DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

JANUARY 2024 HIGHLIGHTS

Congressional Testimony

Principal Deputy Assistant Inspector General for Healthcare Inspections Testifies before the Senate Veterans' Affairs Committee on Vet Centers

Dr. Julie Kroviak testified on behalf of the OIG before the Senate Committee on Veterans' Affairs on January 31. She focused on repeated deficiencies identified by the OIG's proactive Vet Center Inspection Program (VCIP). Vet centers are community-based counseling centers providing a wide range of social and psychological services to eligible veterans, service members, and their families to support a successful transition from military to civilian life, including being responsive to traumatic events experienced in the military. She lauded the dedication of vet center staff, yet recognized that these centers' limited progress over the last three years, particularly for suicide prevention activities, suggests barriers remain in improving and sustaining compliance with critical VA policies. She called for stronger leadership engagement and continuous oversight of vet center staffs' daily activities, particularly for veterans at high risk for suicide. In response to questions, Dr. Kroviak suggested that vet center directors would benefit from reviewing all of the OIG's VCIP reports and that focusing on clear and consistent communication with VA medical centers would help improve vet center performance and outcomes. 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 in January.

Healthcare Investigations

Pharmacist Sentenced in Connection with Compounding Pharmacy Scheme

A multiagency investigation resulted in charges alleging numerous individuals engaged in a scheme to solicit and receive kickbacks from multiple North Texas compounding pharmacies in return for directing prescriptions for patients in federal programs to those pharmacies. The total loss to the government is over $6 million. Of this amount, the loss to VA is over $848,000. A pharmacist was sentenced in the Northern District of Texas to 10 months in prison, over $591,000 in restitution, and a fine of $7,500 after previously pleading guilty to misprision (knowing concealment) of a felony. This investigation was conducted by the VA OIG, Defense

Criminal Investigative Service (DCIS), US Postal Service (USPS) OIG, Department of Labor (DOL) OIG, FBI, and the Department of Health and Human Services OIG.

Veteran Charged with Defrauding VA's Foreign Medical Program

According to a VA OIG investigation, a veteran allegedly submitted fraudulent reimbursement claims to VA's Foreign Medical Program for treatments associated with care providers who not only did not have any record of ever treating the veteran, but who did not even offer the type of medical care claimed to have been received. It is further alleged the veteran claimed to have received care in Colombia while he was actually in the United States. The loss to VA is approximately $429,000. The veteran was indicted in the Southern District of Florida on charges of theft of government funds and mail fraud.

Benefits Investigations

Technical School Employee Sentenced for Role in Education Benefits Fraud Scheme

A VA OIG investigation found that the chief executive officer of a non-college-degree-granting technical school and multiple coconspirators defrauded VA's education benefits program by falsifying attendance records, student grades, and professional certifications to conceal that 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 online coursework 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. A school employee was sentenced in the District of Columbia to 12 months and one day in prison, 12 months of supervised release, and over $3.4 million in restitution to VA.

Former Navy Doctor Sentenced for Disability Insurance Fraud

A multiagency investigation revealed that a former Navy doctor conspired with others to submit fraudulent claims through the Traumatic Servicemembers Group Life Insurance (TSGLI) program. The coconspirators submitted numerous TSGLI claims that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living to generate payouts of $25,000 to $100,000 per claim to individuals who then gave kickbacks to the specific coconspirators who recruited them. VA supervises the administration of the TSGLI program. In total, 10 individuals were convicted in connection with this scheme. The loss to the TSGLI program is approximately $2 million. In addition to being sentenced in the Southern District of

California to 12 months and one day in prison and 36 months of probation, the former Navy doctor was ordered to forfeit $180,000 after previously pleading guilty to conspiracy to commit wire fraud. The VA OIG, Naval Criminal Investigative Service, and FBI conducted the investigation.

Veteran Pleaded Guilty to Making False Statements about His Claimed Disability

According to a VA OIG investigation, a veteran lied to VA about being unable to use both his feet, which resulted in his receipt of VA compensation for almost two decades and vehicle adaption benefits to which he was not entitled. The veteran pleaded guilty in the District of New Hampshire for making false statements. The loss to VA is approximately $662,000.

Defendant Pleaded No Contest to Defrauding VA by Posing as Deceased Veteran's Spouse

An investigation by the VA OIG and Michigan attorney general found that three individuals used aliases to obtain or create fraudulent documents, to include vital records such as birth certificates, to make it appear as if they were the surviving spouses of deceased veterans. These documents were used to fraudulently obtain VA Dependency and Indemnity Compensation (DIC) benefits, VA Survivors Pension benefits, and unclaimed funds from Michigan. In January, one of the three individuals pleaded no contest in the Third Judicial Circuit Court of the State of Michigan to conducting a criminal enterprise and false pretenses for defrauding VA and the Michigan Department of Treasury. Pursuant to the plea agreement, the defendant will be sentenced to serve between 78 months and 20 years of incarceration and be ordered to pay $470,000 in restitution. Of this amount, VA is due to receive $430,000.

Defendant Sentenced for Stealing 30 Years' Worth of VA Survivors' Benefits

From November 1993 to July 2023, an individual received VA DIC benefits intended for his grandmother due to both her husband's and son's military service. A review of the grandmother's bank records revealed that for nearly 30 years, the grandson used her VA benefits for his own personal expenses after she passed away in November 1993. The loss to VA is more than $340,000. Following an investigation by the VA OIG, the grandson was sentenced in the Western District of Missouri to 12 months of home confinement, five years of probation, and over $340,000 in restitution after previously pleading guilty to theft of government property.

Investigations Involving Other Matters

Two Defendants Sentenced in Connection with Workers' Compensation Fraud Scheme

From 2011 until 2017, the former owner of a medical supply and billing company and the company's former chief executive officer conspired to defraud healthcare benefit programs,

including the DOL's Office of Workers' Compensation Program and private workers' compensation programs, by submitting claims for topical medications supplied by the company. The medications were prescribed and dispensed by healthcare providers who were paid kickbacks. Two of the healthcare providers did not have the legal authority to disburse medications in their state. Both the former owner and former chief executive officer from the medical supply and billing company were sentenced in the Western District of Arkansas after previously pleading guilty to conspiracy to commit wire fraud and illegal remunerations. The former owner was sentenced to 48 months of incarceration, three years of supervised release, and a fine of $25,000. The former chief executive officer was sentenced to 32 months of incarceration and three years of supervised release. A third defendant, a healthcare provider, was previously sentenced to 48 months in prison. These three defendants were ordered to jointly pay restitution of over $3.5 million. Two other defendants—a former company executive and another healthcare provider—also pleaded guilty and are awaiting sentencing. The total loss to DOL is over $3.9 million. VA suffered a loss of more than $487,000 in connection with workers' compensation claims filed by VA employees. This investigation was completed by the VA OIG, DCIS, DOL OIG, and USPS OIG.

Former VA Contracting Officer and Transportation Company Owner Pleaded Guilty for Roles in Bribery Scheme

According to an investigation by the VA OIG and FBI, a transportation company owner paid a bribe of $100,000 to a former South Texas Veterans Healthcare System contracting officer in exchange for the award of a set-aside contract to a business that the transportation company owner controlled. The former VA contracting officer pleaded guilty in the Western District of Texas to conspiracy to commit bribery. The owner pleaded guilty to conspiracy to commit bribery and fraud in connection with identification documents or authentication features.

VA Employee Charged with Paycheck Protection Act and Economic Injury Disaster Loan Scheme

A VA OIG investigation resulted in charges alleging that a medical support assistant (while employed at the VA medical center in Houston, Texas) fraudulently obtained a Small Business Administration-backed Paycheck Protection Program loan for over $15,000 and an Economic Injury Disaster loan for $95,000 for a business that was never in operation. The former medical support assistant was charged in the Southern District of Texas with wire fraud.

Nonveteran Charged with Making False Statements in Thousands of Phone Calls to VA's Veterans Crisis Line

Between December 2016 and December 2022, a nonveteran allegedly made over 13,000 calls to the Veterans Crisis Line during which he used Voice over Internet Protocol (VoIP) to mask his identity. The nonveteran allegedly reported experiencing suicidal ideations or actively being

engaged in a suicide attempt during these calls. It is further alleged that the caller sometimes reported having cut himself with a knife, possessing a gun, or being on the verge of falling asleep after taking pills; provided false names, dates of birth, social security numbers, and addresses; and made false claims of being a veteran during these calls. Based on this information, the Veterans Crisis Line contacted local emergency services on hundreds of occasions for the dispatch of first responders to locations around the country. Following an investigation by the VA OIG, the nonveteran caller was arrested and charged in the Eastern District of North Carolina with making a false statement or representation to an agency of the United States.

Veteran Charged with Making Threats against the West Haven VA Medical Center

A multiagency investigation resulted in charges alleging that a veteran told VA Police Service officers at the VA medical center in West Haven, Connecticut, that he wanted to return to the facility with a weapon. The veteran also allegedly made subsequent verbal statements to the FBI about his plans to bring a firearm to the facility. He was arrested after being charged in the District of Connecticut with threatening a government official. This investigation was conducted by the VA OIG, Federal Protective Service, VA Police Service, and FBI.

Another Veteran Was Charged with Making Threats against the Hines VA Hospital Staff and Local Law Enforcement Officers

According to an investigation by the VA OIG and VA Police Service, a veteran allegedly made several telephone calls to the Veterans Crisis Line during which he threatened to shoot staff at the Edward Hines, Jr. VA Hospital and local law enforcement officers. He was arrested in the Northern District of Illinois, and because the Veterans Crisis Line staff were located in different states, he was charged with transmitting a threatening communication via interstate commerce.

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 January.

Information Technology

VA Should Enhance Its Oversight to Improve the Accessibility of Websites and Information Technology Systems for Individuals with Disabilities

VA is required by law to make information on its websites, related resources, and data systems accessible to people with disabilities. The OIG conducted this audit to address concerns from

Congress and a veterans service organization about the accessibility of VA websites and information technology systems. The OIG found areas where VA's efforts and monitoring of Section 508 requirements could be improved to ensure websites and information technology systems are equally accessible to all. Specifically, web managers did not routinely maintain the Web Registry, VA's official repository of websites, as required, and websites were not consistently scanned for compliance until recently. Further, VA officials did not always keep administrations and staff offices apprised of requirements and related procedures, resulting in noncompliant VA information technology systems and an inaccurate VA Systems Inventory, which designates systems as Section 508 compliant, noncompliant, or unassessed. Finally, three directives were not recertified within the required timeline. The OIG made six recommendations to address these shortcomings and safeguard accessibility.

Benefits

Featured Report

Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA

The OIG sought to determine whether VBA continues to use updated public disability benefits questionnaires and provides sufficient oversight, given the significant risk of fraud associated with their misuse. Publicly available questionnaires are completed by veterans' non-VA medical providers, whereas internal questionnaires are completed by VA medical providers. The OIG team found VBA generally accepted and used public questionnaires when determining entitlement to benefits. However, VBA does not have effective controls to mitigate the risk of using fraudulent forms to decide benefits. The team estimated from a statistical sample that of the 31,900 claims completed during the review period (January 1 to December 31, 2022), approximately 22,000 claims (69 percent) had one or more fraud risk indicators. Though these are only possible instances of fraud, the team's projections suggest that the risk to VA during the year reviewed could be approximately $390 million. VBA concurred with the OIG's five recommendations to address the problems.

Management Advisory Memoranda

The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified by OIG hotline allegations or in the course of its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

End User Concerns with Integrated Financial and Acquisition Management System Training

VA's Financial Management Business Transformation Service (FMBTS) is leading and managing the implementation of the Integrated Financial and Acquisition Management System (iFAMS), an enterprise-wide modernization effort to replace legacy systems that facilitate the department's financial and contracting activities. FMBTS personnel are responsible for training end users, which is critical to a successful iFAMS deployment across VA. FMBTS conducts a post-training survey but does not solicit feedback on end users' tasks and daily activities, and the timing of this survey immediately after training does not allow FMBTS to assess how users apply instruction when conducting role-specific activities in iFAMS. The VA OIG surveyed a statistical sample of 255 end users to assess satisfaction with iFAMS training. The team found that end users had concerns with the training provided for some tasks and day-to-day activities, leaving FMBTS with opportunities to enhance the training program. Addressing training weaknesses now is important, as over 100,000 employees have yet to be trained on the system.

VA's Allocation of Initial PACT Act Funding for the Toxic Exposures Fund

Under the PACT Act, VA may use the Cost of War Toxic Exposures Fund (TEF) to ensure health care and claims processing for eligible veterans are supported. Congress authorized an initial appropriation of $500 million to set up the TEF for fiscal years 2023 and 2024 and required that VA produce a spending plan detailing funding allocation, which VA submitted. The OIG issued this memorandum to draw VA leaders' attention to identified concerns, including incomplete methodologies to explain spending plan estimates for claims processing and information technology modernization. Also, amendments were made to avoid violations of the Purpose Statute, and monthly spending reports to Congress had minor calculation inaccuracies due to inconsistent methods. The OIG commends VA for proactive legal reviews to prevent improper spending. No specific recommendations were made, but the OIG requested being informed of actions taken to prevent improper spending when all methodologies are completed.

Veterans Are Receiving Concurrent Monthly Housing Allowance Payments while Participating in Certain VA Educational Programs

During another review, the VA OIG discovered VA is paying concurrent monthly housing allowance benefits to veterans who are simultaneously enrolled in Post-9/11 GI Bill and VA's Veteran Employment Through Technology Education Courses (VET TEC) educational programs. No law prohibits concurrent payments for these educational benefits; however, legislation for other VA educational benefits programs prohibits concurrent payments. Congress introduced bills to continue the VET TEC program in 2023. This memorandum is meant to convey the information necessary for VBA and Congress to determine if this inconsistency should be addressed. Results from a sample of 30 eligible veterans showed that all received

concurrent payments (about $164,500). The OIG team estimated about 208 veterans received a total of $1.1 million in concurrent payments from April 1, 2019, to February 28, 2023. VBA and Congress have an opportunity to consider whether the VET TEC program should continue to allow eligible veterans to receive concurrent payments.

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 January.

National Review

Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal

The OIG reviewed national and healthcare system guidance issued by the Veterans Health Administration (VHA) regarding the inpatient management of alcohol withdrawal. Determining a patient's severity of alcohol withdrawal is critical in facilitating treatment decisions that may prevent the progression of symptoms that could be fatal. Current VHA guidance does not specifically address inpatient management of alcohol withdrawal, which does not fall under one VHA national program office. The OIG found healthcare systems lacked written guidance related to assessing alcohol withdrawal severity; determining the appropriate level of care; evaluating co-occurring conditions; consulting with substance use disorder experts; and administering pharmacotherapy interventions. The under secretary for health concurred with the OIG's three recommendations to identify a national program office for the oversight of alcohol withdrawal management in inpatient settings; to develop written guidance that includes expectations for determining alcohol withdrawal severity, level of care, and when transfer of care is indicated; and to implement related training for inpatient staff.

Healthcare Inspections

Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans Health Administration Oversight Failures

During a review of a former VA surgeon's eligibility to participate in VA's Community Care Network (CCN), the OIG identified multiple failures by the VA Office of Integrated Veteran Care and a third-party administrator (TPA) that undermined credentialing and oversight

processes. The TPA, which is responsible for ensuring all licensed non-VA providers are credentialed, failed to address concerns and inconsistencies in the surgeon's credentialing file. Furthermore, due to a misapplication of privacy rules, the TPA did not release information to VA regarding the surgeon's voluntary relinquishment of their Florida medical license. VA concurred with the OIG's eight recommendations related to reviewing the surgeon's CCN eligibility, contracts, and care provided, as well as the TPA's credentialing decisions for providers.

Care Deficiencies and Leaders' Inadequate Reviews of a Patient Who Died at the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis, Tennessee

Following a patient's death at the Memphis VA medical center, the OIG found multiple deficiencies in its assessment of the quality of care provided during the patient's hospitalization and its facility leaders' response to the care. These include the delayed initiation of a blue alert—an announcement that notifies personnel that a patient is experiencing a medical emergency—due in part to a telemetry technician not following a series of communications within the facility policy's time frame, as well as a charge nurse's failure to communicate nursing assignments. After the patient's death, facility leaders conducted reviews of the care provided. However, a nursing leader did not issue a fact-finding authorization letter and the root cause analysis team did not interview some staff directly involved with the patient's care, and both of these failures hindered the identification of systemic and causal factors related to the event. The OIG made five recommendations to the facility director involving compliance with the cardiac telemetry monitoring policy, nursing assignment communication, critical care consult documentation, and root cause analyses.

Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple

The OIG reviewed allegations that diagnoses of a patient's prostate cancer and lung cancer were delayed at the VA healthcare system in central Texas. A delay in diagnosis was substantiated for the patient's prostate cancer but not for the lung cancer. There was, however, a related concern identified regarding leaders' failure to clearly communicate expectations for lung cancer screening. The OIG concluded that two nurse practitioners failed to offer a prostate biopsy and act on elevated prostate-specific antigen levels and an abnormal prostate exam. Facility leaders also failed to ensure the nurse practitioners were initially competent to practice independently in urology and did not adequately assess the nurse practitioners' ongoing urology-specific competency, and did not effectively communicate to providers the expectations for lung cancer screening. The facility director concurred with the OIG's four recommendations related to reviewing the care both nurse practitioners provided to this and other urology patients, as well as the privileging and professional practice evaluation processes for nurse practitioners.

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. January's CHIP reports centered on the following facilities:

- Richard L. Roudebush VA Medical Center in Indianapolis, Indiana
- Miami VA Healthcare System in Florida
- Wilmington VA Medical Center in Delaware
- Tomah VA Medical Center in Wisconsin
- Veterans Integrated Service Network 22: VA Desert Pacific Healthcare Network in Long Beach, California
- Columbia VA Health Care System in South Carolina
- VA Caribbean Healthcare System in San Juan, Puerto Rico

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.

Allegations of Resident Abuse and Hostile Work Environment at the Tucson VA Medical Center's Community Living Center (CLC) Were Substantiated

The OIG Hotline received allegations that residents of the Tucson VA Medical Center's CLC (a VA nursing home) were subjected to systemic verbal and physical abuse by VA staff and contractors, and a hostile work environment prevented some staff from reporting the abuse that could have helped to protect residents. The allegations and supporting evidence were sent to Veterans Integrated Services Network (VISN) 22—the Desert Pacific Healthcare Network—for review and response. The VISN's fact-finding team conducted staff interviews and reviewed existing records, witness statements, and VA police reports. The team substantiated that verbal abuse and unprofessional conduct occurred, that a hostile work environment did prevent some staff from raising concerns about residents, and that residents had been subjected to inappropriate restraint in the provision of personal care and activities of daily living care. The fact-finding team recommended 14 corrective actions, which the VISN 22 director provided to the medical

center director to review, implement, and monitor. The corrective actions included establishing an orientation and continuing training program for CLC staff and retraining managers on responding to and addressing concerns of resident abuse, unprofessional conduct, and bullying in the workplace.