JANUARY 2025 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 January.

Healthcare Investigation

Four Defendants Plead Guilty to Roles in $110 Million Healthcare Kickback Scheme

The former owner of a home health company, a physician, a pharmacy marketer, and a registered nurse pleaded guilty in the Southern District of Texas to conspiracy to pay and receive healthcare kickbacks. A multiagency investigation revealed the defendants conspired to fraudulently bill federal and private healthcare insurance programs over $110 million for expensive compounded medication in exchange for more than $6 million in kickbacks. The loss to VA is over $2.8 million. This investigation was conducted by the VA OIG, Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service (DCIS), Department of Health and Human Services (HHS) OIG, US Postal Service OIG, Department of Labor OIG, and Texas Health and Human Services.

Benefits Investigations

School Owner Sentenced for Defrauding VA's Post-9/11 GI Bill Program

A VA OIG investigation resulted in charges alleging the owner of a non-college-degree school and its certifying official conspired to submit fraudulent information to conceal the entity's noncompliance with the rules and regulations of the Post-9/11 GI Bill program. In response to an inspector general subpoena, the owner and certifying official allegedly conspired to provide fraudulent information, including falsified contracts and rosters. Between September 2012 and August 2018, VA paid over $17.8 million to the school. The owner was sentenced in the District of New Hampshire to 12 months' home detention, 36 months' probation, and ordered to pay restitution of approximately $200,000 after previously pleading guilty to conspiracy to make false statements. The certifying official was previously indicted on charges of conspiracy to submit false claims and conspiracy to make false statements.

Nonveteran Sentenced for Stealing More Than $450,000 in VA Compensation Benefits from Disabled Veteran

According to an investigation conducted by the VA OIG, Social Security Administration (SSA) OIG, and US Postal Inspection Service, a nonveteran deposited into his personal bank account at least four stolen VA disability checks that were intended for a hospital-bound veteran who had been diagnosed with amyotrophic lateral sclerosis (ALS). After the bank refused to deposit the checks due to a name mismatch, the individual and a coconspirator used stolen identity documents to open another bank account in the victim's name and then successfully made the deposits. Between 2015 and 2020, the individual and his coconspirator stole approximately $460,000 in VA disability benefits checks intended for the veteran. The individual was sentenced in the District of Massachusetts to 23 months' imprisonment, 24 months' probation, and ordered to pay restitution of approximately $460,000 after previously pleading guilty to theft of government benefits and conspiracy to steal government benefits.

Veteran Sentenced to Prison for Compensation Benefits Fraud Scheme

An investigation by the VA OIG, SSA OIG, and HHS OIG revealed that a veteran made false statements regarding the nature of his service-connected disabilities, to include the receipt of a Purple Heart and Combat Action Badge, to fraudulently receive government benefits for nearly 14 years. The veteran submitted fraudulent documentation and made false statements to medical professionals and in his applications claimed that post-traumatic stress was affecting his life to the extent he was unable to work, perform normal daily activities, or care for himself. As a result of his fraud, he also qualified for and received SSA disability benefits and Medicare coverage to which he would not have otherwise been entitled. The veteran was sentenced in the Northern District of Florida to 33 months' imprisonment, 24 months' supervised release, and ordered to pay restitution of over $779,000 after previously pleading guilty to theft of government funds and false statements. Of this restitution amount, VA will receive approximately $378,000.

Former Spouse of Deceased Veteran Pleads Guilty to Fraudulently Receiving VA Benefits

A VA OIG investigation revealed the former spouse of a veteran submitted false documents to VA both after their divorce and following the veteran's death, leading to her fraudulent receipt of dependency and indemnity compensation benefits and participation in VA's Civilian Health and Medical Program. The former spouse took multiple steps in furtherance of this fraud scheme, to include changing her last name to the deceased veteran's last name, fraudulently becoming the administrator of the veteran's estate, and attempting to sue the federal government for $7.3 million. The total loss to VA is over $129,000. The defendant pleaded guilty in the Southern District of Georgia to wire fraud.

Investigations Involving Other Matters

Two Defendants Indicted for Service-Disabled Veteran-Owned Small Business Fraud Scheme

A multiagency investigation resulted in charges alleging two defendants fraudulently established a service-disabled veteran-owned small business (SDVOSB) that was subsequently awarded multiple SDVOSB set-aside contracts. The business allegedly served as a pass-through for a large, non-SDVOSB elevator company that completed nearly all the contracted work. The potential loss to VA is approximately $51 million. The defendants were arrested after being indicted in the Middle District of Florida on charges of conspiracy to commit wire fraud, major fraud against the government, theft of government funds, false statements, and conspiracy to commit money laundering. The investigation was conducted by the VA OIG, Small Business Administration (SBA) OIG, and DCIS.

Two Defendants Pleaded Guilty to Fraudulently Obtaining CARES Act Funds

Another multiagency investigation revealed 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 pleaded guilty in the District of Massachusetts to 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, Internal Revenue Service Criminal Investigation, Insurance Fraud Bureau of Massachusetts, and FBI. As a PRAC member, the VA OIG has assisted federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

Plumbing and Heating Company Owner Sentenced for Economic Injury Disaster Loan Scheme

A VA OIG and FBI investigation revealed the owner of a plumbing and heating company obtained an SBA-backed Economic Injury Disaster Loan for his company for approximately $1.2 million. The loan agreement stipulated that the owner would use all the loan proceeds as working capital for his company to alleviate economic injury caused by the pandemic. He subsequently used a portion of these funds for personal purposes, to include purchasing a diamond ring for approximately $83,000 and spending over $96,000 for remodeling services for his home. The business owner was sentenced in the District of Massachusetts to five months' home confinement to be followed by 19 months' supervised release and ordered to pay restitution of over $179,000 after previously pleading guilty to theft of government property. This investigation was the result of a referral from the PRAC.

Former St. Louis VA Regional Office Employee Sentenced for Paycheck Protection Program Fraud Scheme

A VA OIG investigation revealed that a former St. Louis VA Regional Office employee obtained fraudulent SBA-backed Paycheck Protection Program loans totaling over $40,000 by falsely claiming to be the sole proprietor of a salon generating over $100,000 in annual gross revenue. The defendant was sentenced in the Southern District of Illinois to four months' home confinement, 12 months' probation, and ordered to pay restitution of over $41,000 after previously 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 January.

Benefits

VBA Provided Accurate Training on Processing PACT Act Claims but Did Not Fully Evaluate Its Effectiveness

The PACT Act prompted a rush of new toxic exposure claims and required VA to immediately train staff on reviewing the claims and provide training at least annually. VBA created online training courses and launched them starting on September 20, 2022. The OIG conducted this review to assess VBA's development and implementation of PACT Act training to prepare staff to process claims beginning January 1, 2023. The team found the courses contained accurate information and addressed their stated objectives; the delivery method was appropriate; end-of-course surveys were done; and each course included end-of-course test assessments. However, VBA did not create summary reports analyzing the results of surveys and assessments in fiscal year 2023. Although VBA later completed some summary reports, it never completed others—in part because no deadlines had been set. The OIG recommended completing the missing reports and requiring they be done on deadline in the future.

Healthcare Access and Administration

Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center

The VA OIG substantiated a hotline complaint that the Atlanta VA medical center's call center was not answering calls within VHA's expected time frame due to staffing shortages. Based on

VHA's recommended staffing model, the OIG estimated the call center needed 53 staff to answer the 135,600 calls during the review period; the call center averaged 29 staff. During the review period, 30 percent of callers abandoned their calls (disconnected before speaking to hotline staff), while 22 percent of answered calls were picked up within 30 seconds. VHA expects an abandonment rate of 5 percent or less and that at least 80 percent of all calls are answered within 30 seconds. Other factors contributing to the call center's inability to meet the performance standards included call center supervisors focusing on daily and real-time data rather than cumulative data that could improve monitoring and ensure adequate phone coverage. Call center staff raised concerns during the review about management of specialty clinic and mental health queues. The OIG made three recommendations to the VISN director and one recommendation to the facility director.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports in January.

Care in the Community Inspection

Care in the Community Inspection of VA Desert Pacific Healthcare Network (VISN 22) and Selected VA Medical Centers

This Care in the Community healthcare inspection program report describes the results of a focused evaluation of community care processes at eight VA Desert Pacific Healthcare VISN 22 medical facilities with a community care program located in Arizona, New Mexico, and Southern California. This evaluation focused on four domains: leadership and administration of community care, community care diagnostic imaging results, administratively closed community care consults, and community care provider requests for additional services.[1] The OIG recommended the VISN director, in conjunction with facility directors, ensures community care oversight councils function according to their charters and meet the required number of times per calendar year, facility community care staff enter patient safety events into the Joint Patient Safety Reporting system, and staff make two additional attempts to obtain community providers'

[1] Under specific circumstances, a consult may be administratively closed when documentation from the community care provider is not provided to VA.

medical documentation within 90 days of the appointment following administrative consult closure. In total, the OIG issued 12 recommendations for improvement in the four domains.

Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers

This report describes the results of a focused evaluation of community care processes at seven VA Sierra Pacific VISN 21 medical facilities with a community care program located in California, Hawaii, and Nevada. This evaluation focused on the same four domains discussed above, as well as scheduling and communication with patients referred for community care. The OIG recommended the VISN director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings; facility community care staff confirm patients attended scheduled community care appointments and received care; and staff send approval or denial letters to both community providers and patients for requests for additional services. In total, the OIG issued 13 recommendations for improvement.

Healthcare Inspections

Featured Report

Improvements in Patient Safety, but Concerns Identified with Staffing Shortages Affecting Quality of Care at the VA Community Living Center in Miles City, Montana

The OIG conducted a follow-up healthcare inspection in response to a 2023 OIG report that substantiated an allegation of mistreatment of a resident at the Miles City VA Community Living Center (CLC) and the Fort Harrison VA Medical Center. A CLC is a nursing home that provides care for eligible veterans. CLCs offer a variety of services, including skilled nursing, rehabilitation, and end-of-life care. The OIG did not receive new allegations but initiated the inspection to review the current state of the CLC, including the implementation of previously recommended corrective actions. Specifically, the inspection team assessed the sustainability of changes related to the rights of residents to refuse treatment, patient safety risk and event reporting, screening and admissions, physician care oversight and documentation, and nursing care operations. The OIG determined system leaders' actions to address CLC deficiencies were sustained. There were, however, gaps identified in CLC physician coverage and staffing shortages for the physical therapist and social worker positions, affecting quality of care for residents. The OIG made two recommendations to the facility director to address these gaps.

Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

A healthcare inspection was conducted to assess facility leaders' responses to allegations of a dermatologist's deficiencies in quality of care and documentation. The OIG determined that supervisors failed to correct the dermatologist's misuse of "copy and paste" when preparing clinical documentation as well as delays in performing biopsies, and did not comprehensively review whether the dermatologist documented procedures not actually performed. The chief of staff reported being unaware of the extent of the concerns regarding the dermatologist and the facility director failed to ensure the state licensing board reporting process was initiated timely. The chief of staff also noted that disclosures to patients or their representatives were unwarranted because no patient harm was found during reviews; however, the OIG found the reviews were neither comprehensive nor conducted by a dermatologist. After the healthcare inspection team's site visit, the chief of dermatology identified additional patient care concerns. The OIG concluded further reviews of the care provided by the dermatologist and reconsiderations for disclosures are warranted and made eight recommendations for corrective action.

Deficiencies in Case Management and Access to Care for HUD-VASH Veterans at the VA Greater Los Angeles Healthcare System in California

A healthcare inspection team looked into confidential complaints alleging a veteran was going to be, and other veterans were, discharged from the Housing and Urban Development VA Supportive Housing (HUD-VASH) program "for no reason," but did not substantiate those allegations. Deficiencies were found, however, with the veteran's case management that included the lack of a treatment plan and inadequate discharge documentation. The OIG determined similar deficiencies occurred in the case management of other facility veterans. The inspection team also evaluated access to primary care for veterans enrolled in HUD-VASH who remain unhoused and found the electronic health records of many of them did not have scheduled primary care appointments, had no treatment plans, and no assignments to primary care teams. The OIG made five recommendations to the facility director to address identified issues.

Healthcare Facility Inspections

The Healthcare Facility Inspections Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care in five areas: culture, environment of care, patient safety, primary care, and veteran-centered safety net (for vulnerable populations such as those served by homeless programs). The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, in addition to the well-being of patients and staff. January's healthcare facility inspection reports focused on the following facilities:

- VA Chillicothe Healthcare System in Ohio
- VA Western New York Healthcare System in Buffalo
- Fargo VA Health Care System in North Dakota
- VA Poplar Bluff Health Care System in Missouri
- VA Southern Oregon Healthcare System in White City

Vet Center Inspections

Vet Center Inspection Program reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. The OIG selects and evaluates specific areas of focus on a rotating basis for its vet center inspections. See the report overview section of each report for the areas of focus at the time of the inspection.

In January, the OIG published a report focused on leadership stability, morbidity and mortality reviews, the high-risk suicide flag SharePoint site, and safety plans in Pacific District 5. The OIG found the associate district directors for counseling provided extended coverage for vet center director vacant positions, which limited their ability to provide effective oversight; identified that, based on active policy at the time of the inspection, district leaders did not complete timely, required reviews following notification of suicides and homicides; and found vet center staff noncompliant with completing and providing safety plans to clients. The OIG issued five recommendations for improvement.

Featured Hotline Case

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

A Veteran Wrongfully Claimed Children with Whom He Had No Relationship as Dependents on His VA Disability Compensation Award

Hotline staff received allegations that a veteran stole personally identifiable information of a neighbor's child (no other relationship) and used that information to fraudulently claim the child as a dependent for the past 10 years, which increased his disability compensation benefit award. A review of the child's birth certificate confirmed the veteran was not the child's biological father and the matter was referred to the VA Regional Office in Winston-Salem, North Carolina, for further assessment. The regional office's review found no relationship with the child and

identified that the veteran added two more children to increase his benefit. The office determined those children were also not his children or stepchildren. On October 21, 2024, the regional office sent the veteran a due process notice, but the veteran failed to provide evidence to establish his relationship with the children. Action taken on December 27, 2024, resulted in a taxpayer saving of approximately $34,000.