



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT APRIL 2021 HIGHLIGHTS

This is Adam Roy with the Department of Veterans Affairs Office of Inspector General and you're listening to highlights for April 2021. I'll share investigation updates and briefly summarize recently published reports. But first a brief summary of a recent congressional testimony by Mr. Christopher Wilber, counselor to the Inspector General.

Chris testified at a hearing before the House Committee on Veterans' Affairs Oversight and Investigations Subcommittee on pending legislation including H.R. 2428, the Strengthening Oversight for Veterans Act of 2021. He testified in support of the bill, which would give the VA OIG testimonial subpoena authority. He explained how it would strengthen the OIG's work, discussed examples of inspections and investigations where the OIG could not interview former VA employees, and noted safeguards for witnesses.

Now to investigation updates.

A contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs entered into a final settlement agreement with the Eastern District of California to resolve allegations that it submitted duplicate invoices to VA and failed to reduce billings to VA to reflect negotiated discounts it received from private healthcare providers for services rendered. Pursuant to this agreement, the contractor made an interest payment of approximately \$3.5 million. This settlement was the culmination of a three-year investigation conducted by the VA OIG, VA, and Department of Justice. Over the course of this investigation, this contractor returned approximately \$92 million in overpayments by VA due to duplicate invoice submissions.

The US District Court for the District of South Carolina unsealed various judicial actions which pertained to one of the largest healthcare fraud schemes in US history. The owner of over a dozen durable medical equipment companies, six business associates, and four companies pleaded guilty to charges in connection with an investigation that resulted in charges that the defendants participated in a scheme in which telemedicine companies contracted with telemedicine doctors to prescribe medical equipment for patients with whom there was no doctor-patient relationship. The durable medical equipment companies then submitted grossly inflated claims to federal agencies for payment. The total loss to the government is approximately \$1.2 billion. The investigation was conducted by the VA OIG, FBI, Department of Health and Human Services OIG, and Internal Revenue Service Criminal Investigation.

In another healthcare fraud scheme, five defendants were arrested after being charged in the District of New Jersey. Additionally, two defendants pleaded guilty to conspiracy to violate the anti-kickback statute and conspiracy to commit healthcare fraud. An investigation by the VA OIG, Defense Criminal Investigative Service, FBI, and Health and Human Services OIG resulted in charges that the defendants

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solicited durable medical equipment and cancer genetic screening tests to prospective patients and used telemarketers and telemedicine doctors to generate prescriptions. It is alleged that the telemedicine doctors did not have a relationship with the patients, and the telemarketers sold the completed orders to the testing laboratory. To date, investigative efforts have led to 17 arrests and 10 convictions.

A veteran and his spouse each pleaded guilty in the Southern District of California to theft of government funds. A VA OIG investigation revealed that from October 2015 through April 2020, both defendants made numerous false statements to VA which indicated that the veteran was unemployed and in need of a full-time caregiver. During this same time frame, the veteran worked full-time as a veteran service representative at the VA regional office in San Diego, California.

A former employee of the Coatesville VA Medical Center in Pennsylvania was indicted for threatening and cyberstalking his former coworkers. A VA OIG investigation resulted in charges that the defendant sent sexually explicit, harassing, and threatening interstate communications and mail packages to various former coworkers. The defendant also allegedly targeted the family members of his former coworkers with similarly vulgar communications.

The owner of a heating, ventilation, and air conditioning school was found guilty by a federal jury in the Northern District of Texas on charges of wire fraud and money laundering. The owner fraudulently obtained state and VA approval for his for-profit school, then allegedly used the fraudulently obtained approval status to entice veteran students to attend the school, which resulted in the fraudulent collection of VA education benefits. The loss to VA is approximately \$71 million.

And finally, the US Attorney's Office for the Central District of California announced that a construction firm agreed to a civil settlement and non-prosecution agreement under which the company paid \$2.5 million to settle allegations that it violated federal law through its involvement in federal construction contracts obtained by a related company under a program designated for small businesses owned by service-disabled veterans. The VA will receive \$1.4 million.

The VA OIG published five reports in April. Read the reports and summaries online at www.va.gov/oig.

In an audit published, the OIG contracted with the CliftonLarsonAllen firm to evaluate VA's information security program compliance with the Federal Information Security Modernization Act for FY 2020. The firm evaluated 48 major applications and general support systems hosted at 24 VA sites and concluded that VA continues to face significant challenges meeting requirements and made 26 recommendations. It was recommended VA address security-related issues that contributed to reported information technology material weaknesses and improve deployment of security patches, system upgrades, and system configurations to mitigate significant security vulnerabilities and enforce a consistent process across all field offices.

A national healthcare report reviewed the Veterans Health Administration's community-based outpatient clinic closures that occurred due to the COVID-19 pandemic to evaluate the impact of these closures on

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patient care. Of the Veterans Health Administration's 1,031 clinics, 173 were closed to face-to-face visits on or after February 1, 2020. Reasons for closure fell into four categories including safety of patients and staff due to community spread, need for consolidation of resources to support larger clinics or facilities, lack of staff and personal protective equipment, and small size of the clinic or proximity to other clinics or facilities. The OIG concluded that, generally, patient care needs were not interrupted due to closures and made no recommendations.

The third report evaluated the Veterans Crisis Line responses to callers with homicidal and suicidal ideation and care of one of the callers at the Montana VA Health Care System in Fort Harrison. The OIG substantiated a responder failed to assess a caller's homicidal risk factors, address lethal means, complete an adequate safety plan, communicate critical information to a supervisor, and take actions to prevent a family member's death. The OIG also substantiated two social service assistants failed to dispatch emergency services for a caller following a rescue request. The OIG made 11 recommendations regarding quality management, review of the callers' contacts, administrative investigation boards, responders' communication, oversight, and non-VA health records documentation policy compliance.

The OIG published a management advisory memorandum on inconsistent documentation and management of COVID-19 vaccinations for community living center residents. While reviewing VHA's plans to document receipt and distribution of the COVID-19 vaccine, the OIG found VHA facilities did not consistently document the COVID-19 vaccination status of veterans living in VA's Community Living Centers. The OIG determined that VHA could not know at a national level whether the vaccine was offered to some center residents, and if so, what their status was. Because those residents are in the highest COVID-19 vaccine priority group, they should be offered the vaccine, when possible, before other groups of veterans. With supplies limited, VHA should know which clinic residents still need to be vaccinated. The OIG will continue its oversight work on vaccinations within VHA and plans to issue a full report, including specific recommendations.

Finally, the OIG published a Comprehensive Healthcare Inspection Program report on the Ann Arbor VA Medical Center in Michigan. The report focused on a variety of topics, to include COVID-19 pandemic readiness and response. Thank you for listening to the VA OIG's monthly highlights for April 2021.

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