MARCH 2025 HIGHLIGHTS

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 developments in March.

Healthcare Investigations

Pharmacy Operator Sentenced in Connection with Compounding Pharmacy Fraud Scheme

A multiagency investigation resulted in charges alleging that several individuals operated compounding pharmacies in North Texas and conspired with various doctors to charge government agencies for medically unnecessary compound prescriptions, pain creams, scar gels, and multivitamins primarily to patients covered under the Office of Workers' Compensation Program. A pharmacy operator was sentenced to 180 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of more than $115 million after previously being found guilty of conspiracy to commit healthcare fraud, money laundering, conspiracy to launder money, and conspiracy to defraud the United States. The total loss to the government is approximately $62 million, including an approximately $7.5 million loss to VA. This investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation, Department of Labor OIG, and US Postal Service OIG.

Benefits Investigations

Veteran and Spouse Sentenced for Compensation Benefits Fraud Scheme

Another multiagency investigation revealed that a veteran and his wife submitted falsified documents to VA claiming that the veteran required constant medical care, suffered from posttraumatic stress disorder, and experienced the loss of the use of his feet. The investigation determined that despite his wife serving as his caregiver, the veteran did not require constant care and could walk without assistance. They were sentenced in the Eastern District of Virginia after previously pleading guilty to making false statements to the government. The veteran was sentenced to 45 days' imprisonment, 14 months' home confinement, and 36 months' supervised release, and his wife was sentenced to 30 days' imprisonment, 14 months' home confinement, and 36 months' supervised release. The defendants were also ordered to jointly pay restitution of more than $960,000 to VA. The VA OIG, Federal Bureau of Investigation, and Social Security Administration OIG conducted this investigation.

Veteran Pleaded Guilty to Fabricating Military Service to Receive VA Compensation Benefits

From January 2010 to March 2023, a veteran received VA compensation benefits that were awarded based on false accounts of his military service, specifically pertaining to injuries sustained from a roadside bomb in Iraq. The defendant also applied for a Purple Heart award to the Marine Corps through his local congressman, falsely claiming to have been injured by a roadside explosion. The loss to VA is approximately $344,000. The veteran pleaded guilty in the District of Massachusetts to false statements. The VA OIG and Defense Criminal Investigative Service investigated the case.

Former VA Fiduciary Sentenced for Theft of VA Funds

A VA OIG investigation revealed that the son of a veteran, who previously served as his father's VA-appointed fiduciary, misappropriated more than $90,000, to include almost $80,000 in cash that was withdrawn without permission from the fiduciary account over seven months. The son then refused to provide VA's Fiduciary Hub with any accounting of the funds during his time as fiduciary and eventually cut off communication with VA and his father. The defendant was sentenced in the Northern District of Mississippi to 15 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of more than $111,000 after previously pleading guilty to theft of government funds.

Investigations Involving Other Matters

VA Firefighter Admits to Scheme to Commit Workers' Compensation Benefits Fraud

An investigation by the VA OIG and Department of Labor OIG revealed a firefighter at the Lyons VA Medical Center in New Jersey received workers' compensation benefits for injuries incurred while on duty at the facility that purportedly did not allow him to return to work in any capacity. While receiving these benefits and completing annual certifications confirming that he was unable to return to work, the defendant performed firefighting duties for a local municipality and was employed as a long-haul truck driver. The loss to VA is approximately $479,000. The defendant pleaded guilty in the District of New Jersey to workers' compensation fraud.

Government Subcontractor Sentenced in Connection with Paycheck Protection Program Fraud Scheme

A multiagency investigation revealed that a government subcontractor who provided contract labor services fraudulently obtained a Small Business Administration-backed Paycheck Protection Program loan totaling over $493,000. The loan was intended to cover payroll and other eligible expenses despite those same expenses already being covered by Department of Energy contract funds and other federal sources, including VA. Shortly after receiving the funds,

the company used more than $424,000 on unauthorized expenditures. The loan was subsequently forgiven based upon the company falsely certifying that the proceeds had been used for eligible business expenses. The company was sentenced in the Eastern District of Washington to 12 months' probation and ordered to pay restitution of more than $493,000 after previously pleading guilty to bank fraud. The company's owner also agreed to pay more than $1.1 million as part of a civil settlement to resolve his own civil liability. This investigation was conducted as part of the US Attorney's Office COVID-19 Strike Force by the VA OIG, Department of Energy OIG, and Small Business Administration OIG.

Cleveland VA Medical Center Employee Pleaded Guilty to Paycheck Protection Program Fraud Scheme

A VA OIG proactive investigation revealed that a Cleveland VA Medical Center employee obtained two fraudulent Small Business Administration-backed Paycheck Protection Program loans totaling over $40,000 by falsely claiming to own a business that was never in operation. The defendant pleaded guilty in the Northern District of Ohio to theft of government funds.

Veteran Sentenced for Groping a Nursing Student at VA Medical Center in Albany, New York

A VA OIG and VA Police Service investigation found that a veteran who was a patient inappropriately touched a nursing student who was providing medical care to him at the Samuel S. Stratton VA Medical Center in Albany. The veteran was sentenced in the Northern District of New York to 12 months' supervised release and ordered to register as a sex offender after previously pleading guilty to abusive sexual contact.

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 March.

Financial Efficiency

Featured Reports

The Causes and Conditions That Led to a $12 Billion Supplemental Funding Request

In July 2024, VHA informed Congress it might need an additional $12 billion in medical care funding for the rest of fiscal year (FY) 2024 and all of FY 2025. In August, the OIG began

reviewing VHA's subsequent supplemental funding request, and Congress passed legislation in September requiring the OIG to review the circumstances leading to the announced shortfall. The OIG found the FY 2025 advance appropriations relied on outdated data and assumptions, including lower-than-actual costs for new medications and both direct VA and community care. VHA also believed it could stay under a governing legislative funding cap but failed to remain within its budget despite actions to cut obligations. By November, VHA revised this request to $6.6 billion for the remainder of FY 2025—with $6 billion funded in a mid-March 2025 continuing resolution. VHA concurred with the OIG's recommendations to improve budget assumptions and projection processes.

Review of VA's $2.9 Billion Supplemental Funds Request for FY 2024 to Support Veterans' Benefits Payments

In July 2024, VA announced to Congress that VBA needed about $2.9 billion to avoid delayed payments for disability compensation, pension, and readjustment benefits to over seven million veterans through September 2024. On September 20, a supplemental appropriations law provided the funding and required the OIG to review the circumstances surrounding the request. On October 28, VA officials reported to Congress that supplemental funds were not needed. The OIG found that, had VBA included realized prior-year recoveries in status of funds calculations throughout the year, monthly congressional reports would have shown a reduced risk of a shortfall. VBA officials were concerned about insufficient carryover funding for use at the end of FY 2024 and an expected surge in year-end claims processing that did not materialize, according to a VA analysis of compensation and pension obligations. The OIG made four recommendations to improve financial oversight and communications.

Independent Review of VA's Fiscal Year 2024 Detailed Accounting and Budget Formulation Compliance Reports to the Office of National Drug Control Policy

The OIG reviewed VHA assertions required by the Office of National Drug Control Policy (ONDCP) in VHA's FY 2024 detailed accounting and budget formulation compliance reports. Attestation standards require that the OIG plan and perform the review to obtain limited assurance about whether any material modifications should be made to management's assertions for them to be fairly stated. The OIG believes this review provides a reasonable basis for its conclusion. In the detailed accounting report, VHA reported three material weaknesses, three significant deficiencies, and certain matters concerning noncompliance with laws and regulations, as identified in the OIG report *Audit of VA's Financial Statements for Fiscal Years 2024 and 2023*. Based on its review, the OIG is not aware of any material modifications that should be made to VHA management's assertions for them to be fairly stated.

VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2025

The VA Transparency & Trust Act of 2021 required the OIG to submit semiannual reports for three years comparing actual VA obligations and expenditures for covered funds to those planned. In the first report, the OIG found American Rescue Plan Act fund transactions followed the Transparency Act and mostly followed financial policy (two of the 20 reviewed had errors). However, VA did not comply with Transparency Act financial reporting requirements to submit biweekly reports. Additionally, the third and fourth quarter FY 2024 reports required by the Consolidated Appropriations Acts of 2022 and 2023 were submitted late. No new recommendations are being issued because the transaction errors did not appear to be material to the American Rescue Plan Act fund balance. Moreover, the OIG's recommendations from the September 2024 report to submit biweekly reports and to timely submit quarterly reports are still not fully implemented, requiring ongoing OIG monitoring.

Healthcare Access and Administration

Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas

This review evaluated whether the Houston facility supply chain management staff at the Michael E. DeBakey VA Medical Center in Houston, Texas, established and maintained inventory controls in accordance with VA policy. The OIG identified deficiencies in managing supplies, equipment, and implant inventory at the facility. Supply chain management staff did not ensure accurate recording and accountability of expendable supplies, nonexpendable equipment, and implants in the inventory management systems, as mandated by VHA policy. These deficiencies stemmed from inadequate oversight and failure to follow inventory procedures, risking the loss of supplies or the use of expired products for patient care. The OIG made 10 recommendations to the Houston medical facility director: six recommendations to improve inventory management oversight and compliance with inventory procedures and four recommendations to enhance implant management.

Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight

Veterans are eligible to receive community care under certain circumstances. In October 2020, VHA's Office of Integrated Veteran Care (IVC) began implementing the Veteran Self-Scheduling (VSS) process, which allows eligible veterans to schedule their appointments directly with community providers. Although many facilities implemented the process in 2020, staff were not required to offer the option until September 2023. The OIG found IVC should improve its oversight to strengthen support and mitigate the risk of VSS misuse, which included staff

inappropriately selecting the VSS option for veterans without their permission. IVC did not adequately help facilities use and monitor VSS before requiring implementation. Additionally, neither IVC nor facility leaders implemented controls to identify the potential misuse of VSS. Without better oversight, inappropriate use of the VSS option may go undetected, and veterans may experience delays in care. The acting under secretary for health concurred with OIG's eight recommendations.

Office of Healthcare Inspections

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

National Review

Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022

The OIG assessed aspects of the community care and VA direct care programs at the Montana VA Healthcare System for FY 2022. Among patients who received VA primary care, 98.8 percent did so exclusively through VA direct care. Similarly, 77.5 percent of patients who received VA mental health care did so exclusively through VA direct care. The utilization of specialty care services through only VA direct care or only community care depended on the type of specialty care sought. Most community care referrals were requested due to patients' associated drive times to access needed care. The OIG made five recommendations to the Montana VA Healthcare System director related to timely appointment setting, completion of community care appointments within set timelines, consult management practices, appointment wait times, and the use of eligible community care providers.

Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities

The OIG evaluated the governance structure and responsibilities related to the Veterans Integrated Service Network (VISN) chief mental health officer role. VHA communicated inconsistent mandatory and discretionary VISN staffing requirements. VISN leaders did not consistently use the standardized organizational chart and employed various titles for the officer role. The OIG also identified inaccuracies within VISN-provided organizational charts. Office of

Mental Health leaders established multiple avenues to facilitate communication with these officers. Functional statements (position descriptions) for officers varied and did not consistently align with performance plan elements. Officers reported lack of authority as a major barrier to effectively overseeing and implementing actions for facility-level mental health services. Office of Mental Health and Office of Suicide Prevention leaders suggested that officer position description standardization would help increase officer effectiveness. The OIG made five recommendations to the under secretary for health to address the identified deficiencies.

Care in the Community Inspection

Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers

This OIG Care in the Community healthcare inspection program report describes the results of a focused evaluation of processes at eight VISN 16 medical facilities with a community care program. This inspection focused on six community care domains: (1) leadership and administration, (2) diagnostic imaging results, (3) administratively closed consults (referrals), (4) community provider requests for additional services, (5) healthcare coordination activities for patients referred by VA, and (6) urgent care.[1] The OIG issued 13 recommendations for improvement in the six domains. The recommendations include that the VISN director, together with facility directors, ensure facility community care oversight councils function according to their charters and meet the required number of times per fiscal year; assigned facility staff enter community care patient safety events into the Joint Patient Safety Reporting system; and facility staff import all community care documents into the patient's VA electronic health record within five business days of receipt.

Healthcare Inspections

Continued Sterile Processing Services Deficiencies and Facility Leaders' Failures at the Carl Vinson VA Medical Center in Dublin, Georgia

The OIG conducted a healthcare inspection to determine how surgical instruments that were not suitable for service (nonconforming instruments) were used during a patient procedure at the Carl Vinson VA Medical Center in Dublin, Georgia. The OIG determined Sterile Processing Service and operating room staff failed to remove nonconforming instruments from a surgical tray used during the patient procedure and found other nonconforming surgical instruments. Additionally, facility leaders failed to establish a preventative maintenance program for servicing

[1] Under specific circumstances, a consult may be administratively closed when documentation from the community care provider is not provided to VA.

surgical instruments prior to May 30, 2024. Among the findings, facility leaders did not fully implement an electronic surgical instrument tracking system called CensiTrac and failed to address concerns of the CensiTrac coordinator's performance. The five OIG recommendations included ensuring staff properly identify and address noncomforming instruments and complete related training, review patients potentially affected by about 800 nonconforming surgical instruments, and take staff administrative action as warranted.

Care Failures for a Patient with Alcohol Withdrawal at the Hampton VA Medical Center in Virginia

In response to a congressional referral, the OIG reviewed the care of a patient admitted for alcohol withdrawal at the Hampton VA Medical Center in Virginia. Findings included that nursing staff (1) failed to accurately and timely assess the patient's alcohol withdrawal symptoms and (2) did not consistently administer medications in adherence with the facility's protocol. These lapses, and a delay in documentation, may have affected the overall management of the patient's alcohol withdrawal symptoms. Also, facility providers did not recognize the severity of the patient's condition. Based on past medical history and admissions, the patient was considered high risk for developing delirium. These failures likely contributed to the patient not receiving evidence-based care to prevent delirium and severe alcohol withdrawal before his death after 14 days of hospitalization. The OIG's seven recommendations included greater oversight and record reviews by nursing leaders for staff compliance issues.

Mental Health Inspection

Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

The OIG's Mental Health Inspection Program (MHIP) team focused on inpatient mental health care at the Edward P. Boland VA Medical Center, part of the VA Central Western Massachusetts Healthcare System in Leeds. The inpatient unit included aspects of a recovery-oriented environment and interdisciplinary programming. The OIG identified concerns with oversight and monitoring, such as the absence of a mental health executive council and interdisciplinary safety inspection committee during the 12-month review period. The facility's admission policy also did not include processes for veterans on an involuntary hold. Facility leaders lacked formal processes to monitor compliance with involuntary commitment state laws. Additionally, staff did not comply with required documentation for timely suicide risk screening and evaluation. Discharge instructions were difficult to understand and lacked important details for appointment follow-up and medication management. The OIG issued 16 recommendations addressing deficiencies such as in leadership, clinical care coordination, and suicide prevention.

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. March healthcare facility inspections reports examined the following facilities:

- VA Central Western Massachusetts Healthcare System in Leeds
- VA Dublin Healthcare System in Georgia
- VA Washington DC Healthcare System
- VA Hampton Healthcare System in Virginia

Office of Special Reviews

This office conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. The Office of Special Reviews released the following report in March.

Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego

The VHA Grant and Per Diem program funds community-based transitional housing for veterans experiencing homelessness. The OIG conducted an administrative investigation to examine VHA's oversight of the Veterans Village of San Diego (VVSD), a program grantee providing drug treatment and other services. The OIG found that in 2021 and 2022, staff at the VA San Diego Healthcare System facility responsible for local oversight of the VVSD did not ensure that VVSD personnel remediated issues of understaffing and drug use on campus. Local VA facility staff also lacked important information related to co-located non-VA residents at VVSD engaged in drug sales. Regional and national VA staff failed to provide adequate support and policy guidance. A follow-up team review revealed veteran care and safety issues recurred or persisted until at least September 2024. VA concurred with the OIG's finding and five recommendations and provided acceptable action plans and completion timelines.

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.

Louis Stokes Cleveland VA Medical Center in Ohio Purchased a Mammography Unit for $541,000 and Never Used It

The OIG Hotline received allegations that a mammography unit was purchased to support the opening of a new women's health center at the Louis Stokes Cleveland VA Medical Center in Ohio. The complaint asserted that the medical center's radiology clinic already had two units that were underused, and that the new unit has never been used—sitting idle for more than three years. The matter was referred to VISN 10 for review. The VISN's review substantiated the allegations, finding that the unit was purchased for $541,000 to facilitate projected women's patient growth associated with the 2021 opening of the women's health center. The review noted that patient growth was minimal in calendar years 2020–2021 and remains slow despite earlier projections. Due to the lack of patient growth, the new unit was not needed, and the medical center's attempts to repurpose the unit through clinical restructuring or transfer to another VA health care system proved unsuccessful. The actions taken in this case resulted in the decommissioning and storage of the mammography unit on January 14, 2025. To date, the unit has been posted for sale through the General Services Administration.

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To listen to the podcast on the March 2025 highlights, go to the monthly highlights page on our website.