AUGUST 2024 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 significant developments in August.

Healthcare Investigations

Permanent Injunction Issued against Two Debt Collection Agencies

A multiagency investigation led to a permanent injunction issued by the Northern District of Oklahoma court that prevents the owners of two debt collection companies from engaging in any healthcare billing activity, including continuing a fraud scheme that targeted veterans, service members, and older Americans. A civil complaint alleged that the two companies distributed tens of thousands of fraudulent collection notices in an attempt to obtain over $70 million from beneficiaries of CHAMPVA, TRICARE, Medicare, and other insurance entities for durable medical equipment that patients received many years ago after their surgeries.[1] The debt collection company owners allegedly obtained over $1.7 million through the scheme while lacking any authority to collect any debt from these beneficiaries. To date, the VA OIG seized fraud proceeds of about $700,000. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), FBI, Department of Health and Human Services OIG, US Postal Service OIG, Small Business Administration OIG, and Department of Labor OIG.

Acupuncturist Agreed to Pay $850,000 to Resolve False Claims Act Allegations

A VA OIG proactive investigation resolved allegations that between 2016 and 2020, a medical provider submitted claims to VA for acupuncture services that were significantly overstated, including multiple instances in which the claims submitted for a single day totaled more than 24 hours. The acupuncturist entered into a settlement agreement in the Eastern District of California under which he agreed to pay $850,000 to resolve the allegations that he violated the False Claims Act by submitting fraudulent healthcare claims to VA.

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[1] CHAMPVA refers to the Civilian Health and Medical Program of the Department of Veterans Affairs that covers the cost of some healthcare services and supplies for the spouse or child of a deceased veteran who was receiving disability benefits. TRICARE is the Department of Defense's healthcare program for active-duty and retired service members and their families. Durable medical equipment typically includes items ordered by a physician that can be used by individuals in need of medical support in the home for an extended period and include items such as compression devices, wheelchairs, walkers, respiratory equipment, prosthetic and orthotic devices, and implants.

Benefits Investigations

Vocational School Owner Agreed to Pay More Than $2 Million to Resolve Education Benefits Fraud Allegations

Another VA OIG proactive investigation resolved allegations that the owner of several non-college-degree–granting vocational schools that are part of a nationwide franchise submitted false claims to VA for educational benefits assistance under the Post-9/11 GI Bill. It is alleged that between 2015 and 2020, the owner knowingly enrolled Post-9/11 GI Bill–funded veterans in courses at 20 franchises across the country where 85 percent or more of the students were already veterans or supported students, in violation of the "85/15" rule. The 85/15 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. The owner also allegedly failed to report to VA the tuition reductions it provided to veterans, in violation of the "Last Payer Rule." Under this rule, VA pays the net cost for tuition and fees charged by the school for veteran enrollees after any scholarships, waivers, grants, or other assistance have been applied. The owner entered into a settlement agreement with the Commercial Litigation Branch of the Department of Justice's Civil Division, under which he will pay over $2 million to resolve these allegations.

Veteran Sentenced in Connection with Multiple Fraud Schemes

A multiagency investigation revealed that a veteran submitted false documents to VA to obtain a VA-backed loan for a property valued at $2.1 million. The investigation also found 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. The veteran was sentenced in the District of New Jersey to 151 months in prison, 36 months of supervised release, and forfeiture of $1.4 million after pleading guilty to 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. Restitution will be determined on a later date. The investigation was conducted by the VA OIG, Homeland Security Investigations, DCIS, and FBI.

Investigations Involving Other Matters

Chemical and Laboratory Supply Company Entered into $5 Million Settlement for False Claims Act Allegations

A chemical and laboratory supply company reached a settlement agreement in the Eastern District of Pennsylvania to resolve allegations that it fraudulently overcharged federal agencies for goods purchased between 2008 and 2017. Through its federal procurement contracts, the company agreed to offer or provide government purchasers the same or better prices than were

offered to a specific private-sector customer, but did not do so. By not offering or providing federal government purchasers this contractually stipulated most-favored customer pricing, the company allegedly violated the False Claims Act and agreed to pay $5 million to the federal government, of which over $2.2 million is restitution. Of this amount, VA will receive over $144,000. This investigation was conducted by the VA OIG, General Services Administration OIG, Department of Health and Human Services OIG, and DCIS.

Two Nonveterans Sentenced in "Rent-A-Vet" Construction Fraud Scheme

A VA OIG and FBI investigation initiated in response to a hotline complaint revealed that two nonveterans defrauded VA by falsely obtaining federal set-aside construction contracts intended for service-disabled veteran-owned small businesses (SDVOSBs). Starting in 2007, the two nonveterans had several disabled veterans pose as owners of two companies the nonveterans actually controlled (referred to as a "rent-a-vet" scheme) to fraudulently obtain SDVOSB status. These companies were awarded 77 set-aside government contracts valued at over $78 million. Over several years, the nonveterans provided misleading information to VA indicating that the two companies were operated by service-disabled veterans when the nonveterans were the majority owners who ran and operated both companies. The two nonveterans pleaded guilty to major fraud against the United States and were each sentenced in the Western District of Pennsylvania to one year of probation, including 100 hours of community service; restitution of over $403,000 to VA; and a $50,000 fine.

VA Phlebotomist Sentenced for Video Voyeurism

According to a VA OIG investigation, a phlebotomist (an individual who draws blood) at the Orlando VA Medical Center installed a hidden camera in multiple unisex bathrooms at the facility to secretly record employees without their consent. The phlebotomist, who was previously suspended by VA pending the completion of the investigation and criminal proceedings, pleaded guilty to video voyeurism and was sentenced in the Circuit Court of the Ninth Judicial Circuit for Orange County (Florida) to 24 months in prison and 48 months of supervised release. He was also ordered to participate in individualized sex offender treatment.

Veteran Sentenced for Threatening VA and VA OIG Employees, the White House, and the DC OIG

Another VA OIG investigation revealed that a veteran threatened to kill a VA social worker at the community-based outpatient clinic in Lynchburg, Virginia. The veteran also made threats directed at a VA OIG employee, other VA personnel, the White House, and the District of Columbia Office of the Inspector General. The veteran was sentenced in the Western District of Virginia to 15 months in prison and 24 months of supervised release after pleading guilty to threatening a federal employee.

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 August.

Healthcare Access and Administration

Featured Report

Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times

VHA purchases community health care by contracting with third-party administrators (TPAs), which in turn contract with community providers. Community providers' prescription requests must be filled at VA pharmacies and must consider VA's approved drugs before others, which require special authorization. This audit examined whether VHA's oversight of TPAs ensured community providers prescribed special-authorization drugs consistent with requirements. Community providers were found to have rarely submitted required justifications with these initial prescriptions, leading to about $200.2 million in questioned costs. VHA staffing challenges and increased community care prescriptions also caused a backlog. Community care prescription processing averaged 11 days, exceeding VHA's four-day standard. VHA did not hold TPAs accountable for ensuring community providers followed procedures, and less than 2 percent of community providers completed TPA-developed training. The OIG made seven recommendations to improve community providers' compliance when prescribing special-authorization drugs, such as enhancing prescription system capabilities, addressing training requirements, and clarifying requirements for VA pharmacies to report community providers who are not compliant.

Unauthorized Community Care Dental Procedures Risked Improper Payments

In fiscal year (FY) 2022, VA provided dental care to about 607,000 veterans and referred 186,500 veterans to the community, where they received dental care from non-VA providers. VA must pay for community dental care only when VA dentists authorize the procedures performed. This audit estimated that, between FY 2022 and FY 2025, VA will have made a total of $325.5 million in improper payments for 847,800 unauthorized community dental procedures. This includes $139.1 million that the OIG estimated has already been paid in FY 2022 and FY 2023 and another $186.4 million that VA will pay in FY 2024 and FY 2025 if it does not

reduce payments for unauthorized procedures. The unauthorized procedures fell within three categories: (1) major changes to veterans' treatment plans, (2) minor changes to treatment plans that exceeded VHA's maximum allowed amount during a rolling 12-month period, and (3) referrals that did not specify the authorized dental procedure codes as required. To help VA address these improper payments, the OIG made five recommendations to the under secretary for health related to strengthening prepayment adjudication and postpayment review processes, as well as ensuring preauthorization requirements are followed.

Information Technology

VBA Needs to Improve Oversight of the Digital GI Bill Platform

In March 2021, VBA began transitioning to a Digital GI Bill platform designed to improve education benefits delivery. The VA OIG conducted this audit to assess VBA's progress in implementing the platform. The OIG found VBA encountered delays due to unclear contract requirements and unrealistic expectations, such as not fulfilling a requirement to deliver three test environments for the new platform. Mandated decommissioning of older systems also caused delays. In addition, the project's integrated master schedule was not updated consistently due to the lack of an overall schedule that tracked external dependencies. The OIG found that once the overall schedule was established in February 2023, it was not consistently shared with the contractor. Poor communication between VBA and the contractor contributed to critical scheduling failures that caused delays and increased costs. VBA has renegotiated the original contract, more than doubling the original contract to $932 million. The OIG made three recommendations to the under secretary for benefits to increase the chances of successful implementation under the new contract through improved monitoring, regular communication with the contractor to ensure a consistent and updated master schedule, and strategies to address critical path failures.

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 August.

National Reviews

The OIG Determination of the Veterans Health Administration's Severe Occupational Staffing Shortages for Fiscal Year 2024

Every year, the OIG determines a minimum of five clinical and five nonclinical VHA occupations with the largest staffing shortages within each VHA medical center. The OIG also compared the number of severe shortages against the previous six years' reports to assess changes. Among the most significant findings in this year's staffing report were the following:

- VHA facilities reported a total of 2,959 severe occupational staffing shortages.
- Eighty-six percent of facilities reported severe shortages of medical officers and 82 percent reported severe shortages of nurses.
- "Psychology" was the most frequently reported clinical occupation and custodial worker was the most frequently reported nonclinical occupation with severe shortages.
- Of the 139 facilities surveyed, 137 reported at least one severe occupational staffing shortage, while two facilities identified no severe occupational staffing shortages.

A Select Review of VHA's Implementation of the VA Sustainability Plan

The OIG conducted a review of VHA's implementation of the *2022 United States Department of Veterans Affairs Sustainability Plan*, which describes priority actions for achieving federal environmental sustainability goals. VHA is beginning to plan and implement environmental sustainability actions related to healthcare delivery; however, more is needed to contribute to VA's goals. The role of facility Green Environmental Management System program managers in implementing the sustainability plan is unclear, and VA did not incorporate environmental stewardship values in training as required by Executive Order 14057. Additionally, VHA's long-term cumulative environmental impact of inhalational anesthetics warrants consideration of a comprehensive mitigation strategy, and the prohibition against repurposing single-use medical devices impedes improvement of diversion rates. The OIG made one recommendation to the VA secretary to incorporate required training content. Four recommendations were directed to the under secretary for health related to position responsibilities, training content, and sustainable healthcare practices.

Veterans Crisis Line Implementation of "988 Press 1" Preparation and Leaders' Response

This review focused on how Veterans Crisis Line (VCL) personnel prepared for implementation of the National Suicide Prevention Hotline three-digit dialing code "9-8-8 press 1." Specifically, the review team examined call responder and supervisor staffing and training, information technology equipment and support, and data on quality metrics as well as oversight. While the review revealed that more frontline staff were hired in anticipation of a rise in call volume, VCL

leaders had not increased the number of supervisors to meet the required supervisor-to-staff ratio. The review team identified a concern related to frontline staff's use of "postvention" resources, which are interventions designed to support the bereaved following a loved one's suicide. Regarding information technology, however, the inspection team found that VCL leaders worked effectively with the Office of Information and Technology to assess, plan for, and implement technology changes related to the three-digit transition. Additionally, data on quality metrics were reported monthly to VCL leaders at executive leadership committee meetings and reflected quality oversight. The OIG made two recommendations to the VCL director related to determining the optimal supervisor-to-staff ratio and ensuring staff receive training on all available postvention resources.

Healthcare Inspections

Failures by Telemetry Medical Instrument Technicians and Leaders' Responses at the VA Eastern Colorado Health Care System in Aurora

The OIG inspected the VA Eastern Colorado Health Care System in Aurora to review a telemetry medical instrument technician's actions and leaders' responses to allegations that a technician changed patient alarm settings and placed a communication device on "Do Not Disturb" and a second technician engaged in similar practices, leading to patient harm. The inspection team found that while monitoring a telemetry patient, the first technician failed to document that they had notified nursing staff of the patient's oxygen desaturation alarms. In addition, a registered nurse did not document a change in the patient's condition after staff found the patient unresponsive and pulseless. The team also found that another patient reported experiencing cardiac symptoms, but notification of the event to nursing staff was delayed because the second technician turned off the audio of the patient-monitoring alarms. Nursing leaders did not ensure the technicians' adherence to alarm-monitoring expectations, and a facility executive leader did not provide alarm management oversight. The OIG made six recommendations to the facility director related to medical record documentation, review of the telemetry program, patient safety event reporting, institutional disclosures of adverse events to patients or their representatives, and clinical alarm management.

Deficiencies in Informed Consent for Admission and "Against Medical Advice" Discharge Processes for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

This inspection assessed allegations that staff failed to follow informed consent and against medical advice (AMA) discharge processes at the VA Southern Nevada Healthcare System and involuntarily held a patient for 48 hours in the locked mental health unit. A concern regarding

the inadequate alignment of facility policy with Nevada state law was also identified. The OIG substantiated that staff, lacking a standardized process to follow, failed to hold a required informed consent discussion to communicate to the patient that the unit to which they were being admitted was locked and treated patients with mental health conditions. The OIG determined that although staff did not hold the patient involuntarily for 48 hours and followed the AMA discharge policy as written, the policy was inconsistent with state law. The facility director also did not assign oversight responsibilities for ensuring policy adhered to state law. The facility director concurred with the OIG's seven recommendations related to informed consent discussions, the medical center's policy development process, and staff education on policies.

Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at the VA Central Western Massachusetts Healthcare System in Leeds

In early 2023, following multiple substantiated allegations related to prescription processing delays and inadequate pharmacy staff training at the VA Central Western Massachusetts Healthcare System, the system's associate director identified 12 corrective actions for implementation. The OIG's inspection determined that 11 of these 12 corrective actions were incomplete and that the chief of pharmacy perceived the actions as disciplinary rather than as an opportunity to improve pharmacy services, which affected their implementation. Further, the chief of pharmacy's supervisors did not provide effective and timely oversight to make certain that corrective actions were completed. The OIG made three recommendations to the VISN director related to completing the actions, training pharmacy staff, and ensuring that leaders receive administrative action as appropriate.

Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida

The OIG received allegations that a patient was misled by staff and incorrectly involuntarily admitted to the mental health unit, and that VA staff's actions led to the patient's disengagement from VA mental health care and eventual death by suicide. According to the OIG's assessment, staff admitted the patient under involuntary status despite the patient's request for voluntary admission and that staff incorrectly applied the involuntary Florida Mental Health Act (Baker Act) examination hold criteria when admitting the patient. The inspection team also determined that staff turnover and failure to address the patient's concerns likely contributed to feelings of being misled. The OIG identified deficiencies in staff adherence to and leaders' oversight of VHA policy and the Baker Act but was unable to determine whether a change in care would have resulted in a different outcome. The OIG made 12 recommendations to the system director.

Deficiencies in Facility Leaders' Summary Suspension of a Provider and Patient Safety Reporting Concerns at the VA Black Hills Health Care System in Fort Meade, South Dakota

An inspection team evaluated facility leaders' responses to an alleged impairment of a general surgeon and assessed concerns with patient safety event-reporting at the VA Black Hills Health Care System. The team determined that facility leaders did not issue a summary suspension of the general surgeon's privileges when removing the surgeon from patient care. Because the concern for patient safety was significant enough to warrant this removal, the facility director was obligated to issue a summary suspension of privileges as well. The OIG also concluded that facility leaders failed to complete a focused clinical care review, which limited opportunities to identify additional incidents of potential quality of care concerns and to assess for harm. Furthermore, staff were not consistently reporting patient safety events. The OIG made three recommendations related to policies for summary suspensions and privileging actions, focused clinical care reviews, and patient safety reporting.

Care in the Community Inspection

Care in the Community Inspection of VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers

The OIG evaluates specified performance elements of VHA's Veterans Community Care Program. The resulting inspection report describes selected care coordination activities required to initiate and process referrals for non-VA care (community care). The inspection team reviewed community care processes in five VISN 9 medical facilities with a community care program from June 12 through July 13, 2023. They also examined the facilities' processes for community care referrals and care coordination in the following domains: (1) leadership and administration; (2) diagnostic imaging results; (3) administratively closed referrals; (4) community care provider requests for additional services; and care coordination (scheduling and communication with veterans referred for community care). The OIG issued 14 recommendations for improvement across all five domains.

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families. The OIG selects and evaluates specific areas of focus on a rotating basis for its vet

center inspections. See the report overview section of each report for the focus areas at the time of the inspection. August's VCIP reports focused on the following districts and vet centers:

- Continental District 4 Zone 1: Vet Centers in Fort Collins, Colorado; Kalispell, Montana; Tulsa, Oklahoma; Abilene, Texas; Salt Lake City, Utah; and Cheyenne, Wyoming
- Continental District 4 Zone 2: Fayetteville, Arkansas; New Orleans, Louisiana; Jackson, Mississippi; and Corpus Christi, Fort Worth, and San Antonio Northeast, Texas
- Continental District 4 Vet Center Operations

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To listen to the podcast on the August 2024 highlights, go to the monthly highlights page on the VA OIG website.