DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

JULY 2023 HIGHLIGHTS

Congressional Testimonies

Deputy Inspector General Testifies before the House Veterans' Affairs Subcommittee on Oversight and Investigations on the VA Office of Inspector General Training Act

Deputy Inspector General David Case testified on July 12 before the House Committee on Veterans' Affairs (HVAC) Subcommittee on Oversight and Investigations. His testimony focused on the importance of H.R. 2733, the "Department of Veterans Affairs Office of Inspector General Training Act of 2023," which would mandate that all *new* VA personnel receive training on their responsibilities for reporting potential crimes and other wrongdoing, as well as how to engage with OIG oversight staff. It must be completed within the first year of employment. More than 385,000 *established* VA personnel have taken the training as of June 26, 2023, following a memo from Secretary McDonough, with overwhelmingly positive reviews. The legislation would also allow the OIG to send messages using the department's email system to convey matters of concern at least twice a year to all VA employees. Mr. Case noted in his testimony that institutionalizing the OIG training would empower VA employees to report issues that impede the quality and timing of VA services and benefits received by veterans, their families, caregivers, and survivors. His written congressional statement has been added to the archive of congressional statements on the OIG website. Watch the entire hearing on the committee website.

OIG Director of Claims and Medical Exams Inspection Division Testifies on the Veterans Benefits Administration's Contract Medical Exam Program

Stephen Bracci, director of the Claims and Medical Exams Inspection Division within the OIG's Office of Audits and Evaluations, testified on July 27 before the HVAC's Subcommittee on Disability Assistance and Memorial Affairs. His testimony related to the medical exams for veterans who file claims for disability benefits, which provide critical evidence of a connection between the claimed disability and the veteran's military service and also help determine the degree of the disability's severity. The resulting disability rating in turn defines the monthly monetary benefit the veteran receives. Mr. Bracci's testimony focused on findings and recommendations from three OIG reports that illustrate gaps and limitations in VBA's oversight of contractors who perform the exams for VA. The first report is a comprehensive review that concluded the identified lack of VA oversight on contract exam providers' accuracy and lack of systemic corrective action put veterans at risk for inaccurate decisions.[1] The other two other reports describe more specific concerns: (1) the need to better monitor the distance veterans must travel for exams and (2) to address the backlog of exams and errors from

[1] VA OIG, *Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions*, Report No. 21-01237-127, June 8, 2022.

canceled exams that flowed from the pandemic.[2] Mr. Bracci also discussed the impact the identified weaknesses can have on veterans' experience with the disability benefits claims process and the steps VA must take to effectively implement open OIG recommendations. The hearing can be viewed in its entirety on the committee website.

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 this month.

Healthcare Investigations

Compounding Pharmacy Owner Convicted of Illegal Kickbacks and Money Laundering

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

Former Pharmacy Technician and Codefendant Sentenced for Scheme Involving Stolen Diabetic Test Strips

A former pharmacy technician at the Battle Creek VA Medical Center in Michigan used her position to steal more than $400,000 in diabetic test strips from the facility and then sold them to individuals not

[2] VA OIG, *The Medical Disability Examination Office Needs to Better Monitor Mileage Requirements for Contract Exams*, Report No. 22-02067-82, April 20, 2023; VA OIG, *Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams*, Report No. 20-02826-07, November 19, 2020.

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

Coconspirators Indicted for Healthcare Fraud Scheme

A multiagency investigation resulted in charges alleging that multiple defendants participated in a scheme to defraud federal healthcare programs by submitting more than 1,700 claims for services that were not rendered, as well as other claims that were administered by individuals who were not appropriately licensed to perform the treatment. These claims were allegedly submitted under the national provider identifiers (NPIs) of medical providers without their knowledge or consent. It is further alleged that the defendants routinely altered medical records to conceal their fraud scheme from investigators. The total loss to the government is approximately $413,000. Of this amount, the loss to VA is about $250,000. Two defendants were indicted in the Middle District of Georgia on charges of healthcare fraud and conspiracy to obstruct justice. One of the defendants was also indicted for aggravated identity theft. This investigation was conducted by the VA OIG, DCIS, HHS OIG, and Georgia Medicaid Fraud Control Unit.

Benefits Investigations

Veteran Indicted in Connection with Multiple Fraud Schemes

According to another multiagency investigation, a veteran allegedly submitted false documents to VA to obtain a VA-backed loan for a property valued at $2.1 million. The investigation also alleges that the veteran used his position as an Army financial counselor to target gold star families to invest their survivor benefits in investment accounts that were managed by his private employer. He was indicted in the District of New Jersey on charges of wire fraud, securities fraud, making false statements in a loan application, committing acts furthering a personal financial interest, and making false statements to a federal agency. The investigation was conducted by the VA OIG, Homeland Security Investigations, FBI, and DCIS.

Relative of Deceased Veteran Pleaded Guilty to Theft of Government Funds

From April 2006 to May 2021, a defendant stole VA and Social Security benefits intended for his deceased veteran brother and used them for his own personal expenses. The total loss to the government is over $664,000, including an almost $507,000 loss to VA. The VA OIG and Social Security Administration OIG investigated this case.

School Owner Pleaded Guilty in Connection with Education Benefits Fraud Scheme

The owner of a non-college degree school defrauded the VA education benefits program by making various misrepresentations to VA and the Louisiana Department of Veterans Affairs. The school owner was aware that the funds were intended to train veteran students but used them instead to train and provide service dogs. In some cases, the defendant obtained VA payments and provided no services whatsoever. The total loss to VA is approximately $384,000. The defendant pleaded guilty in the Western District of Louisiana to theft of government funds following an investigation by the VA OIG.

Defendant Pleaded Guilty to Theft of Government Property

From November 1993 to July 2023, a defendant received VA Dependency and Indemnity Compensation benefits intended for his deceased grandmother. The deceased beneficiary was a recipient of VA benefits due to the military service of both her husband and son. A review of the deceased beneficiary's bank records revealed that for nearly 30 years, the defendant used her VA benefits for his own personal expenses. The loss to VA is more than $340,000. Following an investigation by the VA OIG, the defendant pleaded guilty in the Western District of Missouri to theft of government property.

Former VA Employee Convicted of Compensation Benefits Fraud Scheme

A VA OIG investigation found that a former supervisory veterans service representative at the Little Rock VA Regional Office submitted a materially false disability benefits questionnaire (DBQ) to VA. According to evidence presented at trial, the former VA employee obtained a genuine DBQ from a private physician and then created a fictitious DBQ, attaching the signature page from the genuine DBQ to his phony one. This led directly to the defendant receiving special monthly compensation benefits to which he was not entitled. The loss to the government is $114,000. The defendant was convicted by a federal jury in the Eastern District of Arkansas for theft of government funds and false statements.

Investigations Involving Other Matters

Four Defendants Sentenced in Connection with Multimillion-Dollar Workers' Compensation Fraud Scheme

A multiagency investigation resulted in charges alleging that a Texas company recruited injured federal workers by offering to assist in filing their claims with the DOL's Office of Workers' Compensation Programs. The defendants allegedly funneled those employees to medical clinics where doctors wrote prescriptions for compounded medications in exchange for kickbacks from pharmacies. The coconspirators allegedly billed DOL, as well as the Department of Defense's TRICARE program, for more than $126 million. The portion of the billed amount attributable to VA employees is approximately $1.3 million. Four defendants were sentenced in the Southern District of Texas to 150 months in prison, 11 years of supervised release, and restitution of $24 million. This investigation was conducted by the VA OIG, DOL OIG, US Postal Service OIG, and DCIS.

Former VA Licensed Practical Nurse Sentenced for Distribution and Possession of Child Pornography

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

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.

Information Technology

Inspection of Information Security at the Northern Arizona VA Healthcare System

The OIG inspected the Northern Arizona VA Healthcare System to assess whether it met federal information security requirements and found deficiencies with configuration management, security management, and access controls. Configuration management issues included previously unidentified critical vulnerabilities, uninstalled patches, and network operating systems without vendor support—all of which could deprive users of reliable information access and risk unauthorized access or damage to critical systems. Also, the OIG identified almost twice as many devices on the network than the inventory listed. Weak access controls included missing video surveillance, inadequate fire-control equipment, insufficient climate controls, improperly mounted or stored equipment, and communications rooms without backup power supplies. The OIG made six recommendations to the assistant secretary for information and technology and chief information officer to improve controls at the healthcare system and five recommendations to the system's director.

Healthcare Administration

Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff

The VA OIG assessed whether medical facility leaders identified, recruited, and retained nurses and medical support assistants (MSAs) to meet community care needs. The audit found that VHA cannot assess community care staffing levels due to unreliable data and insufficient tools. Facility leaders do not use consistent organizational codes to identify community care staff, and VA's staffing assessment

tool relies on self-reported data that are not effectively verified. Due to data entry errors and a lack of quality review, VHA included inaccurate information in congressionally mandated reports. Despite these limitations, community care leaders generally identified local staffing needs, and authorized requested staff. Most facilities could recruit and retain community care nurses but not MSAs. Some facilities used strategies such as hiring incentives to recruit and retain MSAs or consolidated community care units to process community care referrals. The under secretary for health concurred or concurred in principle with the OIG's five 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 this month.

Featured Report

Facility Leaders' Failures in Communications, Construction Oversight, Emergency Preparedness, and Response to an Oxygen Disruption at the West Haven VA Medical Center in Connecticut

The OIG conducted a healthcare inspection to assess allegations regarding a disruption to the West Haven VA Medical Center facility's oxygen line, as well as patient safety concerns and facility leaders' response. A construction company cut the medical center's oxygen line and caused a disruption in its availability. While relying on portable tanks, a patient experienced an adverse event and ultimately died after a period of inadequate oxygen supply. Contributing factors included a lack of accessible equipment, education, and training. The OIG was unable to determine if the adverse event caused the patient's unresponsiveness or death. Although emergency procedures were implemented after the oxygen disruption, the OIG found deficiencies with communication at that time. Additional issues were found with construction oversight and emergency preparedness, in addition to the facility leaders' response using administrative and quality reviews. The report includes 12 recommendations related to communication, emergency preparedness, oversight, and response to the oxygen disruption.

Healthcare Inspection

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

In response to a congressional request, the OIG inspection assessed leaders' progress toward implementation of prior recommendations from the VHA Office of the Medical Inspector. The OIG evaluated facility leaders' actions related to high reliability organization goals and Veteran Integrated Service Network (VISN) 10 leaders' oversight of, and support provided to, leaders at the John D. Dingell VA Medical Center. The findings flagged concerns with VISN and facility leaders' corrective actions in response to six of the 10 medical inspector recommendations. The OIG identified three additional concerns related to the lack of stable leadership due to vacancies and turnover; the impact of leaders' actions on high reliability organization principles; and the inadequacy of VISN oversight and support. The OIG made nine recommendations to the VISN and facility directors.

Comprehensive Healthcare Inspection

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis. See the Purpose and Scope section of the report for the areas of focus at the time of the inspections. This month's CHIP reports focused on the VA Central California Health Care System in Fresno.

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To listen to the podcast on the July 2023 highlights, go to www.va.gov/oig/podcasts.