



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

NOVEMBER 2024 HIGHLIGHTS

Congressional Testimony

The OIG actively engages with Congress on issues affecting VA programs and operations. The OIG's participation in congressional hearings helps focus legislative action and elevates national attention on topics of concern within the veteran community.

Director of the IT Security Division Testifies on VHA's Cybersecurity Program

Michael Bowman testified before the House Veterans' Affairs Subcommittee on Technology Modernization on November 20. Mr. Bowman's testimony highlighted recurring findings and recommendations from the OIG's annual Federal Information Security Modernization Act (FISMA) audit reports, which evaluate VA's information security and risk management program. He explained how the FISMA audit can be considered a scorecard of the department's IT security program, noting that VA has made only incremental improvements in addressing the deficiencies the OIG has repeatedly identified. Mr. Bowman also discussed VA's nonconcurrence with some recommendations in the most recent FISMA report and explained the value of the additional oversight provided by the OIG's Information Security Inspection Program team. Visit [the congressional relations section of the OIG website](#) to read Mr. Bowman's written statement. The hearing can also be viewed 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 November.

Healthcare Investigations

Former VA Inventory Management Specialist Admitted to Stealing Dental Equipment

A VA OIG and VA Police Service investigation revealed that an inventory specialist at the Mountain Home VA Medical Center in Tennessee stole dental equipment from the facility and subsequently sold it online. The loss to VA for the stolen dental equipment, which was intended for a new clinic in Knoxville, is over \$353,000. The former VA employee pleaded guilty in the Eastern District of Tennessee to theft of government property.

Former Atlanta VA Medical Center Physician Found Guilty of Sexually Assaulting a Female Veteran Patient

A VA OIG investigation resulted in charges alleging that between September 2019 and January 2020, a VA physician sexually assaulted four female patients during medical examinations at the Atlanta facility by groping their breasts and improperly touching their vaginal area. The former physician was found guilty by a jury in the Northern District of Georgia of deprivation of rights under color of law and abusive sexual contact after a two-week trial. The jury found him guilty of the charges related to one victim but acquitted him of charges pertaining to the other three.

Home Healthcare Company Owner Charged for Submitting Fraudulent Claims to VA and Medicaid

According to an investigation by the VA OIG and Missouri Medicaid Fraud Control Unit, from August 2020 to December 2022, the owner of a home healthcare company allegedly submitted fraudulent claims to VA and the Missouri Medicaid program for services that were never provided. The claims were for services reportedly performed while veterans were inpatients at VA medical centers, with some claims stating that patients received more than 24 hours of care in a single day. Of the approximately \$802,000 in total losses, VA's share is about \$605,000. The company owner was charged in the Eastern District of Missouri with wire fraud and false statements.

Former VA Purchasing Agent Sentenced in Connection with Kickback Scheme

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 former VA purchasing agent was sentenced in the Northern District of Illinois to 24 months in prison, 12 months of supervised release, and more than \$1.3 million in restitution after pleading guilty to wire fraud. The VA OIG conducted the investigation.

Benefits Investigations

Veteran Indicted for Allegedly Stealing \$1.1 Million in Disability Compensation Benefits and Caregiving Services over 12 Years

A VA OIG proactive investigation resulted in charges alleging that between July 2012 and October 2024, a veteran fraudulently obtained disability compensation benefits by falsely representing to VA that she was unable to walk or use her right arm and required assistance with performing activities of daily living. It is also alleged that the veteran and two family members conspired to fraudulently obtain caregiving services from VA's Veteran Directed Care program.

The total loss to VA is over \$1.1 million. The veteran and her two family members were indicted in the Western District of Washington on charges of conspiracy to commit theft of government property, theft of government property, healthcare fraud, and false statements.

Veteran and Spouse Pleaded Guilty to Compensation Benefits Fraud Scheme

A multiagency investigation revealed that a veteran and his wife submitted falsified documents to VA claiming that the veteran required constant medical care, suffered from posttraumatic stress disorder, and experienced the loss of the use of his feet. The investigation determined that despite his wife serving as his caregiver, the veteran could walk without assistance. The total loss to the government is almost \$998,000, of which approximately \$820,000 can be attributed to VA. The veteran and his wife pleaded guilty in the Eastern District of Virginia to making false statements to the government. This investigation was conducted by the VA OIG, FBI, and Social Security Administration OIG.

VA Employee Indicted for Receiving Gratuities from Veterans

According to another VA OIG investigation, a rating veterans service representative at the Huntington VA Regional Office in West Virginia allegedly solicited illegal payments from 13 veterans totaling approximately \$25,000. The scheme involved taking money from veterans in exchange for assistance in obtaining a higher service-connected disability rating, resulting in more VA monthly compensation benefits, with the employee charging the veterans 10 percent of any retroactive payment they received from VA. The defendant was indicted in the Southern District of West Virginia on charges of receiving a gratuity while being an employee in the executive branch of the US government.

Investigations Involving Other Matters

Montana Company Falsely Claimed to Perform a Lead Paint Abatement at the Fort Harrison VA Medical Center

A small business that provides hazardous material mitigation services submitted false claims for lead-based paint abatement that was not performed during the renovation of a property at the Fort Harrison VA Medical Center in Montana. The property was used as residential housing units for veterans and their families. The investigation also revealed that a real estate agent failed to provide disclosures about lead paint to residents, resulting in the exposure of veterans and their families to significant lead levels. The small business pleaded guilty in the District of Montana to charges of False Claims Act conspiracy. The real estate agent pleaded guilty in the District of Montana to knowing endangerment. The loss to VA is approximately \$3.5 million. This investigation was conducted by the VA OIG, Department of Housing and Urban Development OIG, and Environmental Protection Agency OIG and Criminal Investigations Division.

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

In response to a complaint made to the VA OIG hotline, OIG and FBI investigators found the former program manager for a nonprofit healthcare organization diverted funds from a \$750,000 VA grant, which was awarded to provide treatment and services to veterans at risk of suicide. The former manager diverted nearly \$50,000 in program funds for his personal use and tried to obtain another \$25,000 before being discovered. While managing the program, he recommended that the nonprofit healthcare organization hire a vendor to provide services funded by the grant. However, the healthcare organization was unaware that 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 to veterans. The former manager was sentenced in the District of New Hampshire to 15 months in prison, 36 months of supervised release, and over \$48,000 in restitution after pleading guilty to wire fraud.

VA Employee Indicted for Fraudulently Obtaining Federal Pandemic Relief Loans

A VA OIG proactive investigation resulted in charges alleging that a licensed practical nurse at the Cleveland VA Medical Center fraudulently claimed to own a daycare business with gross receipts of approximately \$194,000 in 2019 to qualify for a Paycheck Protection Program (PPP) loan and an Economic Injury Disaster Loan (EIDL). Despite not owning the business in 2019, the nurse allegedly obtained an EIDL loan for over \$20,000 and a PPP loan for \$80,000 in 2020 and 2021, and received over \$30,000 in Pandemic Unemployment Assistance benefits while working full-time for VA during the same time period. The nurse was arrested after being indicted in the Northern District of Ohio on charges of wire fraud.

Veteran Sentenced for Threatening VA Staff and Local Law Enforcement Officers

A VA OIG and VA Police Service investigation revealed that a veteran made several phone calls to the Veterans Crisis Line during which he threatened to shoot both staff at the Edward Hines Jr. VA Hospital in Illinois and local law enforcement officers. The veteran was sentenced in the Northern District of Illinois to 24 months in prison and 26 months of supervised release after pleading guilty to 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 November.

Benefits

VBA Did Not Ensure Employees Sent Some Letters Using Its Package Manager Application

The OIG assessed VBA's oversight of unsent packages in Package Manager, part of the Centralized Benefits Communication Management Program introduced in 2018 to modernize mailing. The review team found that due to a lack of oversight, about 2.1 million packages created from January 2018 through October 2022 were still unsent as of November 10, 2022. The review team estimated that about 801,000 of the 2.1 million packages lacked evidence of the letters being sent to one or more of the intended recipients.¹ The undelivered packages requesting evidence for benefit claims that were ultimately denied resulted in VBA not fulfilling its requirement to help veterans obtain evidence in support of the claim. However, the OIG could not determine whether claims were approved or denied had the packages been sent. Unsent packages notifying veterans of claims decisions could have left veterans unaware of reasons for decisions and options for seeking further review. The OIG recommended that the under secretary for benefits implement plans to provide oversight for unsent packages and to manage the packages the team identified in this review as unsent.

Information Technology

Inspection of Information Security at the Health Eligibility Center in Atlanta, Georgia

The VA OIG's information security inspection program assesses whether facilities are meeting federal security requirements related to four control areas the OIG determined to be at highest risk. This inspection of the Health Eligibility Center in Atlanta, Georgia, found deficiencies in three of the four areas:

- Configuration management controls were deficient in vulnerability remediation, system life-cycle management, and remediation of unauthorized software.
- In the area of security management, about 3.3 million veterans' records containing sensitive personal information were not encrypted. VA security policy requires the encryption of sensitive information hosted on computer systems.
- Regarding access controls, the review team found deficiencies in the inventory of facility keys, as well as in logging administrative actions, log retention, and log reviews.

¹ For the remaining approximately 1.3 million packages, there was evidence that (1) the letters were sent through other means to all intended recipients, (2) the letters were not intended to be sent (for example, a VA employee later determined that the letter was unnecessary), or (3) the packages had been deleted and were unavailable to review.

No issues were identified with the facility's contingency planning controls, which include physical and environmental controls. VA concurred with the OIG's five 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 report in November.

Featured Report

Veterans Health Administration Initiated Toxic Exposure Screening as Required by the PACT Act but Improvements Are Needed in the Training Process

The OIG conducted a national review of VHA's implementation of toxic exposure screenings and required training for clinical staff mandated by the PACT Act of 2022. VHA complied with PACT Act Section 603, screening over four million of the nine million enrolled veterans as of November 30, 2023. VHA also complied with Section 604 requirements to train clinical staff on toxic exposure. Despite VHA issuing memoranda requiring additional toxic exposure screening training for VHA clinical staff, the review team found that 21.4 percent of them completed training before performing screenings from November 8, 2022, through January 9, 2023. While the review team did not assess the impact of screening on primary care workload, VHA leaders acknowledged the primary care workload increased. The under secretary for health concurred with the OIG's two recommendations to assess training noncompliance and evaluate the impact of toxic exposure screening on primary care.

Featured Hotline Case

The OIG's hotline staff accepts complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse, and gross mismanagement of VA programs and operations. The following is a case opened by the OIG's hotline division that was not included in the inspections, audits, investigations, or reviews detailed above.

San Diego VA Regional Office Failed to Implement a 2020 Decision by the Board of Veterans' Appeals

The OIG's hotline received allegations that the San Diego VA Regional Office did not reinstate an apportionment of benefit payment for a veteran's estranged spouse, despite a Board of

Veterans' Appeals ruling to do so. The BVA found the termination of the apportionment was improper due to the veteran obtaining a fraudulent divorce decree. The matter was referred to the San Diego Regional Office, which reviewed the veteran's claim folder, substantiated the allegations, and then took action to correct the award. A payment to the estranged spouse was made for \$53,250 and a debt was assessed to the veteran, as he had wrongfully received the funds for the apportionment since 2018.