MARCH 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 this month.

Healthcare Investigations

Fourteen People Indicted for Role in $445 Million Healthcare Fraud Scheme

A multiagency investigation resulted in charges alleging 10 doctors, two pharmaceutical executives, and two management service organizations participated in various healthcare fraud schemes that included paying illegal kickbacks to physicians for prescriptions, substituting unnecessary higher-cost prescriptions, automating prescription refills regardless of medical necessity, eliminating cost control measures such as copayments, providing and billing for unnecessary prescriptions, and misbranding cheaper medication manufactured in China that was billed to insurance programs as if it were more expensive medication. Government and private insurance programs were billed approximately $445 million. VA's Civilian Health and Medical Program and Office of Workers' Compensation Program were billed over $16.8 million. Of this amount, VA had paid approximately $1.9 million. The defendants were indicted in the Northern District of Texas on charges to include conspiracy to violate the Travel Act by violating the Texas Commercial Bribery Statute, conspiracy to deny patients their right to honest services, and conspiracy to commit money laundering. This investigation was conducted by the VA OIG, US Postal Inspection Service, FBI, Defense Criminal Investigative Service, Department of Labor (DOL) OIG, Department of Health and Human Services (HHS) OIG, HHS Medicaid Fraud Control Unit, Office of Personnel Management OIG, Food and Drug Administration Office of Criminal Investigations, IRS Criminal Investigation, and Drug Enforcement Administration.

Two Health Service Company Owners Sentenced for Compounding Pharmacy Conspiracy

According to another coordinated investigation, numerous individuals allegedly 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 at a higher cost. The total loss to the government is more than $6 million. Of this amount, the loss to VA is over $848,000. Two owners of a health services company were sentenced in the Northern District of Texas after pleading guilty to conspiracy to solicit and receive kickbacks. One owner

was sentenced to 36 months in prison, and the other was sentenced to 36 months of probation. Each owner was also ordered to pay restitution of over $4.4 million. A third owner of the same company pleaded guilty to conspiracy to solicit and receive kickbacks and will be sentenced at a later date. This investigation was conducted by the VA OIG, US Postal Service OIG, FBI, Defense Criminal Investigative Service, HHS OIG, and DOL OIG.

Benefits Investigations

Civil Complaint Filed against For-Profit Schools for False Claims Involving the Post-9/11 GI Bill

A VA OIG investigation resulted in a civil complaint alleging that two for-profit computer learning center franchises submitted false claims to VA for Post-9/11 GI Bill tuition payments. The companies allegedly overcharged VA by failing to report tuition waivers and scholarships provided to GI Bill students and falsely certifying compliance with Title 38's ban on incentive compensation tied to student enrollment. If a school offers to waive tuition for a student receiving less than 100 percent assistance, that tuition waiver must be reported to VA and the student's portion must be reduced accordingly. Title 38 also prohibits participating schools from paying any commission, bonus, or other incentive payment based directly or indirectly on securing student enrollments. As a result of the investigation, the VA State Approving Agency withdrew both franchises from participation in the GI Bill program. Between 2014 and 2021, VA paid the two companies approximately $14 million and $26 million, respectively. The civil complaint was filed in the Middle District of Florida against the two companies and their individual owner.

Veteran Convicted of Making False Statements in Recent Trial Pleaded Guilty to Theft of Government Funds

An investigation by the VA OIG, Department of Transportation OIG, and SSA OIG revealed that a veteran received VA individual unemployability and Social Security disability benefits because he maintained that he was unable to work. However, the veteran owned and operated two construction companies that were designated as service-disabled veteran-owned small businesses (SDVOSBs). Investigators also found that, in order for the veteran to obtain a medical certificate to receive a pilot's license, he withheld information on multiple Federal Aviation Administration medical certifications regarding a service-related disability for which he received both VA and SSA disability benefits. A federal jury found him guilty at trial of making false statements to the Federal Aviation Administration in February 2024. The jury was deadlocked on the theft of government fund charges pertaining to VA and SSA, but the veteran pleaded guilty in the Western District of Louisiana to theft of government funds to resolve these remaining charges. In accordance with the plea agreement, he forfeited previously seized funds totaling over $141,000.

Veteran's Sister Admits to Stealing His VA and Social Security Benefits

The sister of a veteran used his government benefits for her personal expenses after he became a full-time resident at the Orlando VA Medical Center's Community Living Center (nursing home). The defendant, who previously served as her brother's VA-appointed fiduciary and Social Security Administration (SSA) representative payee, conducted large monthly wire transfers from his bank account to her own personal bank account after the deposits of his VA and Social Security benefits. She pleaded guilty in the Middle District of Florida to theft of government funds. The loss to VA is approximately $150,000; the loss to SSA is approximately $34,000. The VA OIG and SSA OIG conducted this joint investigation.

Former VA Fiduciary Admitted to Stealing Benefits from Veteran

VA OIG special agents found that a former VA-appointed fiduciary stole about $143,000 intended for the veteran she was appointed to represent. The defendant used the veteran's VA compensation benefits to fund a trip to Las Vegas and to purchase household items and vehicles for herself and her daughter, as well as gave some of the funds away to personal acquaintances. The defendant pleaded guilty in the District of Kansas to misappropriation by a fiduciary.

Investigations Involving Other Matters

Veteran Inpatient Charged with First Degree Murder

A VA OIG investigation resulted in charges alleging that an inpatient at the West Palm Beach VA Medical Center's psychiatric unit strangled to death another veteran who was an inpatient in their shared bathroom. The defendant was arrested in the Southern District of Florida after being charged with first degree murder.

Two Nonveterans Pleaded Guilty to $78 Million Rent-A-Vet Construction Fraud Scheme

A VA OIG and FBI investigation revealed that two nonveterans defrauded VA by fraudulently obtaining federal set-aside construction contracts intended for SDVOSBs. The defendants used several disabled veterans as part of a "rent-a-vet" scheme to fraudulently obtain SDVOSB status for two companies under their control, which were awarded 77 set-aside government contracts valued at over $78 million. Over several years, they provided misleading information to VA indicating that the two companies were operated by service-disabled veterans when the two nonveterans defendants were actually the majority owners who ran both companies. Both defendants pleaded guilty in the Western District of Pennsylvania to major fraud against the US.

Two Defendants Charged with Fraudulently Obtaining CARES Act Funds

A multiagency investigation resulted in charges alleging that two individuals improperly used $2 million in Coronavirus Aid, Relief, and Economic Security (CARES) Act funds to purchase

their home and engaged in a scheme to avoid paying workers' compensation insurance premiums. The defendants were arrested after being charged in the District of Massachusetts with conspiracy to commit mail, wire, and bank fraud. This investigation was conducted in connection with the Pandemic Response Accountability Committee (PRAC) Fraud Task Force by the VA OIG, IRS Criminal Investigation, Insurance Fraud Bureau of Massachusetts, and FBI. As a PRAC member, the VA OIG assists federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

Owner of Defunct Business Charged with Fraudulently Obtaining Federal Pandemic Relief Loans

The VA OIG conducted another PRAC-connected investigation with no direct nexus to VA involving an individual who allegedly defrauded the government by obtaining Small Business Administration-backed Paycheck Protection Program and Economic Injury Disaster Loans for a defunct business that he previously owned. The defendant allegedly certified that the funds would be used to retain employees and for legitimate business expenses. The total loss to the government is approximately $675,000. He was charged in the Eastern District of Louisiana with false statements. This investigation was conducted based on a referral from the US Attorney's Office for the Eastern District of Louisiana and the PRAC.

Former Nonprofit Healthcare Employee Indicted for Fraudulently Obtaining VA Suicide Prevention Grant Funds

An investigation by the VA OIG and FBI in response to a hotline complaint resulted in charges alleging that the former program manager for a nonprofit healthcare organization diverted funds from a $750,000 VA grant awarded to provide treatment and services to veterans at risk of suicide. The former manager allegedly diverted nearly $50,000 in program funds for his personal use—including landscaping, a cruise, and payments to models on OnlyFans.com—and tried to obtain another $25,000 before being discovered. While managing the program, he allegedly recommended that the nonprofit healthcare organization hire a vendor to provide services funded by the grant. However, unbeknown to the healthcare organization, the former manager controlled the vendor, pretended to be a fictitious doctor in emails and on calls, and submitted invoices for services and products that were not actually provided veterans. He was charged in the District of New Hampshire with wire fraud and federal program fraud.

Veteran Sentenced for Starting a Fire at the Cleveland VA Medical Center

A multiagency investigation found that a veteran started a fire in the emergency department at the Cleveland VA Medical Center that caused damages of approximately $78,000 and resulted in the evacuation of patients and staff. The veteran was also in possession of a stolen VA computer and threatened to physically harm a VA nurse earlier that same day. He was sentenced in

Cuyahoga County Court (Ohio) to 48 months in prison and approximately $78,000 in restitution to VA after pleading guilty to charges of aggravated arson, vandalism, receiving stolen property, and aggravated menacing. The investigation was conducted by the VA OIG; VA Police Service; Cleveland Fire Department; and Bureau of Alcohol, Tobacco, Firearms, and Explosives.

Former VA "Agent Cashier" Sentenced for Stealing from Patients and Engaging in Pandemic Assistance Fraud

A former employee at the H. John Heinz III VA Medical Center in Pittsburgh pleaded guilty to embezzlement and mail fraud after stealing over $19,000 from four inpatient accounts. While employed as an agent cashier at the medical center, he was authorized to collect funds and disburse them. The investigation also found that he applied for and received $38,400 in CARES Act funds through the Pandemic Unemployment Assistance program to which he was not entitled because he was employed full-time by VA. He was sentenced in the Western District of Pennsylvania to six months in prison, two years of supervised release, and restitution of over $57,000. The VA OIG, VA Police Service, and DOL OIG conducted the investigation.

Veteran Charged for Threatening to Blow Up Two VA Medical Centers

According to a VA OIG and VA Police Service investigation, a veteran allegedly called in several threats to the Veterans Crisis Line, including to blow up the VA medical centers in Buffalo and Washington, DC. He was arrested after being charged in the Western District of New York with transmitting threatening communications 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.

Management Advisory Memorandum

Scheduling Challenges within the New Electronic Health Record System May Affect Future Sites

The new electronic health record (EHR) system for VA patients includes a scheduling component intended to enhance scheduling efficiency and user experience. However, the VA OIG identified scheduling challenges that include the need for additional staffing and overtime, defective functionality of the displaced appointment queue (the queue where appointments that require rescheduling are routed), inadequate information-sharing between care providers and

schedulers, inaccurate patient information, difficulties changing appointment type (in-person and virtual), and the inability to automatically mail appointment reminder letters. These deficiencies result in inconsistent work-arounds and additional staff effort, increasing the risk for scheduling errors. This management advisory memorandum flags concerns that the identified challenges could have an even greater impact at larger, more complex medical centers and helps VHA determine whether additional actions are warranted for future deployments.

Benefits

Veteran Readiness and Employment Staff Improperly Sent Participants to Veteran Employment Through Technology Education Courses

The Veteran Readiness and Employment (VR&E) Service and Veteran Employment Through Technology Education Courses (VET TEC) programs support veterans seeking education or training for employment. However, requirements differ between the two programs, and a waiver is required for VR&E participants to attend VET TEC programs. The OIG conducted this review to assess the allegation that a VET TEC training provider was knowingly enrolling VR&E participants with improper authorizations. Upon review, the allegation was substantiated; 33 of 42 VR&E participants were improperly enrolled to attend VET TEC courses. The OIG considers the $387,000 spent on those courses as improper payments. VR&E staff were not adequately informed about VET TEC and were generally unaware the program could not be used by VR&E participants. VR&E controls also did not prevent participants from being enrolled in unapproved courses. The OIG made two recommendations to the under secretary for benefits related to implementing policies and controls and providing training to VR&E regional office staff.

Financial Efficiency

VA's Compliance with the VA Transparency & Trust Act of 2021 Semiannual Report: March 2024

The Transparency Act requires VA to report to Congress its plans to spend COVID-19 relief funds, including support related to the American Rescue Plan (ARP) Act. The OIG is charged with overseeing the use of that funding. This fifth semiannual report found that VA deviated from the biweekly reporting requirement, with the last such report submitted in June 2023. VA stated it received congressional approval to deviate from this requirement but was unable to provide supporting documentation. VA's reported obligations through the fourth quarter of fiscal year 2023 generally aligned with the ARP Act spend plan with few exceptions, which did not affect VA's compliance with the Transparency Act. The gap in reporting, however, impedes the ability of Congress and other external parties to determine if funds were properly obligated and expended as required.

Office of Special Reviews

This office conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. The Office of Special Reviews released the following report this month.

Logistics Managers Improperly Allowed Employees to Auction Off Government Property

While conducting an audit of the Denver Logistics Center (DLC), the OIG found an employee recreation group was auctioning items that VA purchasers had requested through free offers associated with supply orders that met a minimum-dollar threshold. DLC staff auction winners took the items for personal use, and the proceeds were used to fund staff social events. The OIG initiated this administrative investigation to examine possible misconduct by VA senior leaders responsible for maintaining ethical procurement practices. DLC purchasing agents claimed free items for 32 purchases from February 2021 through May 2023. The employee recreation group then sold the items to staff through silent auctions. Under federal law, the items were government property because they were part of a purchase made by VA. While leaders and staff had taken ethics and purchase card training, no one at the DLC appeared to have questioned the propriety of the auctions. The OIG found the purchases associated with the free items constituted waste because the DLC purchased the items without considering a preestablished government contract for the same supplies. The DLC halted the auctions and the acceptance of free merchandise in June 2023. VA concurred with the OIG's six recommendations that include a full accounting of losses and recoveries, enhanced training, and other administrative actions.

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 March.

Management Advisory Memorandum

Institutional Disclosure Policy Requirements Should Be Clarified

The OIG identified unclear language in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, as well as inconsistent application of the institutional [medical facility] disclosure

policy during various healthcare inspections that took place during fiscal years 2022 and 2023. The unclear policy language was related to whether sentinel events (patient safety events leading to death, harm, or life-sustaining interventions) automatically trigger the need for institutional disclosures to patients or their personal representatives, which may have contributed to VHA medical facility leaders' confusion about when to make them. The OIG requested the under secretary for health more clearly specify in an amended or updated policy when a sentinel event, as defined by The Joint Commission, should trigger an institutional disclosure and reinforce with VHA staff the indicators and specific events that require them.

Healthcare Inspections

Featured Report

Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death

The OIG found that an error in the new EHR system resulted in VA Central Ohio Healthcare System staff's failure to complete minimum scheduling efforts following a missed appointment for a patient who later died by drug overdose. The team determined that for sites using the new EHR, VHA required fewer patient contact attempts following missed mental health appointments. In this case, a nurse practitioner and psychologist did not comprehensively evaluate and address the patient's mental health needs. A supervisory psychologist did not identify concerns about the patient's mental health and ensure follow-up. Staff also failed to send the patient "caring communications" after a "high risk for suicide" patient record flag was deactivated. Facility leaders did not communicate a root cause analysis with a "lesson learned" to staff. The OIG made one recommendation to the deputy secretary to monitor new EHR scheduling functionality, two recommendations to the under secretary for health to evaluate minimum scheduling effort requirements and establish lessons learned guidance, and three recommendations to the facility director to review the patient's care and staff's compliance with caring communications protocols.

Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus

Following an allegation that implementation of the new EHR led to a prescription backlog, the OIG conducted this inspection and found the new system led to ongoing patient safety and usability issues at the facility. Of particular concern, a software coding error resulted in the transmission of inaccurate medication and allergy information nationally from new to legacy

EHR sites. VHA failed to fully mitigate the known problem and affected patients were not notified. The new EHR's operational inefficiencies also required increased clinical pharmacist staffing, work-arounds, and educational materials to complete pharmacy processes. These inefficiencies led to pharmacy staff burnout, job dissatisfaction, and decreased morale. The OIG issued nine recommendations to VA: three to VA's deputy secretary related to resolving patient safety and usability issues and six to the under secretary for health regarding patient medication data, patient and provider awareness and evaluation of the risk of harm caused by data transmission issues, pharmacy staffing, the technical issues requiring work-arounds, and educational materials to perform pharmacy operations.

Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia

The OIG's inspection revealed that staff did not properly reprocess reusable medical equipment within the Sterile Processing Service (SPS) and that the facility had potentially harmful, abnormal critical water test results. In response, all endoscope use was halted and surgeries and procedures stopped that required reusable medical equipment until an investigation was completed. The team identified multiple issues that contributed to SPS deficiencies, including previously identified issues within SPS that had gone unaddressed, such as the failure to implement CensiTrac Instrument Tracking System (an electronic tracking program that tracks instruments from the beginning of reprocessing through transporting, storing, and use); outdated SPS standard operating procedures; inadequate and ineffective competency training; the insufficient control of traffic in the sterile area that potentially affected the integrity of reusable medical equipment; and the lack of consistent leadership with interim and acting SPS top positions. The OIG made nine recommendations to address these deficiencies, including two recommendations to the VISN director and seven recommendations to the facility director.

Deficiencies in Quality of Care at VA Maine Healthcare System in Augusta

This inspection assessed allegations related to inadequate communication with, and care coordination for, a post-stroke patient who died by suicide at the VA Maine Healthcare System outpatient clinic. The OIG identified deficiencies in the quality of care and completion of quality reviews but was unable to determine whether a change in care would have resulted in a different outcome. While facility staff communicated with the patient and scheduled a primary care appointment, there were failings in the patient's care, including incomplete assessments and documentation after the patient made suicidal statements. There was also a lack of care coordination to assist the patient with receiving rehabilitation services. The team also found weaknesses in the root cause analysis process and failure to conduct a peer review. The OIG's seven recommendations to the facility director were related to suicide screening, safety plans, suicide prevention, root cause analyses, peer reviews, and quality management reviews.

Inadequacies in Patient Safety Reporting Processes and Alleged Deficient Quality of Care Prior to a Patient's Foot Amputation at the Edward Hines, Jr. VA Hospital in Hines, Illinois

The OIG conducted this inspection to determine whether the quality of care at this facility resulted in a patient's foot amputation. The patient reported falling at home while wearing VA-issued diabetic shoes. At the time of the fall, the patient had temporarily stopped taking anticoagulation medication for a procedure, as instructed. The patient developed an arterial occlusion—a blockage in an artery that prevents blood from flowing to a limb—which led to the amputation. The facility's vascular surgeon told the OIG that the arterial occlusion may have been caused when the patient stopped anticoagulation medication or possibly due to the fall. Pharmacy staff managed the patient's anticoagulation medication in accordance with VHA guidance. However, on the day of the fall, a VA podiatrist evaluated the patient and gave instructions to wear the previously provided VA-issued shoes, a type of shoe with known challenges related to fit and heel slippage. The OIG determined that the podiatrist missed an opportunity to provide reeducation or refit the patient with new VA-issued shoes. VA concurred with the OIG's two recommendations related to consulting with patient safety staff and reeducating patients on VA-issued shoes and performing refitting as needed.

National Review

Transition to VA Health Care and Utilization of Benefits for Veterans Who Reported Sexual Assault during Military Service

This review focused on VA health care and benefits utilization by veterans who reported sexual assault to the Department of Defense Sexual Assault Prevention and Response Office (SAPRO) during military service or later disclosed military sexual trauma (MST) to a VHA provider. Veterans who reported to SAPRO were more likely to be female, younger, and in lower pay grades compared to veterans not reporting sexual assault during military service. They were also more likely to apply, and applied sooner, for VA health care, education, and readiness program and employment benefits. VHA patients who reported sexual assault to SAPRO or reported MST to VA were more likely to be diagnosed with mental health disorders and use VA mental health care. SAPRO reporters were also more likely to receive a service-connected disability rating, have a higher rating, and have a mental health disorder component to their disability rating than veterans who did not report to SAPRO. The OIG made one recommendation to the under secretary for health regarding outreach and two recommendations to the under secretary for benefits to evaluate the application and claims process for veterans who reported sexual assault during military service.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that 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. March CHIP reports address the following facilities:

- Manchester VA Medical Center in New Hampshire
- Charles George VA Medical Center in Asheville, North Carolina
- Central Alabama Veterans Health Care System in Montgomery
- Beckley VA Medical Center in West Virginia
- VA Pittsburgh Healthcare System in Pennsylvania
- William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin
- VA Ann Arbor Healthcare System in Michigan
- Cheyenne VA Medical Center in Wyoming
- VA Black Hills Health Care System in Fort Meade, South Dakota

The OIG also analyzes findings across individual CHIP reports to produce summary reports that provide national-level evaluations focused on specific areas of care. During March, the OIG published one CHIP summary report:

Evaluation of Breast Cancer Surveillance in Veterans Health Administration Facilities

This report evaluated the notification to and surveillance of patients with mammogram results requiring action during the COVID-19 pandemic. The individual inspections informing this summary included interviews with key staff and evaluations of clinical processes. The oversight team also reviewed care providers' notifications to patients of mammogram results requiring action to assess whether they were made within VHA's defined time frame. The team also examined patients' completion of the recommended actions. No recommendations for improvement were issued.

***

To listen to the podcast on the March 2024 highlights, go to the monthly highlights page on our website.