DECEMBER 2023 HIGHLIGHTS

Congressional Testimony

Director of the OIG's Healthcare Infrastructure Division Testifies on VA's Personnel Suitability Program

Shawn Steele, director of the Healthcare Infrastructure Division within the OIG's Office of Audits and Evaluations, testified on December 6 before the House Veterans' Affairs' Subcommittee on Oversight and Investigations. Mr. Steele's testimony focused on OIG audits that found VA did not provide effective governance of the program or have effective data and information technology systems to ensure that required background investigations were initiated, completed, or adjudicated within required timelines for staff at medical facilities nationwide—increasing the risk of exposing veterans to care and services from VA personnel who have not been fully vetted for their positions. In response to questions, Mr. Steele discussed the importance of VA implementing and maintaining sufficient human resources personnel to conduct the required screening of personnel. In addition, he underscored the importance of VA's new software system having the functionality to properly support VA staff responsible for prompt background checks. Watch the entire hearing 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

Former VA Medical Center Supervisor Sentenced for Role in Bribery Scheme

A VA OIG investigation found that a former supervisor at the Philadelphia VA Medical Center used his government-issued purchase card to place orders with a particular company for medical supplies that totaled over $1.6 million. The former supervisor, who received cash payments of more than $28,000 from the owner of this company, was sentenced in the Eastern District of Pennsylvania to 36 months of probation, forfeiture of $28,000, and a fine of $5,500 after pleading guilty to accepting gratuities as a public official.

Diagnostic Company to Pay $14.7 Million to Resolve False Claims Act Allegations

A multiagency investigation resolved allegations that from 2014 through 2020, a diagnostic company knowingly submitted false claims to federal healthcare programs, including VA programs, for a higher level of remote cardiac monitoring service than physicians had intended to order or than was medically

necessary. The company allegedly marketed their remote cardiac monitoring device as being capable of performing three different types of heart monitoring services, of which telemetry provided the highest rate of reimbursement. Both the design of their online enrollment portal and guidance from their sales personnel caused unwitting clinical staff to select options that would enroll a patient in telemetry, even when the physician intended to order a less expensive service. The company also allegedly disregarded written notes that clinic personnel included in patient enrollments that specifically reflected the treating physicians' intent to order a service other than telemetry. The company entered into a civil settlement with the US Attorneys' Offices for the District of New Jersey and the Eastern District of Pennsylvania under which it agreed to pay more than $14.7 million to settle these False Claims Act allegations. Of this amount, VA will receive over $1.6 million. This investigation was conducted by the VA OIG, Department of Health and Human Services OIG, Defense Criminal Investigative Service, and Office of Personnel Management OIG.

Two Former VA Registered Nurses Sentenced for Making False Statements Regarding Patient's Death

According to a VA OIG investigation, two former registered nurses at the Oklahoma City VA Medical Center made false statements to investigators related to the suspicious death of an inpatient veteran. Specifically, they stated that they did not pause medication being administered to the veteran before his death when they both knew that they did. Both nurses pleaded guilty in the Western District of Oklahoma to false statements and received respective sentences of six months and three months in prison, with each also receiving one year of supervised release.

Benefits Investigations

Four Business Owners Sentenced for Defrauding VA of More than $2 Million

Four former owners of a business that purported to provide home aid and attendance services to VA beneficiaries were sentenced in the Eastern District of Louisiana after previously pleading guilty to wire fraud. A VA OIG investigation revealed that the defendants conspired to submit hundreds of fraudulent applications to VA for pensions with aid and attendance benefits on behalf of veterans or their surviving spouses. Aid and attendance is a higher monthly pension amount paid to a qualified housebound veteran or surviving spouse for assistance with activities of daily living. The defendants falsely claimed to have provided home aid and attendance to the veterans or spouses before submitting the applications. As a result of these false claims, the defendants misappropriated approximately $2 million in VA funds that were intended for more than 70 veterans or their surviving spouses. The defendants were sentenced to a combined total of 48 months in prison and restitution of over $2.8 million. Each defendant was also sentenced to three years of supervised release.

Technical School Employee Sentenced for Role in Education Benefits Fraud Scheme

Multiple employees from non-college-degree-granting technical school conspired to defraud VA's education benefits program by falsifying attendance records, student grades, and professional certifications to conceal they were not complying with VA's "85/15" rule. This rule is intended to ensure VA is paying fair market value tuition by requiring that at least 15 percent of enrolled students pay the same rate with non-VA funds. Non-college-degree-granting schools require students to attend in-person classes; online courses are not permitted. In addition to falsifying records and allowing students to complete coursework online at their own pace, the coconspirators posed as students when contacted by the state approving agency to confirm graduation and job placement data so they could maintain school eligibility. This is the largest known incident of Post-9/11 GI Bill benefits fraud prosecuted by the Department of Justice. Following the VA OIG's investigation, one of the coconspirators was sentenced in the District of Columbia to 12 months and one day in prison, 12 months of supervised release, and restitution to VA of over $76.7 million.

Deceased Veteran's Spouse Pleaded Guilty to Defrauding VA of Survivor Benefits for Nearly 30 Years

A VA OIG investigation, which was conducted in response to a hotline referral, revealed that the spouse of a deceased veteran fraudulently received VA Dependency and Indemnity Compensation benefits between November 1995 through April 2023. The defendant failed to report two subsequent marriages to VA, which would have made him ineligible to receive these benefits. The loss to VA is approximately $365,000. The defendant pleaded guilty in the Middle District of Florida to theft of government funds.

Investigations Involving Other Matters

Plumbing and Heating Company to Pay $1.3 Million to Resolve Civil Fraud Allegations

A VA OIG and General Services Administration OIG investigation resolved allegations that a plumbing and heating company, which was certified as a service-disabled veteran-owned small business (SDVOSB), violated the False Claims Act by not properly subcontracting with similarly situated SDVOSBs on at least eight contracts across seven VA medical centers. The company entered into a civil settlement with the US Attorney's Office for the Western District of Washington under which it agreed to pay $1.3 million to resolve these allegations.

Former VA Nurse Practitioner Sentenced for Workers' Compensation Fraud Scheme

According to a VA OIG and Social Security Administration (SSA) OIG investigation, a former VA Boston Healthcare System nurse practitioner claimed in statements to the Department of Labor's Office of Workers' Compensation Programs (OWCP) and SSA that she was completely incapable of employment due to an on-the-job injury sustained while employed by VA in 2017. Despite these claims, the former nurse practitioner owned and operated an active dermatology practice. She was sentenced to

three years of supervised release with the first six months to be served on home detention after pleading guilty in the District of Massachusetts to theft of government property and false statements. She was also ordered to pay restitution of over $314,000. Of this amount, VA will receive more than $235,000.

Veteran Sentenced for Making Threats against a VA Employee and the Loma Linda VA Medical Center

A veteran used a phone number–cloaking application to threaten to kill a VA employee and their family and then later made threats to destroy the Loma Linda VA Medical Center in California with an explosive device. The veteran was sentenced in the Central District of California to 32 months in prison and 36 months of supervised release after pleading guilty to threatening a federal employee. The VA OIG and FBI conducted this investigation.

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 December.

Benefits

The Office of Integrated Veteran Care Needs to Improve Community Dialysis Oversight and Develop a Strategy to Align Future Contracts with the MISSION Act

VHA relies heavily on community providers for dialysis services for veterans, using community care network (CCN) contracts and nationwide dialysis services contracts (NDSCs). The current NDSCs reimburse providers more than the Medicare rate, as they were awarded before the passage of the MISSION Act, which generally prohibits this practice. The OIG found that VHA experienced barriers to ensuring compliance with its prescribed referral process, which prioritizes the use of CCN providers (who receive up to the Medicare rate) over NDSC providers. VHA also did not clearly assign oversight responsibilities for community dialysis services or use available data to inform decisions. The audit team found some inaccurate or incomplete data in the information system used by dialysis coordinators to identify available providers as well. The OIG recommended VHA clarify guidance on local dialysis contract options, establish roles and responsibilities, improve data accuracy, and ensure future dialysis service contracts meet MISSION Act payment rate requirements.

Financial Efficiency

VA Should Validate Contractor Energy Baseline and Savings Estimates and Ensure Payments Are Legally Compliant

Energy savings performance contracts allow government agencies to implement energy conservation measures without paying direct capital costs up front. Energy service companies finance the capital costs of these energy upgrades and are compensated through the energy cost savings received. For VA, the measures help reduce energy or water usage at medical facilities—for example, by installing low-energy lighting and low-flow bathroom fixtures. Estimates of energy cost savings come from the contractor. Before awarding the work, VA must validate that the estimates are reasonable. If they are overstated, VA may be locked into a payment schedule that exceeds its actual energy savings. The OIG found VA did not independently review contractors' estimated savings calculations at four of 13 medical facilities using energy savings performance contracts due to a lack of effective policies and quality control procedures. The OIG made four recommendations to address these weaknesses.

Significant Deficiencies Found in VA's Denver Logistics Center Inventory Management Operations and Systems

VA's Denver Logistics Center (DLC) manages millions of dollars of supplies for VHA facilities and patients. VA policy holds staff who use, supervise, or control VA-owned goods accountable for those goods from acquisition to disposition. The OIG audit examined whether the DLC maintained accurate inventories of VA-owned goods and found significant deficiencies in inventory management operations. The audit also revealed the DLC's inventory management system software has access and security vulnerabilities and lacked transparency. The DLC has largely operated under minimal oversight that the OIG found to be ineffective at ensuring VA policies were followed and VA-owned goods protected. The independent nature of DLC operations coupled with the deficiencies identified in this audit impede the DLC from effectively fulfilling its mission and create a heightened risk of fraud, waste, and abuse. VA concurred with the OIG's 19 recommendations to improve DLC operations, oversight, and information system deficiencies.

VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds

The OIG conducted this audit to determine if VA adhered to program requirements in using more than $1 billion in seismic funds from FY 2019 through FY 2021. The OIG reviewed 92 projects and determined 42 of the buildings were nonessential, as opposed to critical buildings that must remain operational during a seismic event. The cost to address deficiencies in these 42 buildings was around $616 million. Yet as of February 23, 2023, seismic evaluations had not been performed on 135 essential buildings. The Seismic Program Office's ineffective prioritization increases the risks to veteran and employee safety and hampers VA's ability to provide lifesaving care during and after an earthquake.

The OIG made four recommendations including completing seismic evaluations for all critical and essential buildings and making seismic designation information available to those who certify the Capital Asset Inventory, which is the authoritative record of VA's real property inventory.

Audit of VA's Financial Statements for Fiscal Years 2023 and 2022

The VA OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to audit VA's financial statements as of the end of fiscal years (FYs) 2023 and 2022. CLA provided an unmodified opinion and noted material weaknesses and significant deficiencies in internal controls and instances of noncompliance with laws and regulations. Regarding internal controls, CLA identified three material weaknesses and three significant deficiencies. CLA is responsible for the audit report and the report's conclusions. The OIG does not express opinions on VA's financial statements, internal controls, or compliance with the Federal Financial Management Improvement Act of 1996 or conclusions on VA's compliance with laws and regulations. The independent auditors will follow up on these internal control and compliance findings and evaluate the adequacy of corrective actions taken during the FY 2024 audit of VA's financial statements.

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 care providers. The Office of Healthcare Inspections released the following reports in December.

Featured Report

Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault

The OIG conducted a national review of VHA's policy on management of emergent care for acute sexual assault victim-survivors. Sexual assault is an invasive form of interpersonal violence with medical, psychological, and legal consequences. Care for acute sexual assault is a low frequency but crucial occurrence in VHA, presenting challenges in maintaining staff's procedural knowledge. The OIG found deficiencies in adherence to requirements to ensure provision of sexually transmitted infection prophylaxis, pregnancy prophylaxis, psychological counseling, and informed consent. VHA policy establishes requirements to ensure safe, quality care. Facility and community resources as well as jurisdictional requirements on reporting and evidence collection vary across facilities, and opportunities exist for many facilities to improve guidance to ensure proper implementation of VHA policy and provide frontline staff with relevant, accessible local procedures and resources. The under

secretary of health concurred with the OIG's eight recommendations to address practice deficiencies and improve guidance.

Comprehensive Healthcare Inspections

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 each report for the areas of focus at the time of the inspections. December's CHIP reports centered on the following facilities:

- VA Providence Healthcare System in Rhode Island
- W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina