APRIL 2025 HIGHLIGHTS

Congressional Testimony

The OIG actively engages with Congress on issues affecting VA programs and operations. The OIG's participation in congressional hearings helps focus legislative action and elevates national attention on topics of concern within the veteran community. All written statements to Congress can be found on the OIG website. The full hearings can be viewed on the committee website.

Acting Assistant Inspector General for Healthcare Inspections Testifies on VA's Mental Health Policies

Dr. Julie Kroviak, acting assistant inspector general for the Office of Healthcare Inspections, testified on April 30 before the House Veterans' Affairs' Subcommittee on Oversight and Investigations. Her testimony focused on the OIG's independent oversight of VA's mental health services, programs, and policies. Dr. Kroviak discussed VHA personnel's suicide risk assessments and the care management of veterans—from the first opportunity to screen veterans for risk factors through interventions and follow-up or ongoing care. In response to questions, Dr. Kroviak discussed actions VHA must take to implement the OIG's recommendations regarding consistent execution of VHA policies to provide high-quality mental health services to veterans.

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments in April.

Healthcare Investigations

Drug and Alcohol Rehabilitation Center Agrees 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, that 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 (HHS) OIG. The case was handled by the US Attorney's Office for the District of New Jersey. It is the first such case involving VA substance use disorder programs resolved with assistance from the VA OIG's Office of Investigations.

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

Another multiagency investigation resolved allegations that a national chain pharmacy filled unlawful prescriptions for excessive quantities of opioids and then sought payment from Medicare and other federal healthcare programs, to include the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The pharmacy agreed to a $300 million civil settlement with the Department of Justice to resolve allegations that from approximately August 2012 through March 1, 2023, its pharmacies and various subsidiaries filled millions of fraudulent prescriptions for opioids and other controlled substances in violation of the Controlled Substances Act and False Claims Act. The pharmacy also agreed to pay an additional $50 million if the company is sold, merged, or transferred prior to fiscal year (FY) 2032. VA's portion of the settlement is approximately $632,000. This investigation was conducted by the VA OIG, Department of Labor (DOL) OIG, HHS OIG, Federal Bureau of Investigation (FBI), Drug Enforcement Administration, Defense Criminal Investigative Service, Office of Personnel Management, and Defense Health Agency.

Home Healthcare Company Owner Sentenced to Four Years in Prison for Healthcare Fraud and Tax Crimes

The owner of a home healthcare company routinely billed federal healthcare programs, such as Medicare, Medicaid, and VA, for services not rendered from 2016 to 2021. The owner also concealed that she was excluded from participation in all federal healthcare programs due to a prior drug-related felony conviction. She was sentenced in the Southern District of Ohio to 48 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of more than $8.4 million to the Ohio Department of Medicaid and more than $195,000 to VA after previously pleading guilty to healthcare fraud and making and signing (or subscribing)

a false tax return. This multiagency investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation, Medicaid Fraud Control Unit of the Ohio Attorney General's Office, US Secret Service, and HHS OIG.

National Sales Director for a Mobile Diagnostics Company Pleaded Guilty to Kickback Scheme

This investigation resulted in charges alleging that the national sales director for a mobile diagnostics company and others entered into improper agreements through which physicians were paid bribes and kickbacks to order unnecessary transcranial doppler tests (an ultrasound that measures blood flow in the brain). An operations manager for the mobile diagnostics company and three physicians previously pleaded guilty in connection with this scheme. The potential loss to VA is approximately $650,000. The director pleaded guilty in the District of Massachusetts to conspiracy to violate the Anti-Kickback Statute. The investigation was conducted by the VA OIG, US Postal Inspection Service, Internal Revenue Service Criminal Investigation, HHS OIG, FBI, and DOL Employee Benefits Security Administration.

Benefits Investigations

Massage School Owner Pleaded Guilty in Connection with Education Benefits Fraud Scheme

An owner of a for-profit, non-college degree school purported to offer 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.

Former Scuba Diving School Owner Charged for Education Benefits Fraud

A VA OIG investigation resulted in charges alleging the former owner of a scuba diving school defrauded VA's Post-9/11 GI Bill and Vocational Rehabilitation and Employment programs by falsely representing to VA that some of the school's VA-funded students had completed various scuba diving courses. The allegations included that these students had either stopped attending the courses or never attended at all. In addition, the school owner directed staff to falsify student attendance records, grade sheets, and certificates of completion to make it appear as if the students had attended class with the knowledge that these records would be reviewed by the state approving agency and VBA employees during VA compliance surveys. The loss to VA is over $907,000. The school owner was charged in the Middle District of Georgia with presenting false claims.

Brother of Deceased Veteran Indicted for Theft of Government Benefits

An investigation by the VA OIG and Social Security Administration OIG resulted in charges alleging the brother of a deceased veteran continued to collect and withdraw VA compensation benefits and Social Security benefits intended for the decedent following the veteran's death in November 2012. The defendant allegedly used the funds for his personal benefit. He was indicted in the Western District of Louisiana. The loss to the government is more than $289,000. Of this amount, the loss to VA is approximately $128,000.

Investigations Involving Other Matters

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 Coronavirus Aid, Relief, and Economic Security 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 VAMC 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.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to advance the integrity of its programs and operations. Its work helps VA improve program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The office released the following reports in April.

Featured Report

The PACT Act Has Complicated Determining When Veterans' Benefits Payments Should Take Effect

The OIG conducted this review to determine whether claims processors are properly assigning effective dates for PACT Act–related claims. Accuracy is important in determining when veterans' benefits payments begin. After reviewing 100 of these claims completed from August 10, 2022, through August 9, 2023, the OIG estimated that incorrect effective dates were assigned for 24 percent of the 131,000 claims processed in that time. An estimated 26,100 of those claims resulted in at least $6.8 million in improper payments (both underpayments and overpayments). Some 2,300 additional claims had date errors, but the review team could not determine their monetary impact because claims processors made claims decisions without evidence to definitively establish correct dates. The OIG made six recommendations, including better equipping claims processors to assign the most advantageous effective date allowed by law and correcting all errors on cases identified by the review team.

Financial Efficiency

Independent Audit Report on a Transportation Company's Billing Practices Under a VA Healthcare System Contract

VA asked the OIG to conduct an audit of a contractor that provided eligible veterans with wheelchair van and other nonemergency transportation services to and from medical appointments. The OIG found the company may not have complied with contract terms due to differing interpretations of vague contract language, resulting in an estimated $1.81 million in potential overbillings between January 1, 2019, and December 31, 2021. Of this amount, $1.34 million was related to unclear contract terms and the company's methodology for billing remote trips with multiple stops as though each drop-off was a separate trip. The company also used mileage estimates instead of miles traveled and may have misclassified trips, resulting in potentially overbilling VA by an additional $470,537. The OIG recommended—and VA agreed—that VA should confer with its Office of General Counsel on whether any funds could or should be recouped.

Information Technology

Improper Sharing of Sensitive Information on Cloud-Based Collaborative Applications

The OIG received a hotline allegation from a VA medical center employee about improper sharing of sensitive information on VA's internal network. The complainant reported that an employee could search for fellow employees on the internal network and find documents and emails that contained sensitive personal information—from human resources paperwork such as interview questions and reference checks to personally identifiable information for veterans getting surgery. The OIG confirmed sensitive personal information was accessible by users who had no business need to access it and that the information exceeded the security authorizations of the systems it resided on. Among other actions, the OIG recommended removing unauthorized sensitive personal information from collaborative application sites such as SharePoint and directing facilities and programs not only to standardize SharePoint administration but also to inventory and consolidate their SharePoint sites and enforce recommended architecture to allow greater control of permissions and content.

Integrated Financial and Acquisition Management System Interface Development Process Needs Improvement

After previous failed attempts, VA is modernizing its finance and acquisition systems by implementing the Integrated Financial and Acquisition Management System (iFAMS) in waves. As of June 2023, six waves had been implemented, representing only about 3.6 percent of total iFAMS users. As of FY 2024, the life cycle cost estimate to deploy and sustain the system across VA is anticipated to be about $8.6 billion through 2050. Interfaces are critical to implementing iFAMS successfully because they facilitate the flow of data between systems. The VA OIG conducted this audit to determine whether the interface development process aligned with stated goals. The OIG found that validation sessions lacked essential details, and the Financial Management Business Transformation Service (FMBTS) missed opportunities to confirm the system functioned properly during the Consolidated Wave Stack. FMBTS should comprehensively test essential functions for both real-world application and technical assessment. The OIG made four recommendations.

Benefits

A Prohibited Default in the Clinically Indicated Date Field Limited Some Veterans' Eligibility for Community Care at the Omaha VA Medical Center in Nebraska

The OIG conducted this review to assess the merits of two hotline complaints received in March and April 2024 alleging Omaha VA Medical Center leaders manipulated the clinically indicated

date for consults (referrals), thereby limiting veterans' access to community care. The OIG substantiated the allegations, determining that from March 7, 2024, through April 11, 2024, facility leaders implemented a prohibited 29-day default for the clinically indicated date field that applied to referrals for specialty care and for some primary and mental health care. Before implementing the default, both the medical facility director and the chief of staff were made aware that there should not be a default. Once implemented, it took facility leaders 19 days to remove it. Furthermore, the OIG found providers were not given training on clinically indicated dates until more than six months after the default was removed. The OIG made four recommendations.

Hiring of Claims Processors Generally Met Requirements and the Attrition Rate Remained Steady

The expansion of benefits under the PACT Act of 2022 compelled VBA to increase capacity to process the influx of claims. VBA reported it exceeded its goal to hire 2,520 claims processors (veterans service representatives and rating veterans service representatives) by September 2023. The OIG conducted this audit to determine whether VBA followed required steps to hire qualified claims processors using PACT Act funds. In addition, the audit team calculated attrition rates for claims processors and evaluated measures implemented to retain these staff. The OIG found VBA's human resources staff generally followed the required steps to hire qualified claims processors from October 1, 2022, through September 30, 2023. The team also determined, however, that the median tenure of claims processors who resigned from VBA may have occurred just when they gained competency. The OIG made no recommendations but reported ways to improve those procedures and ongoing retention efforts.

Facility Maintenance and Construction

VHA Should Improve Monitoring of Underground Storage Tanks to Minimize Environmental and Health Risks at VA Medical Facilities

Underground storage tanks (USTs) are a critical part of VHA healthcare facilities' infrastructure, as they store fuel for boilers and backup generators. If the tanks are not properly installed and maintained, any chemicals they contain can be released into the environment, posing health and safety risks. This audit report examines whether VA is managing USTs according to identified federally established regulations. Although there were no instances of chemical releases from the reviewed USTs found during the audit, the OIG identified inaccurate records of USTs or related monitoring equipment, prolonged responses to and correction of automatic tank gauge alarms, and inconsistent reporting of regulatory inspections and results. The seven recommendations included providing guidance on recording UST assets and ensuring related VHA directives and federal, state, and local codes, laws, and regulations are followed.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The office released the following reports in April.

Healthcare Inspections

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

The OIG conducted an inspection at the VA Eastern Kansas Healthcare System and substantiated that a patient experienced a delay in the diagnosis of and treatment for lung cancer. The inspection team identified concerns with system providers' neglecting to order a bronchoscopy and follow up on test results, community care staff's failure to retrieve patient records, and the absence of an established process for community care providers to communicate abnormal test results to ordering providers. System leaders did not meet the documentation requirements for institutional disclosure to inform the patient of delays in diagnosis and care. The OIG found a broad system failure of community care staff not making three attempts to retrieve patient records within 90 days of completed community care appointments. System leaders did not develop the lung cancer screening program's infrastructure prior to implementation and the program lacked oversight and multidisciplinary engagement. The OIG made one recommendation to the under secretary for health related to the communication of patients' abnormal test results and one recommendation to the Veterans Integrated Service Network (VISN) director regarding the system's lung cancer screening program. The OIG made four recommendations to the healthcare system director related to test results, institutional disclosures, and community care records.

Deficiencies in Trainee Onboarding, Physician Oversight, and a Root Cause Analysis at the Overton Brooks VA Medical Center in Shreveport, Louisiana

An OIG healthcare inspection at the Overton Brooks VA Medical Center (the facility) in Shreveport, Louisiana, assessed an allegation that a physician who was not privileged at the facility provided care to intensive care unit (ICU) patients. The inspection team also identified concerns with a quality review. The OIG substantiated that the physician provided patient care for three hours with attending physician oversight in the facility's ICU. Failure to follow VHA trainee onboarding processes and inadequate oversight to ensure physicians providing coverage

for the ICU were credentialed and privileged contributed to the event. The OIG identified deficiencies with the facility's root cause analysis (RCA) process. Further, the facility implemented an additional RCA concurrence step that created the potential for confidentiality breaches and service line leaders' influence on RCA findings. The OIG made one recommendation to the under secretary for health and three recommendations to the facility director.

Healthcare Facility Inspections

The Healthcare Facility Inspections Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care in five areas: culture, environment of care, patient safety, primary care, and 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, in addition to the well-being of patients and staff. April's healthcare facility inspections reports examined the following facilities:

- VA Memphis Healthcare System in Tennessee
- VA Bronx Healthcare System in New York
- VA Western Colorado Healthcare System in Grand Junction

Featured Hotline Case

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

Home Oxygen Program at the Palo Alto VA Medical Center in California Lacked Clinical Oversight, Posing a Patient Risk

The OIG Hotline received allegations that the Palo Alto VA Medical Center's Home Oxygen Program lacked clinical oversight, posing a risk to the continued prescription eligibility of the 197 patients enrolled in home oxygen services. 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 review found that two of three program clinical leadership positions were vacant, and these vacancies resulted in poor program management and oversight. Also, providers failed to review and manage prescriptions—approximately 20 percent of the enrolled patients' prescriptions had lapsed in FY 2024. In addition, vendor audits in the second, third, and fourth quarters of FY 2024 were not conducted. The VISN implemented 10 corrective actions to bring

the program into compliance, including assigning program clinical leaders, tasking the medical center's chief of prosthetics to review and monitor all FY 2025 audits, and initiating provider training.[1] The VISN also coordinated with facility clinical and prosthetics staff to create a proactive prescription monitoring process.

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Listen to the April 2025 monthly highlights podcast on the VA OIG's website.

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