MAY 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 May.

Healthcare Investigations

Manufacturer Ordered to Pay Over $1.5 Billion in Criminal Fines and Forfeiture for Distributing Misbranded Opioid Drug

An opioid manufacturer was sentenced in the Eastern District of Michigan to pay a criminal fine of $1.086 billion and forfeiture of $450 million as part of a global settlement with the Department of Justice. Under the settlement, the company agreed to plead guilty to a misdemeanor charge of violating the Federal Food, Drug, and Cosmetic Act by introducing misbranded drugs into interstate commerce. A multiagency investigation resolved allegations that the manufacturer's sales representatives marketed their opioid drug to prescribers by making false claims pertaining to the medication's purported abuse deterrence, tamper resistance, and crush resistance. In an attempt to increase revenue, the manufacturer allegedly partnered with a consulting company to devise a marketing scheme that targeted healthcare providers that the company knew were prescribing their opioid for nonmedically accepted indications. The loss to federal healthcare programs is approximately $208.5 million. Of this amount, the loss to VA is approximately $8.5 million. This investigation was conducted by the VA OIG, FBI, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), Food and Drug Administration Office of Criminal Investigations, and Amtrak OIG.

Physician Sentenced for Unnecessary Tests and Taking Bribes and Kickbacks

A multiagency investigation revealed that a physician entered into an improper agreement with a diagnostic imaging company through which he was paid bribes and kickbacks in exchange for ordering unnecessary transcranial doppler tests. The physician received about $148,000 and billed the government and private insurance companies over $3 million in unnecessary tests. The loss to VA is at least $650,000. The physician was sentenced in the District of Massachusetts to 12 months and one day in prison, 12 months of supervised release, approximately $1.3 million in restitution, and forfeiture of over $148,000 after pleading guilty to conspiracy to commit healthcare fraud and conspiracy to violate the Anti-Kickback Statute. The investigation was

conducted by the VA OIG, IRS Criminal Investigation (CI), US Postal Inspection Service, Department of Labor Employee Benefits Security Administration, FBI, and HHS OIG.

Former VA Vendor Found Guilty in Connection with Kickback Scheme

According to a VA OIG investigation, between 2016 and 2020, a purchasing agent employed at the Jesse Brown VA Medical Center in Chicago, Illinois, conspired to rent medical equipment from a vendor in exchange for kickbacks of at least $220,000. The vendor received about $2.8 million in VA purchase card orders from the purchasing agent, of which approximately $1.3 million was fraudulent. The vendor was found guilty after a weeklong trial in the Northern District of Illinois on charges of wire fraud. The former VA purchasing agent had previously pleaded guilty to wire fraud.

Defendant Pleaded Guilty for Role in $51 Million Healthcare Fraud Scheme Involving Durable Medical Equipment, Genetic Cancer Screening Tests, and Compounded Medications

According to a multiagency investigation, numerous defendants allegedly owned and operated durable medical equipment companies, pharmacies, and medical testing laboratories that were used to defraud federal healthcare benefit programs, including VA's Civilian Health and Medical Program (CHAMPVA). The defendants offered and paid kickbacks and bribes in exchange for fraudulent doctors' orders for durable medical equipment, genetic cancer screening tests, and compounded medications. The total loss to federal and private healthcare benefit programs is approximately $51 million. The total loss to VA is approximately $330,000. One company owner pleaded guilty in the District of New Jersey to conspiracy to commit healthcare fraud in connection with a scheme to violate the Anti-Kickback Statute. This investigation was conducted by the VA OIG, FBI, DCIS, and HHS OIG.

Doctor and Lab Owner Sentenced in Connection with Kickback Scheme

Another multiagency investigation resulted in charges alleging that two laboratories engaged in a kickback scheme involving marketers and physicians that resulted in approximately $300 million in losses to the government. Of this amount, the loss to VA is approximately $165,000. The laboratories, through marketers, paid hundreds of thousands of dollars to doctors for advisory services that were never performed in return for laboratory test referrals. The owner of one laboratory was sentenced in the Northern District of Texas to 30 months in prison, two years of supervised release, approximately $180,000 in restitution, and a fine of $10,000. A doctor was sentenced to 18 month in prison, two years of supervised release, $143,000 in restitution, and a fine of $40,000. The VA OIG, FBI, HHS OIG, and DCIS also carried out this investigation.

Benefits Investigations

Veteran Sentenced for Making False Statements about His Claimed Disability

A VA OIG investigation found that a veteran lied to VA about being unable to use both his feet, which resulted in his receipt of VA disability compensation benefits for almost two decades and vehicle adaption benefits to which he was not entitled. The veteran was sentenced in the District of New Hampshire to 18 months in prison, 36 months of supervised release, and $662,000 in restitution after pleading guilty to making false statements.

Former VA Fiduciary Sentenced for Stealing Benefits from Veteran

A former VA-appointed fiduciary stole about $143,000 intended for the veteran she was appointed to represent. The fiduciary 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. She also gave some of the funds away to personal acquaintances. The fiduciary was sentenced in the District of Kansas to 36 months of supervised release and ordered to pay restitution of over $143,000 after pleading guilty to misappropriation by a fiduciary. The VA OIG completed the investigation.

Veteran Pleaded Guilty to Theft of Government Funds

According to another VA OIG investigation, a veteran owned and operated a construction business while in receipt of VA individual unemployability benefits. For over a decade, the defendant falsely reported to VA that he had no income despite operating the construction company. The loss to VA is over $260,000. The veteran pleaded guilty in the District of South Carolina to theft of government funds.

Investigations Involving Other Matters

Veteran Charged with Abusive Sexual Contact at the Albany VA Medical Center

A VA OIG and VA Police Service investigation resulted in charges alleging that a veteran repeatedly groped an attending paramedic in the back of an ambulance as he was being transported for treatment to the Samuel S. Stratton VA Medical Center in Albany, New York. The alleged assault occurred after the ambulance arrived on the facility's property. The veteran was indicted in the Northern District of New York for abusive sexual contact.

Defendant Pleaded Guilty for Paycheck Protection Act and Economic Injury Disaster Loan Scheme

A VA OIG and IRS CI investigation revealed the owner of a tax and accounting services business prepared false tax documents that assisted others to fraudulently obtain Small Business Administration–backed Paycheck Protection Program and Economic Injury Disaster Loans for

nonexistent or defunct businesses. The total loss to the government is approximately $1.2 million. The defendant pleaded guilty in the Eastern District of Louisiana to false statements, theft of government funds, fraud, and false statements to the IRS. This investigation was the result of a referral from the COVID-19 Pandemic Response Accountability Committee (PRAC). 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.

VA Employee Sentenced for Fraudulently Obtaining Federal Pandemic Relief Loans

VA OIG investigators found that a medical support assistant employed at the Michael E. DeBakey 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 employee was sentenced in the Southern District of Texas to 30 days in prison, three years of probation, and $110,000 in restitution after pleading guilty to wire fraud.

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 May.

Benefits

Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams

Contract exam vendors, used to assess medical evidence for veterans' disability benefits claims, must comply with statutory accessibility and workplace safety standards. Responding to concerns documented in exam recipients' satisfaction surveys, the OIG inspected contract exam facilities and reviewed Medical Disability Examination Office (MDEO) oversight of exam vendors. The OIG identified one or more deficiencies at 114 of the 135 exam facilities visited that impeded some veterans' access and increased safety risks. MDEO did not provide necessary oversight; it lacked independent access to facilities, did not enforce exam vendors' mandate to inspect and self-certify their facilities, and relied on vendors to distribute their own exam satisfaction survey cards. MDEO also did not have standardized inspection procedures and training, nor did they conduct complaint-driven inspections about unclean, unsafe, or inaccessible facilities. The OIG acknowledges MDEO leaders' improvement plans shared during

the review but made nine recommendations for corrective action, including that MDEO more closely monitor inspections, visit sites, use a better inspection checklist, maintain a facilities inventory, and have independent access.

Delays Occurred in Some Veterans' Benefits Claims While Awaiting Decision

VBA's National Work Queue (NWQ) division generally uses the NWQ tool and ranking rules to prioritize and distribute claims across VBA's regional offices for processing. The OIG conducted this review after discovering some claims at the NWQ division were awaiting decisions for one year or longer. Of the 10,541 claims aged 365 days or older that, on August 1, 2022, were at the NWQ division awaiting decision and not distributed to a regional office, over 99 percent required routing to teams that process special mission herbicide-related claims. Limited staffing assigned by Office of Field Operations leaders generally caused delays. However, the team also identified instances in which the NWQ division's ranking rules unintentionally contributed to delays or the NWQ tool incorrectly ranked some claims. The Office of Field Operations' FY 2022 internal controls assessment did not evaluate claims prioritization and distribution. The OIG made two recommendations to reduce delays in claims processing, which have been closed as implemented based on documentation provided by VA.

Software Delayed the Establishment of Supplemental Claims for Veterans' Appeals of Benefits Decisions

When veterans disagree with a monthly compensation review decision, they may elect a higher-level review. If additional evidence is needed, a supplemental claim is created, which should be established within 48 hours of higher-level review completion. In December 2022, a hotline complaint alleged it took weeks for supplemental claims from higher-level reviews to be established. The OIG substantiated this allegation from a random statistical sample of 190 higher-level reviews completed in calendar year 2022 and in January 2023. A software synchronization issue was delaying supplemental claims. VBA's Office of Administrative Review took corrective actions in January 2023 and is planning to transition to another software application. VBA officials shared, prior to providing their comments on the OIG report, that they had proactively created a formal process for establishing supplemental claims in the interim. After verifying documentation of this procedure, the OIG review team determined an official recommendation was not necessary.

Healthcare Access and Administration

Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia

The OIG received a hotline complaint about delays at the Martinsburg VA Medical Center in processing and scheduling veterans' community care consults. These consults are referrals for

clinical services from non-VA providers. The OIG substantiated that as of February 28, 2023, there were over 5,000 active consults (personnel were processing them). For these active consults, staff took over 100 days to try to contact the veteran and—well in excess of the seven-day scheduling requirement—more than 45 days on average to schedule veterans for care in the community. The community care scheduling delays occurred because of (1) ineffective processes used to manage community care consults; (2) shortages of specialty care providers, such as in orthopedics and cardiology; and (3) a lack of controls to ensure manager accountability for consult timeliness. The OIG made four recommendations to ensure veterans' personal information is only shared on a need-to-know basis, to evaluate alternative workflows to improve consult processing, to explore ways to increase the availability of specialty care providers, and to add metrics related to the community care chief's performance plan standards.

Financial Efficiency

Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2023

The OIG conducted this review to determine whether VA complied with the requirements of the Payment Integrity Information Act of 2019 (PIIA) in FY 2023. Of the total estimated $3.2 billion reported by VA in FY 2023 for seven programs, about $1.8 billion represented a monetary loss and about $1.4 billion was considered either a nonmonetary loss that cannot be recovered or an unknown payment. VA satisfied all but one of the PIIA's 10 requirements, failing to report an improper and unknown payment rate of less than 10 percent for two VA programs that had estimates in the materials accompanying their financial statements. VA satisfied the additional reporting requirements for two high-priority programs with prior-year monetary losses from improper payments of more than $100 million reported in FY 2023. The OIG recommended reducing improper and unknown payments to below 10 percent for the Pension Program and the Purchased Long-Term Services and Supports Program. Both are repeat recommendations that have not been implemented from the FY 2022 report.

Information Technology

Evaluation of the May 2023 Power Outage at the Hines Information Technology Center in Illinois

A power outage occurred at the Hines Information Technology Center on May 4, 2023, lasting for approximately 22 hours and preventing more than 10,000 VA employees from accessing critical data and systems. The OIG found the Hines center's physical access controls did not prevent the activation of a circuit breaker that caused the inadvertent outage. Also, instead of having redundant power distribution paths, the Hines center's circuit breaker functions as a

master power switch between the uninterruptible power supplies and the information technology equipment. Consequently, equipment and applications lost power when an employee activated the circuit breaker. The OIG recommended the Office of Information and Technology provide redundant electrical distribution paths at the Hines center, cover and add warnings to circuit breakers, and develop and test a detailed contingency plan to reduce system downtime in the event of a future power outage.

Follow-up Information Security Inspection at the VA Financial Services Center in Austin, Texas

The OIG conducts information security inspections to assess whether VA facilities are meeting federal security requirements. In this follow-up inspection of the Financial Services Center (FSC) in Austin, Texas, the OIG focused on three control areas it determined to be at highest risk: configuration management, security management, and access controls. Multiple configuration management deficiencies were identified in vulnerability management and flaw remediation, database scans, database baseline configurations, and unsupported components. The FSC's security management controls were found deficient in the monitoring of component inventory. Weaknesses in access controls were in monitoring inappropriate or unusual activity and reviewing physical access logs. Three of the deficiencies were also identified during the 2021 inspection. The OIG made eight recommendations to the assistant secretary for information and technology and chief information officer to improve controls, including four recommendations repeated from the 2021 inspection.

Federal Information Security Modernization Act Audit for Fiscal Year 2023

Federal agencies must annually review their information security programs and report on compliance with the Federal Information Security Modernization Act (FISMA). The OIG contracted with CliftonLarsonAllen LLP (CLA) to evaluate VA's information security program for FY 2023. After assessing 45 major applications and general support systems hosted at 23 VA facilities and on the VA Enterprise Cloud, CLA concluded that department continues to face significant challenges meeting FISMA requirements. The audit found significant deficiencies that can be remedied by improving the deployment of security patches, system upgrades, and system configurations; improving performance monitoring of controls; communicating security deficiencies; and addressing security-related issues that contributed to the information technology material weakness reported in the FY 2023 audit of VA's consolidated financial statements. CLA made 25 recommendations and will follow up on outstanding recommendations, evaluating the adequacy of corrective actions in the FY 2024 audit of VA's information security program.

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 reports in May.

Featured Reports

VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives

In September 2023, VA announced it had erroneously awarded millions of dollars in critical skill incentive (CSI) payments to VA central office (VACO) senior executives. VA cancelled the payments, notified Congress, and requested that the OIG review the matter. CSIs were authorized by the PACT Act, which significantly expanded access to VA health care and benefits for veterans exposed to toxic substances. The OIG found VA's award of $10.8 million in incentives to 182 VACO senior executives lacked adequate justification and was inconsistent with the PACT Act and VA policy. This was due, in part, to breakdowns in VA leadership and controls, as well as missed opportunities to intervene at multiple levels. VA concurred with the OIG's two findings and eight recommendations and provided acceptable action plans. The OIG will monitor VA's progress until sufficient documentation has been received to close the recommendations as implemented.

Supplement to OIG Report, *VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives*

Additional analysis of the improper CSI awards has raised concerns that the under secretary for health may have recommended incentives for at least 10 senior executives in VACO who directly reported to him, and for whom he was, therefore, not authorized to act as the approving official. Because there were inconsistencies in available data on direct reports, the OIG released this supplemental memorandum to summarize information conveyed to the VA secretary to further assess whether additional actions are warranted. The OIG also requested that VA provide information on whether any other approving officials exceeded their authority in recommending or approving CSIs to VACO senior executives and factor the results into its action plans for implementing the related OIG report recommendations.

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 May.

Healthcare Inspections

System Leaders' Response to Allegations Related to Access to Behavioral Health Care at the El Paso VA Health Care System in Texas

The OIG reviewed the actions taken by leaders at the El Paso VA Health Care System in response to allegations related to veterans' access to behavioral health care and patient privacy. The OIG determined that the leaders' actions ensured that the system's clinic staff did not deny patients access to care; patients were seen in the time frame and at the location that met their preferences and needs; and patient privacy was maintained during virtual behavioral health service appointments for which patients used VA-provided tablets. While no cases of concern were identified, the OIG noted potential issues arising from advice given by providers in emergent and urgent patient situations who may not be versed in state-specific emergency detention order laws. The OIG made one recommendation to the system director related to system policies and guidance aligning with federal and state laws.

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. May's CHIP reports examined the following facilities:

- Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri
- VA Maryland Health Care System in Baltimore
- Roseburg VA Health Care System in Oregon

Featured Hotline Case

The OIG's hotline staff accept 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.

VBA Failure to Resolve an Erroneous Suspension of a Disabled Veteran's Benefits Resulted in Financial Hardship for the Veteran and His Family

The OIG Hotline received allegations that VBA erroneously suspended a disabled veteran's benefits and failed to resolve the issue for more than three months, causing a financial hardship to the veteran and his family. In January 2024, the Board of Veterans' Appeals granted service-connected disability compensation to a veteran, including six years of retroactive compensation that resulted in an award of over $150,000. VBA issued the payment to the veteran's financial institution; however, because the institution does not accept deposits greater than $50,000, the payment was returned to VBA. The returned payment caused VBA to suspend the veteran's benefits, placing him and his family in a financial hardship.[1] Despite 10 or more contacts from the veteran for over three months, VBA had not restored the veteran's benefits until hotline staff intervened by requesting a review by VA's Winston-Salem Regional Office. The regional office's responsive fact-finding investigation substantiated the allegation. The veteran's benefits were restored within one day of the hotline referral, and the retroactive payment was reissued to the veteran within six days.

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

[1] The OIG is further investigating potential systemic issues regarding how the returned payment triggered a suspension of the veteran's benefits.