JULY 2024 HIGHLIGHTS

Congressional Testimony

Director of the OIG's Compensation Programs Inspection Division Testifies on VBA's Quality Assurance and Training

Steve Bracci, director of the Compensation Programs Division in the OIG's Office of Audits and Evaluations, testified before the House Veterans' Affairs Committee's Subcommittee on Disability Assistance and Memorial Affairs on July 23. Mr. Bracci's testimony highlighted findings and recommendations from seven OIG reports on disability compensation claims processing by Veterans Benefits Administration (VBA) staff. He discussed the challenges VBA faces in meeting the objectives of its quality assurance and training programs, which include processing errors on veterans' individual unemployability claims, inconsistencies implementing changes to the disability rating schedule, issues with claims automation, and unwarranted medical disability reexaminations of veterans. In response to questions, Mr. Bracci discussed steps VA must take to effectively implement OIG recommendations. Visit the congressional relations section of the OIG website to read Mr. Bracci's written statement. The hearing can be viewed on the subcommittee 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 July.

Healthcare Investigations

Pharmacist and Accountant Sentenced in Connection with Healthcare Fraud Scheme Involving Unlawful Kickbacks

A multiagency investigation resulted in charges alleging that numerous defendants participated in a scheme to defraud federal healthcare programs by billing over $75 million for expensive compounded medications. Although intended to be tailored to individual patient needs, these medications were designed to maximize reimbursements regardless of medical necessity. Compounding pharmacy owners and others paid illegal kickbacks to medical marketers that recruited area doctors to write these expensive prescriptions by offering "investment opportunities" so that the doctors could profit from the scheme. The total loss to VA is approximately $3.3 million. A former pharmacist and a former accountant for one of the compounding pharmacies were each sentenced in the Northern District of Texas to 18 months in

prison and 12 months of supervised release after pleading guilty to conspiracy to defraud the United States. The defendants were also ordered to jointly pay over $59.8 million in restitution with several others convicted in connection with this case. Of this amount, VA will receive over $1 million. This investigation was conducted by the VA OIG, FBI, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service, and Department of Labor (DOL) OIG.

Two Health Services Company Owners Sentenced for Compounding Pharmacy Conspiracy

According to another multiagency 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. 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 pleaded guilty to conspiracy to solicit and receive kickbacks, and were sentenced in the Northern District of Texas to 14 months and 15 months in prison, respectively, with each receiving one year of supervised release. Each owner was also ordered to pay over $4.4 million in restitution. This investigation was conducted by the VA OIG, US Postal Service OIG, Defense Criminal Investigative Service, DOL OIG, FBI, and HHS OIG.

Former VA Doctor Found Guilty of Illegally Distributing Over 1.8 Million Doses of Opioids and Engaging in a $5 Million Healthcare Fraud Scheme

A former chief of medicine at the Alexandria VA Medical Center in Pineville, Louisiana, illegally distributed more than 1.8 million doses of Schedule II controlled substances, including oxycodone and morphine, to more than 350 VA patients and other non-VA patients without a legitimate medical purpose and defrauded healthcare benefit programs of approximately $5.4 million. While working full-time as the facility's chief of medicine, the defendant maintained a clinic located more than 200 miles away through which he pre-signed patient prescriptions outside the usual course of professional practice and without determining their medical necessity. With the defendant's knowledge, patients filled their prescriptions using their insurance benefits, causing healthcare programs to be fraudulently billed. The former chief of medicine was found guilty at trial by a federal jury in the Eastern District of Louisiana of conspiracy to unlawfully distribute and dispense controlled substances, unlawfully distributing and dispensing controlled substances, maintaining a drug-involved premises, and conspiracy to commit healthcare fraud. The VA OIG, HHS OIG, and FBI completed this investigation.

Former VA Pharmacist Pleaded Guilty to Theft of VA Pharmaceuticals

A former pharmacist at the Miami VA Medical Center stole approximately 24 bottles of propofol from the facility for his own personal use. He pleaded guilty in the Southern District of Florida to theft of pre-retail medical products. The VA OIG conducted this investigation.

Benefits Investigations

For-Profit Schools and Their Owner Agree to Pay $1.35 Million to Resolve False Claims Allegations Involving Alleged Post-9/11 GI Bill Overcharges

A VA OIG investigation resulted in a civil settlement resolving allegations 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 the Title 38 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 about $14 million and $26 million, respectively. Under this settlement reached in the Middle District of Florida, the two franchises and their owner agreed to pay $1.35 million to VA.

Veteran Sentenced in Connection with Benefits Fraud Scheme

A VA OIG and Social Security Administration (SSA) OIG investigation found that a veteran submitted multiple false statements and misrepresentations that concealed his work activities in order to continue to receive VA Individual Unemployability benefits and Social Security disability insurance benefits. In 2015, the veteran opened and operated multiple companies under his spouse's name to conceal his ownership from the government. The veteran was sentenced in the Southern District of Mississippi to 14 months in prison, 36 months of supervised release, and more than $315,000 in restitution after pleading guilty to making false statements and failing to disclose an occurrence of an event that would affect Social Security disability payments. Of this restitution, VA will receive more than $155,000.

Veteran's Sister Sentenced for Stealing His VA and Social Security Benefits

Another joint investigation by the VA OIG and SSA OIG revealed that 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 the VA-appointed fiduciary and SSA representative payee for her brother (who is now deceased), made 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 was sentenced in the Middle District of Florida to 36 months of supervised release and $149,000 in restitution to VA and $28,000 in restitution to SSA after pleading guilty to theft of government funds.

Investigations Involving Other Matters

Pharmacy Owner and Physical Therapy Clinic Owner Charged in Connection with Workers' Compensation Fraud Scheme

A multiagency investigation resulted in charges alleging that a pharmacy owner, a physical therapy clinic owner, and others conspired to defraud DOL's Office of Workers' Compensation Program (OWCP) by submitting claims for medically unnecessary prescription drugs from 2017 until 2020. The clinic owner allegedly sent prescriptions for high-reimbursing drugs to the pharmacy in exchange for illegal kickbacks. The pharmacy allegedly then filled medically unnecessary prescriptions for injured federal workers who had benefits through OWCP (which seeks reimbursement from VA and the other federal agencies for these claims through "charge backs"). The total loss to OWCP is over $5.6 million. Of this amount, the loss to VA is approximately $526,000. The pharmacy owner and the physical therapy clinic owner were both charged in the Southern District of Texas with conspiracy to defraud the United States and conspiracy to pay and receive healthcare kickbacks. This investigation was conducted by the VA OIG, DOL OIG, US Postal Service OIG, and FBI.

Veteran Sentenced for Firearm Possession at the Tulsa VA Outpatient Clinic

A veteran arrived at the Ernest Childers VA Outpatient Clinic in Tulsa with a loaded handgun and plastic zip ties after previously making threats to "shoot" and "murder people" if he was not scheduled for an appointment with VA. The veteran pleaded guilty in the Northern District of Oklahoma to possession of a firearm in a federal facility and was sentenced to 48 months in prison and 36 months of supervised release. The VA OIG, VA Police Service, Tulsa Police Department, and FBI investigated.

Veteran Sentenced for Making Threats toward VA Facilities

A VA OIG and VA Police Service investigation revealed that a veteran threatened to blow up the VA medical centers in Buffalo, New York, and Washington, DC, via several telephone calls and text messages to the Veterans Crisis Line. The veteran was sentenced in the Western District of New York to time served (101 days) and one year of supervised release after pleading guilty to assault and intimidation of federal employees.

Another Veteran Pleaded Guilty to Threatening Staff at Edward Hines, Jr. VA Hospital and Local Law Enforcement Officers

Another investigation by the VA OIG and VA Police Service found that a veteran made several telephone calls to the Veterans Crisis Line during which he threatened to shoot both staff at the Edward Hines, Jr. VA Hospital and local law enforcement officers. He pleaded guilty in the Northern District of Illinois to transmitting a threatening communication via interstate commerce.

Owner of Defunct Business Pleaded Guilty to Fraudulently Obtaining Federal Pandemic Relief Loans

An individual 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 falsely 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. The defendant pleaded guilty in the Eastern District of Louisiana to false statements. This VA OIG investigation was conducted in response to a referral from the US Attorney's Office for the Eastern District of Louisiana and the 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.

Another Defendant Pleaded Guilty to Fraudulently Obtaining Federal Pandemic Relief Loans

The VA OIG and US Secret Service conducted another PRAC-connected investigation with no direct nexus to VA involving an individual who fraudulently obtained Small Business Administration-backed Paycheck Protection Program and Economic Injury Disaster Loans for a nonoperational business with no employees. The defendant pleaded guilty in the Eastern District of Louisiana to theft of government funds and false statements. The loss to the government is over $387,000.

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 July.

Management Advisory Memorandum

Featured Report

The Pause of the Program Integrity Tool Is Impeding Community Care Revenue Collections and Related Oversight Operations

The Veterans Health Administration (VHA) uses Program Integrity Tool data to determine if healthcare claims from community providers should be billed to veterans or private insurance companies for treatment of conditions not related to military service, and to detect waste or fraud such as duplicate claims payments. In February 2023, VHA paused the tool's operations after becoming aware of issues with its database code logic and that stored data had been compromised. While the tool is offline, community care claims continue to be received and paid through the claims processing payment systems. However, VHA cannot bill veterans or private insurance companies for community care claims dated after the pause. As a result, there will be a backlog of about 40 million paid community care claims that must be processed when the tool is reactivated. The OIG estimates that the pause has resulted in about $665.5 million in collections that had not been recovered as of February 2024.

VBA Did Not Always Properly Implement Compensation Cost-of-Living Adjustments

VA provides tax-free monthly compensation to veterans for service-connected disabilities, including special monthly compensation for certain serious disabilities or combinations of disabilities. The OIG identified instances in which VBA did not properly implement each annual cost-of-living adjustment (COLA) for disability compensation. The team found that certain special monthly compensation amounts had been calculated incorrectly for each annual COLA since December 1, 2016, resulting in some monthly payments being slightly higher or lower than they should have been. They also found that the increased amounts for disability compensation, additional compensation for dependents, and clothing allowance for the COLA effective December 1, 2022, were not published in the Federal Register, as required. The VA OIG issued this management advisory memorandum to formally and transparently convey this information so that VBA can determine if additional actions are warranted.

Benefits

Better Collection of Family Preference Data May Minimize Risk of Burial Scheduling Delays

After the OIG received an allegation to its hotline that burials at the Santa Fe National Cemetery took more than 30 days to complete, an audit team analyzed data for all National Cemetery

Administration (NCA) burials completed from January 1, 2022, through March 31, 2023. On average, the time from notification to burial was 33 days with a range of 1 to 799 days. Although NCA policy does not set a time requirement, the OIG conducted this audit to determine whether NCA's oversight ensures the preferences of families are appropriately considered when scheduling burials and can identify potential burial delays. The team found that NCA lacks sufficient data to determine if it is scheduling burials in accordance with family preferences and identifying potential burial delays. The OIG therefore recommended NCA gain the capability to identify and monitor potential scheduling delays and ensure family preferences are being met at national cemeteries.

VBA Needs to Improve the Accuracy of Decisions for "Total Disability Based on Individual Unemployability"

Per VA policy, veterans unable to maintain employment because of service-connected disabilities should be granted total disability based on individual unemployability (TDIU), which results in monthly compensation. The VA OIG found claims processors did not consistently follow TDIU policies and procedures, resulting in at least $100 million in both improper underpayments and overpayments to veterans from May 1, 2022, to April 30, 2023. The team estimated that 74 percent of granted claims and 76 percent of denied claims completed during this period had at least one claims processing error. These errors occurred because of inadequate system controls, inconsistent interpretations of VBA's procedures manual, and claims processors' limited exposure to TDIU claims. The OIG made seven recommendations to the under secretary for benefits to help improve the accuracy of TDIU claims decisions.

Information Technology

Lessons Learned for Improving the Integrated Financial and Acquisition Management System's Acquisition Module Deployment

VA has one of the largest acquisition functions in the federal government. To modernize its related processes, VA is implementing the Integrated Financial and Acquisition Management System (iFAMS) to replace multiple outdated systems. The OIG conducted this review to determine whether the iFAMS acquisition module was sufficiently planned and tested. The team found system requirements were identified, necessary functionality was understood, and the system was tested with stakeholders. However, acquisition stakeholders in particular were not adequately included in decision-making. Because feedback on problems was not effectively addressed, administrators have expressed concerns with, and resistance to, the acquisition module of iFAMS. VA concurred with the OIG's four recommendations, which focus on more fully engaging with and responding to affected personnel from the start of any new system acquisition and throughout implementation, and fixing the identified problems before further deployment.

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 July.

Healthcare Inspections

Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana

The OIG substantiated allegations that staff at the VA medical center in Shreveport failed to meet multiple VHA Suicide Prevention Program policy requirements in the care of two patients, one of whom died by suicide. In addition to mismanaging flags indicating a high risk for suicide in patient records, staff failed to complete suicide-risk screening and assessments, document Veterans Crisis Line request responses, and take proper actions following a suicide. The OIG team also identified concerns related to one-to-one patient observation staffing, and posting and recruiting for suicide prevention program vacancies. The OIG made one recommendation to the Veterans Integrated Service Network (VISN) director related to suicide prevention staffing and seven recommendations to the facility director regarding compliance with suicide prevention policy and one-to-one observation staff assignments.

Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia

This inspection reviewed surgical service and quality management concerns at the Hampton VA Medical Center. The OIG found multiple failures in facility leaders' responses to clinical care concerns and subsequent privileging actions involving the assistant chief of surgery, as well as not reporting the surgeon to the state licensing board. The team also identified deficiencies in conducting professional practice evaluations of surgeons; holding morbidity and mortality conferences in accordance with policy; referring cases for peer review; conducting peer reviews with concurrent management reviews; and completing institutional disclosures as required. VA concurred with the OIG's 12 recommendations to correct these issues.

Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

During this inspection, the OIG found that a patient experienced a delay in receiving basic life support during a medical emergency on the grounds of the VA medical center in Phoenix. The patient later died at a community hospital. The OIG also learned of deficiencies related to the initiation of the patient's emergency medical care, including conflicting facility policies that were also inconsistent with VHA requirements, insufficient layperson CPR training, and lack of automatic external defibrillators in specific public access areas, such as the Ambulatory Care Clinic lobby and the first floor hallways. The inspection team found quality of care concerns occurring before the emergency as well as inadequate quality reviews following it. Finally, the team found that the facility leader's response when made aware of the event did not align with high reliability organization principals and I CARE values. The medical center director concurred with the OIG's 10 recommendations to address these deficiencies.

Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming

An OIG inspection team assessed an allegation of inadequate clinical care of a patient who died by suicide in the inpatient medical unit. Despite the patient being admitted to the facility for the treatment of suicidal ideations and alcohol withdrawal, clinical staff did not adhere to policies and procedures related to suicide risk assessments and evaluations, documentation and communication, and environmental safety. The OIG found that clinical staff managed the patient's alcohol withdrawal symptoms using the Clinical Institute Withdrawal Assessment of Alcohol Revised protocol and lorazepam orders, except for one medication error that had no impact on the patient's outcome. Facility leaders evaluated and addressed the patient's suicide through actions that included a root cause analysis in accordance with VHA policy. The OIG made four recommendations related to screenings, evaluations, documentation, and removing environmental risks for suicidal patients.

Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10

The OIG evaluated concerns related to the care and treatment coordination provided by staff at VISN 10—specifically the VA Ann Arbor Health Care System and Battle Creek VA Medical Center—for a patient who died.[1] A healthcare inspection team also reviewed the sufficiency of

[1] VHA divides the United States into 18 regional networks, known as VISNs, which manage the day-to-day functions of medical centers and provide administrative and clinical oversight. For more information, see www.va.gov/HEALTH/visns.asp.

VHA leaders' actions before and after the patient's death. The inspection found that inpatient mental health providers at the healthcare system failed to sufficiently address a patient's mental health treatment and discharge coordination needs, while medical center staff did not consider the patient's transfer request from a non-VA agency. Further, inconsistent with VHA policy, a residential treatment standard operating procedure did not allow veteran self-referral or referral from non-VA agencies. Finally, while VHA leaders took appropriate action to identify the patient's treatment needs and options when notified of the transfer request, the OIG found VISN 10's Interagency Reconciliation Council lacked defined objectives and processes to monitor outcome progress. The OIG made six recommendations involving eligibility verification procedures, transfer coordination, the residential treatment standard operating procedure, the council's objectives and processes, as well as a review of the patient's care.

Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas

Medical center staff failed to provide in-person evidence-based psychotherapy until over a year after a patient's request. Facility staff also did not offer the patient equipment to participate in virtual sessions and did not consistently document contact attempts. The OIG inspection team also determined that a psychologist and psychiatrist did not sufficiently address the patient's access to lethal means (in this case, a firearm). In addition, after assigning the patient a high risk for suicide flag, staff did not meet with the patient, document a suicide risk assessment, or update or review the patient's safety plan, as required. Inconsistent with a VHA requirement, an Office of Mental Health and Suicide Prevention leader reported that Homeless Program staff are not expected to review or update safety plans for patients with high risk for suicide patient record flags. The OIG made one recommendation to the under secretary for health to clarify requirements for suicide risk assessment completion and safety plan reviews and issued five recommendations to the medical center director related to evidence-based psychotherapy consult management, lethal means safety, and high risk flag follow-up.

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