DECEMBER 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 December.

Healthcare Investigations

Consulting Firm Agreed to Global Settlement to Resolve Criminal and Civil Allegations Involving Advice Provided to a Pharmaceutical Manufacturer

A multiagency investigation resolved allegations that a consulting firm offered improper advice to a large pharmaceutical manufacturer on techniques the company could use to "turbocharge" the sales of their extended-release opioid drug. It is further alleged the consulting firm intentionally destroyed records to obstruct the government's investigation. From 2014 to 2017, VA purchased approximately $88 million of the promoted drug. The consulting firm entered into a global resolution with the Department of Justice under which the company will pay $650 million and enter into a five-year deferred prosecution agreement to resolve a criminal and civil investigation into their conduct. Of this amount, VA will receive approximately $3.3 million. In accordance with the global settlement, the consulting firm was charged in the Western District of Virginia with knowingly conspiring to aid and abet the misbranding of prescription drugs and knowingly destroying records with the intent to obstruct an investigation. A former senior partner at the consulting firm also agreed to plead guilty to knowingly destroying records. This investigation was conducted by the VA OIG, FBI, Department of Health and Human Services OIG, and Office of Personnel Management OIG.

Former VA Registered Nurse Sentenced for Drug Diversion

A VA OIG investigation revealed that a former registered nurse at the West Haven VA Medical Center in Connecticut diverted controlled substances intended for the facility's intensive care unit patients approximately three times a week during a six-month period in 2023. To cover up her crimes, she misrepresented in VA medical records and tracking systems that she administered the narcotics to the patient or properly disposed of the remaining portions that were not used. The former nurse was sentenced in the District of Connecticut to 24 months of probation with the first six months as home confinement after pleading guilty to obtaining a controlled substance by fraud, deception, or subterfuge.

Benefits Investigations

Three Defendants Indicted in Federal Mortgage Fraud Scheme

A multiagency investigation resulted in charges alleging the owner and two employees of a short sale company engaged in a mortgage fraud scheme. The defendants allegedly researched and located properties that were in the pre-foreclosure short sale process and approached the homeowners about listing the properties for sale. After signing a listing agreement with the homeowners, the defendants allegedly submitted various fraudulent documents to financial institutions and mortgage companies for the purpose of freezing or halting the foreclosure process. Based on these representations, the financial institutions halted foreclosure proceedings, waived fees collection, and unknowingly allowed the defendants time to find a real buyer, or in other instances, cancel the deal when they could not locate a legitimate buyer. The defendants allegedly submitted fraudulent documents for at least 88 properties—including some with VA-backed loans—totaling over $8 million in sales and $390,000 in commissions. The loss to financial institutions is at least $2.5 million and the loss to VA is approximately $600,000. The defendants were arrested after being indicted in the Eastern District of Texas on charges of conspiracy to commit wire fraud and conspiracy to submit false statements. This investigation was conducted by the VA OIG, Department of Housing and Urban Development (HUD) OIG, and Federal Housing Finance Authority OIG.

Two Real Estate Agents Sentenced to Prison for Defrauding Clients in Short Sale Fraud Scheme

According to another multiagency investigation, two real estate agents conspired with others to defraud VA, HUD, banks, and mortgage servicers through multiple fraud schemes, including acting as brokers in the sale of distressed residential real estate (bank-owned properties that are being listed for sale by a real estate firm, through an agreement with a given financial institution), while secretly using straw buyers to purchase those properties, which they subsequently "flipped." The scheme involved over 100 properties, of which at least 10 were covered by VA's loan guaranty program. One of the real estate agents was sentenced in the District of Massachusetts to 42 months in prison, 36 months of supervised release, over $2.5 million in restitution, and forfeiture of approximately $612,000. Of the restitution, VA will receive over $171,000. The other real estate agent had been previously sentenced to 12 months and one day in prison and 24 months of supervised release, and was ordered to forfeit over $277,000 and pay restitution that will be determined on a later date. This investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation, and FBI.

Former Veterans Benefits Administration (VBA) Quality Review Specialist Sentenced for Theft of Government Funds

Between December 2019 and August 2022, a VBA quality review specialist at the St. Paul VA Regional Office created 21 false VA claims in the names of multiple VA beneficiaries and then directed the resulting payments to his personal bank accounts. He was sentenced in the District of Minnesota to 60 months of probation and over $389,000 in restitution after pleading guilty to theft of government funds. The VA OIG investigated this case.

Daughter of Deceased VA Beneficiary Pleaded Guilty to Wire Fraud

VA OIG investigators found that the daughter of a deceased VA beneficiary continued to collect and withdraw her mother's VA dependency and indemnity compensation benefits following the mother's death in November 2005. The daughter pleaded guilty in the Middle District of Florida to wire fraud. The loss to VA is approximately $338,000.

Veteran Admitted to Stealing VA Unemployability Benefits for 13 Years

A VA OIG and Social Security Administration OIG investigation revealed that while receiving VA individual unemployability benefits from 2011 to 2024, a veteran operated a mixed-martial arts company under his spouse's name to conceal his ownership. The veteran made multiple misrepresentations and false statements to VA and the Social Security Administration on employment questionnaires and documents to receive these unemployability benefits, as well as tried—unsuccessfully—to obtain Social Security disability insurance benefits. The loss to VA is over $283,000. He pleaded guilty in the Southern District of California to failure to disclose events to the Social Security Administration.

Another Veteran Sentenced for Theft of VA Unemployability Benefits

From 2019 to 2023, a veteran received VA individual unemployability benefits despite serving as the chief executive officer for an organization that he founded. In this capacity, he worked 40 to 60 hours per week; managed over $400,000 in assets and about 6,000 volunteers; met with business and political leaders; and engaged in news media interviews, podcasts, and community events. The veteran made multiple misrepresentations and false statements to VA to receive individual unemployability benefits. The loss to VA is approximately $126,000. The veteran was sentenced in the Eastern District of Kentucky to six months in prison, 12 months of supervised release with the first six months to be home detention, and restitution to be determined at a later date after being found guilty at trial of theft of government benefits.

Former VA Fiduciary Indicted for Stealing Benefits from Veteran

A VA OIG investigation resulted in charges alleging that a VA-appointed fiduciary made cash withdrawals of VA funds intended for a veteran and used them for his own personal expenses. The loss to VA is about $178,000. He was arrested after being indicted in the Northern District of Florida for theft

of government funds.

Investigations Involving Other Matters

Veteran Pleaded Guilty to Groping a Nursing Student at Albany, New York, VA Medical Center

A VA OIG and VA Police Service investigation found that a veteran grabbed the breast of a nursing student who was providing medical care to him at the Albany Stratton VA Medical Center. He pleaded guilty in the Northern District of New York 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 December.

Featured Reports

Survivors Did Not Always Receive Accurate Retroactive Benefits for Dependency and Indemnity Compensation Claims Reopened Under the PACT Act

Dependency and Indemnity Compensation is a monthly benefit paid to eligible survivors of service members who died in the line of duty or as a result of a service-related injury or illness. Under the PACT Act, survivors with previously denied claims may be newly eligible for compensation related to veterans' toxic exposure. These survivors may reapply for benefits and might receive retroactive payments dating back to the original date of entitlement. The OIG conducted this review to assess the accuracy of VBA's processing of Dependency and Indemnity Compensation claims reopened under the PACT Act. The OIG reviewed statistical samples of claims that were reopened under the PACT Act after having previously been denied and found errors in claims that were granted after being reprocessed. The OIG made three recommendations to correct errors and improve the claims process.

Staff Incorrectly Processed Claims When Denying Veterans' Benefits for Presumptive Disabilities Under the PACT Act

This review focused on whether VBA staff processed PACT Act claims for presumptive disabilities consistent with applicable laws and procedures before denying them. The findings include that claims processors sometimes requested unwarranted medical examinations or

opinions for disabilities the PACT Act already presumed to be connected to military service. These actions delayed processing and resulted in unnecessary payments for medical examinations and opinions as well as underpayments to veterans. The team identified claims that correctly denied service connection but cost VBA an estimated $1.4 million for unwarranted examinations and medical opinions over the six-month review period in 2023. Two veterans who were improperly denied service connection were also underpaid about $56,700 during that time. Other denials based on inadequate or conflicting information could also affect veterans' benefits. The OIG acknowledges VBA's efforts to address these errors and its concurrence with the OIG's two recommendations to improve guidance for claims processors.

Financial Efficiency

Audit of VA's Financial Statements for Fiscal Years 2024 and 2023

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) 2024 and 2023. CLA provided an unmodified opinion and noted three material weaknesses and three significant deficiencies in internal control and instances of noncompliance with laws and regulations. CLA is responsible for the audit report dated November 15, 2024, and the conclusions expressed in the report. The OIG does not express opinions on VA's financial statements, internal controls, or compliance with the Federal Financial Management Improvement Act of 1996, nor does the OIG express 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 2025 audit of VA's financial statements.

Management Advisory Memorandum

VA Can Enhance Reporting of Its Progress to Reduce Drug Overdose Deaths

The Office of National Drug Control Policy (ONDCP) is responsible for overseeing the President's National Drug Control Strategy across the federal government to reduce substance use disorder rates and overdose deaths. ONDCP asked the OIG to review the accuracy of VA's FY 2023 reported progress for four measures related to reducing overdose deaths:

1. Patients with nonfatal overdoses with case reviews
2. Patients estimated as very high-risk risk for overdose or suicide and a substance use disorder who were actively engaged in substance use disorder treatment
3. Number of patients receiving contingency management
4. Percentage of patients receiving medication for an opioid use disorder

VA's reporting was accurate for measures 3 and 4 but omitted patients receiving community care for measure 1 and patients receiving residential treatment for measure 2. These populations were overlooked because VA lacked quality controls to verify and archive data before reporting. Facilities also struggled with laboratory testing requirements for contingency management. The OIG requested that VA inform ONDCP and the OIG of actions taken to update the accuracy of its future reporting for measures 1 and 2 and noted that the Veterans Health Administration (VHA) should coordinate with ONDCP to determine whether datasets should be archived.

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 December.

National Review

VHA Policy and Practice Support Age-Specific Osteoporosis Screening in Women

The OIG conducted this review of VHA to assess policy pertaining to osteoporosis screening and to determine osteoporosis screening rates in women patients aged 65 and older enrolled in VHA primary care. VHA policy states that preventive care for women patients must include osteoporosis screening that generally align with US Preventive Service Task Force recommendations. The OIG found that most women patients meeting age-specific criteria for osteoporosis screening were offered or underwent bone mineral density testing. VHA implemented measures to improve osteoporosis screening, including the development of a toolkit and a clinical reminder. Improvement in osteoporosis screening rates temporally correlated with the implementation of the clinical reminder, although the OIG observed that there were sites where reminder use was not identified for any of the sampled patients. VA concurred with the OIG's recommendation related to identifying barriers to clinical reminder use.

Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination

This review assessed VHA inpatient mental health unit suicide risk identification processes, suicide prevention safety plans, mental health treatment coordinator (MHTC) role requirements,

and discharge care coordination procedures.[1] The OIG conducted electronic health record reviews of a random sample of 200 patients from a study population of 16,108 unique patients with a mood disorder diagnosis discharged from across 84 VHA mental health units from October 1, 2019, through September 30, 2020. The reviews found that staff failed to document suicide risk screening for 27 percent of patients and did not complete safety plans for 12 percent. Over 30 percent of facilities lacked an MHTC policy and staff failed to assign an MHTC for nearly 40 percent of patients. Over half of the 73 surveyed patients could not identify the assigned MHTC or another staff member to contact for help. More than 25 percent of MHTCs were uninvolved in discharge care coordination. The OIG made eight recommendations related to suicide risk identification and safety planning; MHTC written guidance and assignment; and post-discharge mental health appointment scheduling and treatment engagement.

Inadequate Staff Training and Lack of Oversight Contribute to VHA's Suicide Risk Screening and Evaluation Deficiencies

The OIG evaluated VHA's standardized Suicide Risk Identification Strategy (Risk ID) process, including suicide risk screening and evaluation training, adherence, and oversight procedures. VHA's required suicide prevention training did not include annual and setting-specific suicide screening and evaluation requirements; completion of Risk ID training was not monitored; and annual or setting-specific Risk ID performance benchmarks have not been established. VHA's annual screening adherence was 55 percent and evaluation adherence was 82 percent in FY 2023. Except for emergency department and urgent care settings, VHA does not monitor setting-specific Risk ID adherence. VHA staff encountered several barriers to completing Risk ID screening and evaluation, including limited engagement of facility clinical staff, lack of facility leaders' support, limitations of performance data, and unclear responsibilities. The OIG's six recommendations were related to suicide risk and intervention training, suicide screening and evaluation performance benchmarks, setting-specific Risk ID monitoring, and effectively addressing barriers to Risk ID nonadherence.

Healthcare Inspections

Allegation of Underutilization of Mental Health Clinics, and Concern for Delays in Patient Care, at the Hinesville VA Clinic in Georgia

This inspection was conducted by the OIG to assess allegations that select therapists do not maintain optimal clinic utilization rates and that the Choose My Therapy (CMT) program created barriers to patients receiving care at the Hinesville VA Clinic. The OIG substantiated the

[1] The OIG evaluated the MHTC policies or standard operating procedures provided by 71 of 106 (67 percent) facilities with mental health units.

allegations and found that the therapists generally had utilization rates below VHA's lowest recommended target of 80 percent. The OIG analyzed data of 285 unique patients who received a diagnostic evaluation and found that patients experienced delayed access to mental health care. Specifically, a median wait time of at least three weeks between three subsequent individual psychotherapy sessions. Delayed initiation of mental health treatment may put patients at risk for negative outcomes, and VHA expects sessions to occur weekly. Further analysis of the data showed a progressive loss of patients engaged in treatment.[2] The clinic staff also used a prohibited spreadsheet waitlist that was discontinued in April 2023. VA concurred with the OIG's six recommendations related to clinic utilization, current procedural terminology codes, consult management, patient scheduling, review of patients who experienced therapy delays, and evaluation of facility CMT programs.

Improvement in the Patient Safety Program with Continued Opportunities to Strengthen Veterans Integrated Service Network 7 Oversight at the Tuscaloosa VA Medical Center in Alabama

As a follow-up to two prior OIG reports, this healthcare inspection evaluated the status of the facility's patient safety program and Veterans Integrated Service Network (VISN) 7's oversight, and actions taken to protect community living center residents at risk for elopement (unsupervised wandering or departure). Facility leaders addressed the deficiencies identified in prior OIG reports, and the facility patient safety program is compliant with VA-mandated standards. The OIG determined that leaders' actions resulted in a facility culture in which patient safety has become paramount and that VISN oversight of the patient safety program improved. However, there is a need for qualitative reviews of patient safety data. The facility resolved previous concerns regarding the safety and security of the residents in the community living center, including those at risk for elopement. The OIG made three recommendations to the VISN director related to qualitative reviews of patient safety data.

Healthcare Facility Inspections

The Healthcare Facility Inspections (HFI) Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care provided using five content domains: 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

[2] The OIG analyzed the number of patients at the diagnostic and treatment planning and subsequent psychotherapy-coded sessions as provided by clinic therapists from October 1, 2022, through April 11, 2024.

patients and staff. December's HFI reports focused on the following facilities:

- Durham VA Health Care System in North Carolina
- VA Northport Healthcare System in New York
- Birmingham VA Health Care System in Alabama

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 OIG's hotline division that was not included in the inspections, audits, investigations, or reviews detailed above.

VA Mental Health Outpatient Clinic in Virginia Mismanaged Mental Health Referrals, Triage Procedures, and Facility Practices

The OIG Hotline received allegations that a VA mental health outpatient clinic in Fredericksburg, Virginia, mismanaged health referrals by marking them as complete as soon as they were received rather than when the veterans were evaluated, and also took over two months to complete veterans' evaluations and another two months to review the evaluations. In addition, veterans waited for two or more months for follow-up appointments. The OIG hotline staff referred the allegations to VISN 6, which reviewed and then substantiated them. To address the deficiencies, the VISN developed a 12-step action plan that provides detailed guidance and required corrections for the consult processes, new patient appointment date selection, timing of offering community care or VA Video Connect, primary care mental health integration consult requirements, and return-to-clinic orders.