

Top Examples of VA Fraud, Waste & Abuse

VA Employees Turn a Blind Eye to Missing Drugs

A recent Government Accountability Office report found lack that of oversight and internal controls for prescription opioids and employee accountability put VA medical centers at risk for drug diversion. The VA IG has hundreds of open cases of drug diversion with little effort by VA to provide true accountability.

Read more: http://www.military.com/daily-news/2017/02/21/drugs-vanish-some-va-hospitals.html

VA Employee is Arrested and Ultimately Convicted for her Role in an Armed Robbery A VA clerk assigned to the VA Medical Center (VAMC) in San Juan, Puerto Rico was arrested her role in an armed robbery committed in Puerto Rico in 2015 with an accomplice. According to media reports, the VA employee was held in jail on \$100,000 bond and missed work at the Puerto Rico VAMC while awaiting trial, but was later allowed to return to work at VA in unclassified duties until her trial was final.

Read more: http://dailycaller.com/2016/03/22/va-worker-gets-job-back-despite-armed-robbery-charge/

VA Nurse Shows up to Work Drunk and Assists in an Invasive Surgery on a Veteran

A VA nurse at the Wilkes-Barre VA Medical Center was on call, but still drank several beers at a local casino. When he was paged to come into work to perform surgery on a veteran, he showed up to work under the influence, and is seen on camera footage running into objects as coming into the building. He then assisted in the surgery on the veteran and others in the surgical room said they could smell alcohol on his breath. The employee eventually resigned but no other employee has been disciplined for allowing the intoxicated employee to assist with the surgery.

Read more: http://www.mcall.com/news/nationworld/pennsylvania/mc-va-asks-why-drunk-nurse-is-still-on-the-job-20160227-story.html

The Biggest Construction Failure in VA History

The Department of Veterans Affairs replacement Denver VA Medical Center is the biggest construction failure in VA history. Since the project's inception, the cost of the hospital has

ballooned from \$328 million to \$1.73 billion. Yet as the project spiraled out of control, VA ignored congressional pleas to get things back on track at almost every turn. Instead of putting forth a realistic plan for covering the enormous cost overruns in Denver by finding efficiencies in its existing budget and eliminating waste, VA has essentially demanded that taxpayers subsidize the department's incompetence with an \$830 million bailout. To date, no employees have been held accountable for this fiasco.

Read more http://www.washingtonpost.com/blogs/federal-eye/wp/2015/03/18/vas-colorado-hospital-has-a-shocking-sticker-1-7-billion-yes-billion/

Budgetary Shortfall

during VA's investigation and settlement.

The Department of Veterans Affairs once again showed their incompetence and inability to properly budget their appropriated funds. In FY 2015 VA faced a budget shortfall of more than \$2.5 billion, mainly because of increased demand by veterans for health care, including new life-saving treatments for Hepatitis C. Deputy Secretary Sloan Gibson told HVAC that VA health care sites experienced a 10.5 percent increase in the workload for the 12-month period that ended in April. To date, no individual has been disciplined or held accountable for the budget shortfall.

 $Read\ more\ \underline{http://bigstory.ap.org/article/186c9cb8eeff4c11b67c347e87fbe81d/va-says-it-faces-\underline{25b-budget-shortfall}$

Over \$31,000 inappropriately spent by a VA employee – takes over a year to fire them

A VA employee out of Nashville, TN who was sexting at work, inappropriately spent government money, and conducted inappropriate travel on the taxpayers' dime and who owed thousands of dollars back to the government. VA reached a settlement agreement with the employee which only required the individual to pay back 1/3 of the amount of money the IG said the employee owed; allowed the employee to resign as opposed to being fired from VA; expunged all documentation from his official record regarding misconduct as a VA employee;

and required VA to pay the employee several thousand dollars to cover attorney's fees incurred

Read more: http://www.tennessean.com/story/news/2014/03/30/nashville-va-officials-face-discipline/7067605/

VA employee crashes government car and kills passenger while under the influence A VHA Voc Rehab specialist out of the Central Alabama Veterans Health Care System crashed a government car and a passenger ended up dying. He tried to lie to police as to how the car crashed, but he was later indicted for a DUI. As of September 2014, 16 months after the incident, he was still working at VA.

Read more: http://www.montgomeryadvertiser.com/story/news/local/2014/09/21/tuskegee-vaemployee-charged-dui-still-employed/15998469/

VA employee takes a veteran who is a recovering addict to a crack house

A VA employee at the Central Alabama Veterans Health Care System took a veteran, who was a recovering drug addict, to a crack house where he purchased illegal drugs for the veteran as well as purchased him a prostitute. The employee also "borrowed" a VA check from the veteran. The employee was still employed at VA well over a year later after the incident until they were finally able to remove him.

Read more: http://www.montgomeryadvertiser.com/story/news/local/alabama/2014/08/17/report-va-employee-took-recovering-vet-crack-house/14190573/

\$6 to \$10 Billion spent illegally each year for many years

An example of waste is the annual \$6B – \$10B misuse of procurement funds expended by VA by not following federal acquisition regulations and other laws. According to VA's Senior Procurement Executive, Jan Frye, billions have been illegally spent every year for many years, if not decades.

Read more: Veterans Affairs improperly spent \$6 billion annually, senior ...

West Los Angeles VAMC

A senior VA employee at the West Los Angeles VAMC was identified to have purged approximately 40,000 Veterans care requests without conducting a medical review as a means to hide wait times. A senior VA official also testified that appointment wait times were "about four days" when VA's own documents reveal wait times in Los Angeles to be an average of 48 days and some wait times as long as 90 days.

Read more: http://www.cnn.com/2015/03/13/us/va-investigation-los-angeles/

Purchased Care without a Contract

In violation of federal acquisition regulations and current law that protect the Veteran (patient safety) and protect the government, VA has been obligating the federal government by entering into dubious relationships with health care providers by circumventing contracting requirements.

Read more: http://www.washingtonpost.com/blogs/federal-eye/wp/2015/06/02/va-acknowledges-it-has-no-contracts-in-place-for-some-outside-medical-care-for-veterans/

Suicide & Medication

Numerous examples of VA's practice of overprescribing medication were exemplified by the revelation of a VA doctor in Tomah, Wisconsin nicknamed "The Candyman." Additional examples of overmedication, some characterized as suicides were identified in a year's long HVAC-GAO investigation that revealed Veteran deaths due to drug interactions, drug toxicity, and improper medication management.

Read more: http://www.infozine.com/news/stories/op/storiesView/sid/62105/

Hundreds of Thousands of Veterans Cannot Access Health Care

The access scandal of 2014 uncovered that Veterans were not receiving timely health care has been rocked by an ongoing HVAC investigation that noted hundreds of thousands of Veterans enrollment applications for care were never even processed by VA's Health Eligibility Center (HEC) in Atlanta, in essence denying Veterans that initial access to care. VA's own documents reveal more than 238,000 Veterans died while waiting for VA to enroll them for health care and a VA whistleblower further noted 34,000 Iraq/Afghanistan Veterans were denied access to VA healthcare despite having 5 years of guaranteed eligibility, 16,000 Iraq/ Afghanistan Veterans have lost their guaranteed eligibility due to VA errors and errors with the VA Enrollment System cause phone numbers to not port over to the NEAR LIST, meaning VA could not follow up with Veteran regarding applications.

Read more: http://www.theadvertiser.com/story/news/2015/07/15/document-veterans-backlog-already-died/30188833/

Manipulation & Fraud in Reporting Veteran Owned Small Business Goals

In a 2011 document, the Office of Federal Procurement Policy (OMB) determined it was no longer necessary for federal departments to certify the accuracy of data related to the attainment of meeting small business goals. From then on the federal government appeared to be not only meeting small business goals, but excelling at doing so. But specifically in the case of VA, the attainment of goals related to Service Disabled Veteran Owned Small Businesses (SDVOSB's) (SDVOSB) and Veteran Owned Small Businesses (VOSB's) were knowingly false.

Read more: http://www.military.com/daily-news/2015/06/23/congress-to-examine-fraud-in-vas-vet-owned-small-business-goals.html

Information Technology

VA's cybersecurity continues to be a material weakness for the Department with its 16th straight year of FISMA failures and multiple breaches identified, including a VA contract employee who left a VA laptop in China for his brother's use.

Read more: http://www.va.gov/oig/pubs/VAOIG-13-01730-159.pdf