025	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	25-00706-217	–	$90,657
PREAWARD CONTRACT AUDITS*				
4/7/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01152-88	$8,622,743	–
4/9/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01233-102	$2,575,804	–
4/14/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-00530-101	$224,418	–
4/15/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01270-98	$1,286,946	–
4/29/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-00541-110	$23,841,005	–
5/6/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01574-109	$15,561	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS* (CONTINUED)				
5/9/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01929-107	$822,879	—
5/14/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-00754-128	—	—
6/2/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-00169-117	$4,388,835	—
6/3/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02218-131	$1,116,267	—
6/6/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-00738-127	—	—
7/1/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02628-166	$4,559,587	—
7/7/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02403-142	$2,646,671	—
7/8/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	24-01945-168	$548,422,103	—

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS* (CONTINUED)				
7/10/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02592-150	$13,184,626	–
7/15/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02591-173	$940,300	–
7/29/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02001-178	–	–
8/5/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01497-195	$4,588,504	–
8/15/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01999-201	–	–
8/22/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02081-209	$23,298,960	–
9/2/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01558-208	$987,400	–
9/11/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02994-207	$17,671,863	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS* (CONTINUED)				
9/12/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02138-224	$1,368,715	–
9/22/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02755-225	–	–
9/22/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02405-231	$828,602	–
9/23/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01841-218	$28,965,524	–
9/25/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-01749-222	–	–
OFFICE OF HEALTHCARE INSPECTIONS				
CARE IN THE COMMUNITY INSPECTIONS				
7/29/2025	Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan	24-00824-174	–	–
7/30/2025	Medical Facilities in VISN 4: VA Healthcare	24-00825-176	–	–
HEALTHCARE FACILITY INSPECTIONS				
4/1/2025	VA Memphis Healthcare System in Tennessee	24-00611-82	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE FACILITY INSPECTIONS (CONTINUED)				
4/3/2025	VA Bronx Healthcare System in New York	24-00598-91	–	–
4/10/2025	VA Western Colorado Healthcare System in Grand Junction	24-00595-93	–	–
5/20/2025	VA North Florida/South Georgia Veterans Health System in Gainesville	24-00604-121	–	–
5/22/2025	VA Augusta Health Care System in Georgia	24-00617-118	–	–
5/28/2025	VA Oklahoma City Healthcare System in Oklahoma	24-00596-129	–	–
6/3/2025	VA Puget Sound Health Care System in Seattle, Washington	24-00612-119	–	–
6/4/2025	VA Portland Health Care System in Oregon	24-00609-124	–	–
6/10/2025	VA St. Louis Healthcare System in Missouri	24-00600-136	–	–
6/12/2025	VA Atlanta Healthcare System in Decatur, Georgia	24-00606-137	–	–
6/17/2025	Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia	24-00616-139	–	–
7/9/2025	VA Connecticut Healthcare System in West Haven	24-00610-164	–	–
7/10/2025	VA Coatesville Healthcare System in Pennsylvania	24-03207-161	–	–
7/10/2025	VA Boston Healthcare System in Massachusetts	24-00613-162	–	–

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

TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE FACILITY INSPECTIONS (CONTINUED)				
7/10/2025	VA Health Care System in Wyoming	24-00615-163	–	–
8/6/2025	VA Central Ohio Health Care System in Columbus	24-00593-181	–	–
8/6/2025	VA Cincinnati Healthcare System in Ohio	24-00605-182	–	–
8/7/2025	VA Spokane Healthcare System in Washington	24-03417-188	–	–
8/21/2025	VA Texas Valley Coastal Bend Healthcare System in Harlingen	25-00189-199	–	–
9/9/2025	VA Jackson Healthcare System in Mississippi	25-00191-212	–	–
9/11/2025	VA Medical Center in Walla Walla, Washington	24-00599-202	–	–
9/11/2025	VA Alexandria Healthcare System in Pineville, Louisiana	24-03418-205	–	–
9/23/2025	VA Healthcare System in Florida	25-00190-226	–	–
HEALTHCARE INSPECTIONS				
4/17/2025	Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth	24-00990-99	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
4/24/2025	Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana	24-01566-100	–	–
5/21/2025	Deficiencies in Emergency Care for a Female Veteran at Martinsburg VA Medical Center in West Virginia	24-02359-123	–	–
7/2/2025	Deficiencies in Credentialing, Privileging, and Evaluations for Surgeons at the St. Cloud VA Medical Center in Minnesota	24-02806-157	–	–
7/16/2025	Care in the Community Deficiencies and Ineffective VISN Oversight at the VA Maryland Health Care System in Baltimore	24-02031-171	–	–
7/17/2025	Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington	24-02690-167	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
7/31/2025	Deficiencies in Care at the Batavia Community Living Center Contributed to a Resident's Death at the VA Western New York Healthcare System in Buffalo	24-02930-175	–	–
7/31/2025	Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque	24-02059-177	–	–
8/6/2025	Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas	24-00193-186	–	–
8/20/2025	Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana	25-00400-189	–	–
9/23/2025	Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina	24-02634-229	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
9/30/2025	Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens	24-01092-228	–	–
MENTAL HEALTH INSPECTIONS				
6/26/2025	VA Salem Healthcare System in Virginia	24-01861-144	–	–
6/26/2025	VA Philadelphia Healthcare System in Pennsylvania	24-01862-151	–	–
NATIONAL HEALTHCARE REVIEWS				
8/12/2025	OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2025	25-01135-196	–	–
8/14/2025	Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight	24-01618-198	–	–
9/11/2025	Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes	23-02507-210	–	–

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TABLE 7. REPORTS AND OTHER PRODUCTS ISSUED THIS PERIOD (CONTINUED)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
VET CENTER INSPECTIONS				
5/27/2025	Select Vet Centers in Midwest District 3 Zone 2	24-00394-122	–	–
8/5/2025	Select Vet Centers in Midwest District 3 Zone 3	24-00395-179	–	–
8/5/2025	Select Vet Centers in Midwest District 3 Zone 1	24-00393-180	–	–
OFFICE OF INVESTIGATIONS				
ADMINISTRATIVE INVESTIGATIONS				
5/1/2025	Former Orlando VA Medical Center Executive Violated Ethics Rules	23-02157-106	–	–
8/21/2025	Former Acquisition Academy Executive Violated Ethical Standards and VA Policy	23-03768-204	–	–
Total			**$1,816,234,521**	**$1,399,494,795** *($1,026,100,000 unsupported costs)*

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Note: Dollar figures may not sum due to rounding.

Follow-Up Process for OIG Recommendations

OMB Circular A-50, as revised, provides guidance to agencies and inspectors general to ensure timely resolution of recommendations, emphasizing that follow-up is an "integral part of effective management" and a "shared responsibility" between agency leadership and OIG officials.[40] Corrective actions are essential for managing risk and improving departmental operations. The circular requires agencies to establish processes for prompt resolution and implementation of OIG recommendations. The OIG's follow-up process is based on these principles.

When undertaking audits, inspections, and reviews, the OIG aims to identify improvements and ensure timely implementation. Draft reports are shared with VA management for comment, allowing them to respond and outline implementation plans. The goal is for all recommendations to be implemented within one year of the final report, with rare exceptions for extraordinary circumstances.

Beginning 90 calendar days after report issuance, and continuing quarterly thereafter, follow-up staff request status updates from the responsible VA office. These updates summarize actions taken during the preceding 90 days and indicate whether the office believes it has met the intent of any open recommendations and is requesting closure.

While OIG follow-up staff track and report on progress, the OIG team issuing the report must remain involved as subject matter experts and must concur in writing before a recommendation is closed. Closure decisions require documentation or independent verification—not just assertions. Moving into FY 2026, the OIG will implement a new follow-up process for open recommendations.

Unimplemented (Open) 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.[41] Table 8 identifies recommendations made prior to this reporting period that are open (unimplemented) as of September 30, 2025.

[40] OMB Revised Circular A-50, *Audit, Inspection, or Evaluation Follow-Up*, November 7, 2024.

[41] 5 U.S.C. § 405(b)(2) (as amended by Pub. L. 117-263).

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/28/2018	VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016	18-00474-300	1	–
12/13/2018	Inadequate Governance of the VA Police Program at Medical Facilities	17-01007-01	1	–
12/17/2019	Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance eporting for Eastern Area Medical Centers	17-03718-240	1, 7–8	–
2/10/2021	Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi	20-01036-70	2	–
2/25/2021	Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement	19-07053-51	6, 11	–
5/25/2021	Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03178-116	5	–
6/10/2021	Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency	20-00541-133	1–4	–
6/15/2021	Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs	20-01487-142	2	$129,700,000

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
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, 6, 8	–
7/7/2021	Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program	20-03185-151	2–6	–
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	–
9/23/2021	Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors	20-01802-234	2	$20,000,000
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	–
11/8/2021	Audit of VA's Compliance Under the DATA Act of 2014	20-04237-09	1, 3–4, 9	–
12/8/2021	VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services	20-01099-249	3	$341,700,000

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
12/8/2021	VHA Risks Overpaying Community Care Providers for Evaluation and Management Services	21-01807-251	1	$59,600,000
1/20/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020	21-01507-61	1–2, 4	—
2/17/2022	First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions	20-03086-70	2	—
2/17/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020	21-01506-76	3	—
3/17/2022	Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington	21-00781-108	3	—
4/7/2022	Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities	20-00827-126	2	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT 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	1–4	–
5/24/2022	VHA Continues to Face Challenges with Billing Private Insurers for Community Care	21-00846-104	2–3	–
6/22/2022	Mission Accountability Support Tracker Lacked Sufficient Security Controls	21-03080-142	3	–
7/21/2022	Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure	21-02704-135	2–3	–
7/28/2022	VBA Improperly Created Debts When Reducing Veterans' Disability Levels	21-01351-151	2, 4	–
8/3/2022	The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring	21-02401-190	3	–
9/22/2022	Home Improvements and Structural Alterations Program Needs Greater Oversight	21-03906-226	1	$12,676,084
10/25/2022	Comprehensive Healthcare Inspection Summary Report: Evaluation of Quality, Safety, and Value in Veterans Health Administration Facilities, Fiscal Year 2021	22-00818-03	2	–

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
11/17/2022	Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearms	21-00175-19	1	—
12/8/2022	VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments	21-03063-04	2, 4–5	—
1/12/2023	Vet Center Inspection of Midwest District 3 Zone 3 and Selected Vet Centers	21-03232-37	3	—
1/18/2023	Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama	22-01854-13	7	—
1/24/2023	Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California	21-03734-32	4	—
1/31/2023	Improvements Recommended in Visit Frequency and Contingency Planning for Emergencies in Intensive Community Mental Health Recovery Programs	21-01711-50	1	—
5/25/2023	Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers	21-03233-122	2, 11	—
5/25/2023	Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers	21-03269-123	1–2, 8–9	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
6/7/2023	Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania	22-02960-70	4	–
6/8/2023	Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota	22-02961-71	1, 9	–
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	2–4	–
7/11/2023	Inspection of Information Security at the Northern Arizona VA Healthcare System	22-04104-112	2	–
7/18/2023	Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan	22-04099-153	1	–
7/19/2023	Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff	21-03544-111	3	–
8/8/2023	Concerns with Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina	22-02797-169	1	–

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/7/2023	VHA Faces Challenges Implementing the Appeals Modernization Act	22-02064-155	1–14	—
9/14/2023	A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas	22-00507-211	1	—
9/21/2023	Information Security Inspection at the VA Beckley Healthcare System in West Virginia	23-00089-144	2, 8–9	—
9/22/2023	Comprehensive Healthcare Inspection Program Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities	23-01177-215	1	—
9/25/2023	Improvements Needed for VBA's Claims Automation Project	22-02936-175	1, 4	—
9/26/2023	Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans	22-00414-113	2	—
9/26/2023	Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth	22-02017-224	1, 4	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/27/2023	VA Should Strengthen Enterprise Cloud Security and Privacy Controls	22-03525-195	3	–
9/27/2023	Inspection of Information Security at the VA El Paso Healthcare System in Texas	23-01179-204	2, 5, 7	–
9/28/2023	Inspection of Information Security at the VA Dublin Healthcare System in Georgia	23-01138-203	5	–
11/29/2023	Care in the Community Summary Report for Fiscal Year 2022	22-03772-28	1–4	–
12/12/2023	Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault	21-01445-30	8	–
12/13/2023	Significant Deficiencies Found in VA's Denver Logistics Center Inventory Management Operations and Systems	22-02739-210	9, 14–16, 18	–
12/14/2023	VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds	22-00410-197	1	–
1/4/2024	Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal	21-01488-44	2–3	–

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/17/2024	VA Should Enhance Its Oversight to Improve the Accessibility of Websites and Information Technology Systems for Individuals with Disabilities	22-03909-19	1–3, 5	—
2/8/2024	Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk	21-03255-02	1, 3, 5	—
2/21/2024	Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied	23-00153-41	1	$3,300,000
3/6/2024	Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia	22-01315-90	2	—
3/12/2024	Deficiencies in Quality of Care at VA Maine Healthcare System in Augusta	23-00528-92	3	—
3/21/2024	Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death	23-00382-100	2	—
4/3/2024	Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta	23-00109-121	11	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
4/4/2024	Deficiencies in Attention Deficit Hyperactivity Disorder Diagnostic Assessment, Evaluation of Stimulant Medication Risks, and Policy Guidance	22-03013-129	2, 5	—
4/9/2024	Veterans Health Administration's Failure to Properly Identify and Exclude Ineligible Providers from the VA Community Care Program	22-02398-131	1–2	—
4/10/2024	Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah	23-00013-128	5	—
4/18/2024	Inspection of Southeast District 2 Vet Center Operations	22-03941-144	2	—
4/24/2024	Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care	23-00540-146	3	—
4/25/2024	Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System in Richmond	23-00104-134	3	—
5/8/2024	Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams	23-01059-72	1	—
5/15/2024	Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon	23-00110-168	10–11	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
5/30/2024	Follow-Up Information Security Inspection at the VA Financial Services Center in Austin, Texas	23-02186-97	2	—
6/5/2024	Inspection of Information Security at the VA Bedford Healthcare System in Massachusetts	23-02330-127	9	—
6/24/2024	Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety	23-02179-188	2	—
6/27/2024	Review of Perceived Barriers in Coordinating Veteran Maternity Care	22-00900-186	1	—
6/27/2024	VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits	23-01266-78	1	$1,008,400,000
7/10/2024	Lessons Learned for Improving the Integrated Financial and Acquisition Management System's Acquisition Module Deployment	23-00151-117	4	—
7/16/2024	Better Collection of Family Preference Data May Minimize Risk of Burial Scheduling Delays	23-01773-166	1	—
7/17/2024	VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability	23-01772-162	1–3	$100,000,000

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
7/23/2024	Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia	23-00995-211	1–7	–
7/24/2024	Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona	23-02958-203	10	–
7/25/2024	Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming	23-03159-204	2	–
8/8/2024	Unauthorized Community Care Dental Procedures Risked Improper Payments	23-00749-171	4–5	$325,500,000
8/13/2024	Failures by Telemetry Medical Instrument Technicians and Leaders' Response at the VA Eastern Colorado Health Care System in Aurora	23-03531-218	1	–
8/15/2024	Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times	23-01583-183	2	$200,232,348

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
8/15/2024	Care in the Community Inspection of VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers	23-01737-205	9, 13	—
8/27/2024	Inspection of Select Vet Centers in Continental District 4 Zone 2	22-04108-235	2	—
8/28/2024	VBA Needs to Improve Oversight of the Digital GI Bill Platform	23-01252-175	3	—
8/28/2024	Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida	23-03677-237	2	—
9/3/2024	Follow-Up Financial Efficiency Inspection of the Southeast Louisiana Veterans Health Care System in New Orleans	23-02907-216	5	—
9/4/2024	A Hiring Initiative to Expand Substance Use Disorder Treatment Needed Stronger Coordination, Planning, and Oversight	22-03672-199	3	—
9/12/2024	Improved Oversight Is Needed to Correct VISN Identified Deficiencies in Medical Facilities' Supply Chain Management	23-02123-202	1–6	—
9/17/2024	VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: September 2024	22-00879-249	1–3	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
9/18/2024	Additional Controls Are Needed to Improve the Reliability of Grant and Per Diem Program Data	23-02610-226	1–3	–
9/23/2024	VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents	22-03591-231	1–5, 8–9	–
9/25/2024	Alleged Mismanagement of Contracts for Wheelchair-Accessible Transportation Services by the Health Administration Service at the Dallas VA Medical Center in Texas	23-03128-213	2	$3,739,068
9/25/2024	VHA Needs to Establish Controls for Its Ambulatory Care Budget Estimate	23-01624-243	1–4	–
9/26/2024	Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama	23-02393-250	2–3, 8	–
9/26/2024	Mental Health Inspection of the VA Augusta Health Care System in Georgia	24-00675-259	4, 6, 10	–
9/30/2024	Inspection of Select Vet Centers in Pacific District 5 Zone 2	24-00388-266	2, 11	–

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
10/24/2024	Heart Transplant Program Review: Facility Leaders Failed to Ensure a Culture of Safety and the Section Chief Engaged in Unprofessional Conduct at the Richmond VA Medical Center in Virginia	23-03526-07	2–3	—
11/13/2024	Inspection of Information Security at the Health Eligibility Center in Atlanta, Georgia	24-01232-02	1	—
11/14/2024	Veterans Health Administration Initiated Toxic Exposure Screening as Required by the Promise to Address Comprehensive Toxics (PACT) Act but Improvements Needed in the Training Process	23-02682-09	1–2	—
11/14/2024	VBA Did Not Ensure Employees Sent Some Letters Using Its Package Manager Application	23-00547-187	1–2	—
12/18/2024	Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination	21-02389-23	1–5	—
12/18/2024	Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies	23-02939-13	1–5	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
12/19/2024	Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama	24-00588-19	1–4	—
12/19/2024	Improvement in the Patient Safety Program with Continued Opportunities to Strengthen Veterans Integrated Service Network 7 Oversight at the Tuscaloosa VA Medical Center in Alabama	24-01623-30	1–2	—
1/8/2025	Healthcare Facility Inspection of the VA Chillicothe Healthcare System in Ohio	24-00550-32	1	—
1/8/2025	Inspection of Pacific District 5 Vet Center Operations	24-00390-41	3–5	—
1/16/2025	Care in the Community Inspection of VA Desert Pacific Healthcare Network (VISN 22) and Selected VA Medical Centers	23-01739-26	4–5, 7–10, 12	—
1/22/2025	Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers	24-00566-16	5, 8, 11	—
1/23/2025	Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona	24-00194-42	1–8	—
1/30/2025	Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center	23-01609-14	1–4	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
1/30/2025	Deficiencies in Case Management and Access to Care for HUD-VASH Veterans at the VA Greater Los Angeles Healthcare System in California	24-01598-43	1, 5	—
2/4/2025	Deficiencies in Invasive Procedure Complexity Infrastructure, Surgical Resident Supervision, Information Security, and Leaders' Response at the Lieutenant Colonel Charles S. Kettles VA Medical Center in Ann Arbor, Michigan	24-00234-53	4–5, 8, 12	—
2/13/2025	Financial Efficiency Inspection of the VA Tampa Healthcare System	24-00103-27	4–6, 10	$5,935,700
2/20/2025	Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services	23-00748-28	1, 3–7	$980,300,000
2/25/2025	Healthcare Inspection VISN Summary Report: Evaluation of Practitioner Credentialing and Privileging for Fiscal Years 2023 to 2024	24-01827-57	2–3	—
3/5/2025	Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego	22-03076-65	1–3	—

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
3/5/2025	Healthcare Facility Inspection of the VA Central Western Massachusetts Healthcare System in Leeds	24-00594-61	1	–
3/5/2025	Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds	24-01859-62	4, 6–7, 10–11, 14	–
3/6/2025	Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia	24-00592-60	2–8	–
3/6/2025	Continued Sterile Processing Services Deficiencies and Facility Leaders' Failures at the Carl Vinson VA Medical Center in Dublin, Georgia	24-02277-69	1–2, 4–5	–
3/13/2025	Healthcare Facility Inspection of the VA Washington DC Healthcare System	24-00551-64	1–2, 4	–
3/18/2025	Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas	24-00166-35	2-6, 9-10	$1,200,000
3/19/2025	Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight	24-01143-44	1-8	–
3/19/2025	Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022	24-02106-80	1, 3-4	–

TABLE 8. OPEN RECOMMENDATIONS FROM PRIOR REPORTING PERIODS (CONTINUED)

DATE	TITLE	REPORT NUMBER	REC. NUMBER(S)	POTENTIAL COST SAVINGS
3/20/2025	Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers	24-00823-68	2-13	—
3/26/2025	Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia	24-00603-86	1-6	—
3/26/2025	Care Failures for a Patient with Alcohol Withdrawal at the Hampton VA Medical Center in Virginia	24-02232-87	1-3, 5-7	—
3/27/2025	The Causes and Conditions That Led to a $12 Billion Supplemental Funding Request	24-03127-66	1-4	—
3/27/2025	Review of VA's $2.9 Billion Supplemental Funds Request for FY 2024 to Support Veterans' Benefits Payments	24-03692-76	1-4	—
3/31/2025	Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities	23-02350-95	1-4	—
Total				**$3,192,283,200**

VA Management Decisions

The IG Act requires federal inspectors general to report information regarding any management decision made during the reporting period with respect to any audit, inspection, or evaluation issued during a *previous* reporting period.[42] The VA OIG has no information responsive to this requirement.

However, this section identifies instances in which VA management did not concur with VA OIG recommendations made during the current reporting period with additional context provided.

FEDERAL INFORMATION SECURITY MODERNIZATION ACT AUDIT FOR FISCAL YEAR 2024

Federal agencies must annually review their information security programs and report on compliance with the Federal Information Security Modernization Act (FISMA). The OIG contracted with CliftonLarsonAllen LLP (CLA) to evaluate VA's information security program for FY 2024. After assessing 49 major applications and general support systems hosted at 23 VA facilities and on the VA Enterprise Cloud, CLA concluded VA continues to face significant challenges meeting FISMA requirements. The audit found continuing deficiencies related to access controls, configuration management controls, security management controls, and service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction. Of CLA's 23 recommendations (many of which addressed repeat deficiencies from previous FISMA reports spanning multiple years), VA concurred with 12 and did not concur with 11. CLA will follow up on outstanding recommendations and evaluate corrective actions in the FY 2025 audit of VA's information security program. VA did not concur with the following recommendations to the assistant secretary for information and technology:

4. Implement improved mechanisms to ensure system owners and information system security officers follow procedures for establishing, tracking, and updating plan of action and milestones (POA&Ms) for all known risks and weaknesses including those identified during security control and other assessments.

5. Implement measures to ensure that system stewards and other officials responsible for system level POA&Ms are closing items with relevant support that shows sufficient remediation of the identified weakness.

VA disagreed with recommendations 4 and 5, citing a 99 percent compliance rate and a risk-based approach to managing POA&Ms. However, CLA testing of 48 systems found inconsistencies in documentation and unsupported POA&M closures and did not demonstrate a 99 percent compliance rate.

10. Ensure system owners consistently implement processes for periodic reviews of user account access. Remove unnecessary and inactive accounts on systems and networks.

11. Coordinate with system owners and local system management to ensure the consistent monitoring and reviewing of privileged accounts, service accounts, and accounts for individuals with access to source code repositories are performed across VA systems and platforms.

[42] 5 U.S.C. § 405(b)(6) (as amended by Pub. L. 117-263).

12. Implement improved processes to ensure compliance with VA password policy and security configuration baselines on domain controllers, operating systems, databases, applications, and network devices.

VA did not concur with recommendations 10, 11, and 12, citing a "significant level of maturity" in access management, supported by high compliance rates across reviewed systems and the implementation of automated monitoring tools for secure configuration. However, independent testing revealed persistent weaknesses, including inconsistent user access reviews, delayed account deactivations, incomplete user privilege requests, and service accounts that were not needed or had outdated credentials.

16. Implement automated software management processes on all agency platforms to identify and prevent the use of unauthorized software on agency devices.

17. Implement improved procedures for establishing, documenting, and monitoring an accurate software and logical hardware inventory for system boundaries across the enterprise.

For recommendations 16 and 17, VA asserted that its application monitoring and hardware inventory processes have mitigated associated risks, and that a new enterprise software asset management program is nearing completion to further enhance oversight. However, CLA testing identified ongoing weaknesses, including an unenforced whitelist policy to block unauthorized software, incomplete software inventories, and insufficient tracking of mission-critical components.

20. Implement improved mechanisms to continuously identify and remediate security deficiencies on VA's network infrastructure, database platforms, and Web application servers in accordance with established policy timeframes. If patches cannot be applied or are unavailable, other protections or mitigations should be documented and implemented to address the specific risks.

21. Continue to implement improved segmentation controls that restrict vulnerable medical devices from unnecessary access from the general network.

22. Implement improved processes to require system owners and management to provide adequate credentials to ensure security scans are authenticated to end devices where feasible and the subsequent vulnerabilities are remediated in a timely manner.

23. Improve the process for tracking and resolving vulnerabilities that cannot be addressed by enterprise processes within policy timeframes. Implement mitigations for identified security deficiencies by applying security patches, system software updates, or configuration changes to reduce applicable security risks.

Regarding recommendations 20–23, VA's nonconcurrence cited robust vulnerability management and medical device protection programs, including high compliance rates, risk-based assessments, and plans to implement Zero Trust architecture. However, CLA testing identified persistent critical and high-risk vulnerabilities due to outdated systems and weak configurations, along with medical devices using operating systems no longer supported by the vendor for security updates.

OTHER DISCLOSURES

Certain disclosures required by the IG Act, as amended, and other federal statutes fall outside the scope of the other sections in this report. Information responsive to these reporting requirements is provided below.

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.[43] During this reporting period, the OIG reviewed five legislative or regulatory proposals and made one comment. The OIG also reviewed 22 internal VA directives and handbooks that guide the work of VA employees and provided one comment.

Attempts to Interfere with the Independence of and Refusals to Provide Information or Assistance to the OIG

The IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information.[44] It also authorizes the OIG to have access to all VA records, documents, or other materials related to VA programs and operations, as well as to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the Act. When such information or assistance is unreasonably refused or not provided by VA, an inspector general is required to report that to the head of the agency.[45] All federal OIGs are required by the IG Act to provide a summary of each such report.[46] The VA OIG reports no such instances occurring during this reporting period.

Peer and Qualitative Assessment Reviews

The VA OIG's offices of Audits and Evaluations, Healthcare Inspections, and Investigations are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by these offices meets the applicable requirements and standards. The IG Act, as amended, requires inspectors general to report the results of any peer review of its operations conducted by another office of inspector general during the reporting period or identify the date of the last such review, in addition to any outstanding recommendations that have not been fully implemented.[47] This information is presented in table 9. The IG Act also requires inspectors general to report the results of any peer review they completed of another office of inspector general during the reporting period, as

[43] 5 U.S.C. § 405(a)(2) (as amended by Pub. L. No. 117-263).

[44] 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

[45] 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

[46] 5 U.S.C. § 405(b)(15)(B) (as amended by Pub. L. No. 117-263).

[47] 5 U.S.C. § 405(b)(8)(A), § 405(b)(8)(B), and § 405(b)(9) (as amended by Pub. L. No. 117-263).

well as any outstanding recommendations that have not been fully implemented.[48] This information is presented in table 10. 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 9. MOST RECENT PEER REVIEWS CONDUCTED OF THE VA OIG

TYPE	DATE COMPLETED	REVIEWING OIG	RATING	OPEN RECOMMENDATIONS
Audits	3/24/2025	Department of Agriculture	Pass	None
Inspections and Evaluations	9/22/2023	Department of the Interior	Pass	None
Investigations	2/3/2025	Small Business Administration	Pass	None

TABLE 10. MOST RECENT PEER REVIEWS COMPLETED BY THE VA OIG

TYPE	DATE COMPLETED	OIG REVIEWED	RATING	OPEN RECOMMENDATIONS
Audits	9/18/2024	Treasury Inspector General for Tax Administration	Pass	None
Inspections and Evaluations	9/14/2021	Department of War (then Defense)	Pass	None
Investigations	11/21/2023	Federal Deposit Insurance Corporation	Pass	None

Allegations and Investigations Relating to 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.[49] 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.[50] Federal law prohibits inspectors general from disclosing "any information from

[48] 5 U.S.C. § 405(b)(10) (as amended by Pub. L. No. 117-263).

[49] 5 U.S.C. § 405(b)(14)(A) and §405(b)(14)(B) (as amended by Pub. L. No. 117-263).

[50] 41 U.S.C. § 4712 (b)(2).

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 received 12 new complaints of alleged whistleblower reprisal by VA contractors or grantees during this reporting period and opened two investigations. Seven of the 12 complaints remain under initial review. The remaining three complaints did not meet the criteria in section 4712 for investigation. 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.[51]

Closed Work Not Disclosed to the Public

The VA OIG is required to provide detailed descriptions of any inspection, evaluation, or audit report—or any investigation involving a senior government employee—that was closed during the reporting being but not disclosed to the public.[52] As a matter of practice, the VA OIG publishes all reports unless disclosure is prohibited by law or regulation. Accordingly, there are no closed, undisclosed reports responsive to this reporting requirement for this period.

With respect to investigations, the OIG may close a case when allegations are unsubstantiated or the matter is referred to another entity, such as the US Office of Special Counsel. During this reporting period, the Office of Investigations closed one criminal investigation with unsubstantiated allegations involving a senior government employee.

The OIG received an allegation that a VA physician had a personal financial interest in four companies that also conducted business with VA. The investigation determined that the physician served as a public speaker for one of the companies. However, the physician never received financial payments from this company or the other three listed in the complaint. The physician received only one payment of $89 in 2021 from an unrelated company for food and beverages. In addition, VA never conducted business with three of the four companies identified by the complainant. Having identified no criminal conduct, the OIG did not refer this matter to the Department of Justice. This matter was not referred to VA for administrative action because the allegations were not substantiated.

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.[53] The act

[51] 41 U.S.C. § 4712(c).

[52] 5 U.S.C. § 405(b)(16)(A) and § 405(b)(16)(B) (as amended by Pub. L. No. 117-263).

[53] Pub. L. No. 117-136 § 2(a).

also requires the VA OIG to disclose certain information in its semiannual report to Congress about its use of this authority.

The OIG did not serve any testimonial subpoenas during this reporting period, nor did staff conduct any interviews of individuals pursuant to a testimonial subpoena served during a prior reporting period. The US Attorney General did not object to any proposed subpoenas. The inspector general has not encountered any challenges or concerns exercising the authority, and there are no other matters to report.

Allegations and Investigations Relating to Human Trafficking

The Trafficking Victims Prevention and Protection Reauthorization Act of 2022 requires inspectors general to report at least annually on the number of allegations received that pertain to human trafficking as well as information on any investigations that may have resulted and any recommended actions to improve the agency's or department's programs and operations. During this reporting period, the OIG received one allegation related to human trafficking that is under review. The OIG did not close any investigations pertaining to allegations received during a previous reporting period. The OIG made no recommendations to improve VA programs and operations pursuant to this information.

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:

- Felix Beltran, a resident agent in charge in Washington, DC, was activated by the US Army in March 2025.
- Matthew Clark, an auditor in Dallas, Texas, was activated by the US Army in February 2022. He returned in November 2024 and was reactivated in March 2025.
- George Kurtzer, an IT specialist in Chicago, Illinois, was activated by the US Air Force in September 2024.
- Abraham Raymond, a criminal investigator in Bedford, Massachusetts, was activated by the US Air Force in April 2025 and returned in May 2025.
- Ricardo Wallace-Jimenez, a criminal investigator in Spokane, Washington, was activated by the Washington Air National Guard in October 2024 and returned in April 2025.

OIG Agents Recognized by US Department of Justice

Resident Agent in Charge Joshua Lollar and retired Special Agent Mark Mientek received Agent of the Year awards from the US Attorney's Office for the Middle District of Florida for their investigation involving New Horizons Computer Learning Center franchises in Tampa and Orlando. The investigation resolved allegations that the franchises submitted false claims to VA for Post-9/11 GI Bill tuition payments. It was alleged the franchises repeatedly failed to report tuition waivers for students receiving less than 100-percent assistance under the GI Bill and failed to comply with Title 38 by paying commissions, bonuses, or other incentive payments to enrollment representatives based on their enrollments of GI Bill students. Based upon the investigation, the VA State Approving Agency withdrew both from participation in the GI Bill program. In June 2024, the franchises and their owner entered into a civil agreement under which they agreed to pay $1.35 million to VA to resolve these allegations.

OIG Teams Recognized with Eight Awards from the Council to the Inspectors General on Integrity and Efficency

Each year, the Council of the Inspectors General on Integrity and Efficiency 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 for these outstanding achievements:

- An Award for Excellence in Audit for the report *VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents*

AWARDS AND RECOGNITION

- An Award for Excellence in Audit for the report *Unauthorized Community Care Dental Procedures Risked Improper Payments*
- An Award for Excellence in Audit for the report *Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services*
- An Award for Excellence in Evaluations for the reports *Review of VA's $2.9 Billion Supplemental Funds Request for FY 2024 to Support Veterans' Benefits Payments* and *The Causes and Conditions That Led to a $12 Billion Supplemental Funding Request*
- An Award for Excellence in Evaluations for the report *VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits and Delays Occurred in Some Veterans' Benefits Claims While Awaiting Decision*
- An Award for Excellence in Evaluations for the report *VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability*
- An Award for Excellence in Inspections for the report *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama*
- An Award for Excellence in Investigations for efforts to hold a VA physician accountable for sexually assaulting a female veteran patient at the Atlanta VA Medical Center

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 the Inspector Genera's 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;

(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 Decisions

(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)[54];

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—

[54] As so in original. Probably should be (11).

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

(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;

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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On the cover: Army paratroopers assigned to the 82nd Airborne Division conduct a parachute jump at the Sicily Drop Zone, Fort Bragg, North Carolina (US Army photo by Sergeant Vincent Levelev). Multinational ships and aircraft steam in formation off the East Coast of the United States in support of UNITAS 2025, the 66th iteration of the world's longest-running multinational maritime exercise (US Navy photo by Mass Communication Specialist 2nd Class Mike Shen). U.S. Marines participate in the Navy and Marine Corps 250th Anniversary celebration parade in Philadelphia, Pennsylvania, the birthplace of the sea services (US Navy photo by Mass Communication Specialist 3rd Class Sylvie Carafiol).

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