



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT June 2021 Highlights

This is Adam Roy with the Department of Veterans Affairs Office of Inspector General and you're listening to highlights for June 2021. I'll share investigation updates and briefly summarize several published reports.

Seven defendants were indicted in the Southern District of Texas for their roles in a healthcare fraud and kickback scheme that totaled approximately \$110 million. An investigation by the VA OIG and several other agencies resulted in charges alleging that the defendants conspired to fraudulently bill federal and private healthcare insurance programs for compounded medication. The loss to VA is over \$2.8 million.

A nonveteran was sentenced to 27 months' imprisonment and restitution of approximately \$25,000 after previously pleading guilty to aggravated identity theft and theft of medical services. An investigation by the VA OIG and VA Police Service revealed the defendant assumed the identity of a veteran, who was a family friend, to gain admittance to the Mountain Home VA Healthcare System in Tennessee.

An employee at the VA Joint Ambulatory Care Center in Pensacola, Florida, pleaded guilty to charges of video voyeurism and disorderly conduct. An investigation by the VA OIG and VA Police Service revealed that on approximately 17 occasions, the defendant illegally placed a recording device that resembled a cell phone charger in a unisex employee restroom. The defendant admitted that he placed the device in the restroom to record individuals and then later watched the footage.

A former housekeeper at the West Haven VA Medical Center in Connecticut was sentenced to 90 days' imprisonment and one year of supervised release after pleading guilty to larceny. An investigation by the VA OIG, VA Police Service, and West Haven Police Department revealed that the defendant stole a box of personal protective equipment from the medical center. The defendant then resold the contents of the box, which were masks and face shields, to employees at a nearby gas station.

A veteran was indicted in the Eastern District of Missouri for theft of public funds. A VA OIG investigation resulted in charges alleging the defendant has been rated as 100 percent service-connected disabled for bilateral blindness since 2000 despite maintaining a valid driver's license. It is alleged that the veteran was observed driving nearly daily and mowing his lawn. The loss to VA is approximately \$880,000.

A former VA-appointed fiduciary pleaded guilty in the Western District of Pennsylvania to misappropriation by a fiduciary. A VA OIG investigation revealed that the defendant embezzled VA funds intended for his veteran brother, including over \$130,000 in unauthorized money transfers, over \$25,000 in ATM cash withdrawals, and numerous purchases for his own personal use. Some of the purchases included a diamond ring, a pickup truck, and two motorcycles.

A defendant was sentenced in the Northern District of Texas to over seven years' incarceration, 36 months' supervised release, and restitution of over \$6 million after previously pleading guilty to conspiracy to commit healthcare fraud. An investigation by the VA OIG, Department of Labor OIG, Department of Homeland Security OIG, and US Postal Service OIG revealed that over a three-year period the defendant submitted fraudulent claims for durable medical equipment to Department of Labor's Office of Workers' Compensation Program. The total loss to the government is approximately \$6 million. Of this amount, the loss to VA is approximately \$2.5 million.

The VA OIG published 20 reports in June. Read the reports and their summaries online at www.va.gov/oig. I'll now highlight several reports.

The VA OIG assessed VA's efforts to implement an information technology system that supports the Program of Comprehensive Assistance for Family Caregivers, which provides benefits for caregivers of eligible veterans. The VA MISSION Act of 2018 expanded program eligibility from veterans injured after 9/11 to include veterans injured in any conflict. The OIG recognizes VA's efforts and challenges as millions of veterans may now be considered for the program. However, VA did not meet the act's deadlines for implementing and reporting on the system. It lacked effective governance and leadership when upgrading and replacing the legacy system. The new IT system, named the Caregiver Record Management Application, was fully implemented on October 1, 2020. Although the system meets Mission Act requirements, VA did not establish its appropriate security risk category and fully assess privacy vulnerabilities. The OIG made four recommendations for corrective action.

The VA OIG reviewed how effectively VA managed its emergency caches during the first wave of the COVID-19 pandemic in early 2020. These caches contain a standard supply of drugs and medical supplies, including personal protective equipment, for use during a pandemic. The review team found that only nine of 144 medical facilities activated their emergency caches from February through June 2020. Medical facility directors reported that they did not need the supplies or that the quantity was not sufficient for a pandemic. In addition, the Veterans Health Administration changed the process for mobilizing caches during the pandemic but did not communicate this clearly to medical facility directors. The review team also identified problems with cache maintenance and monitoring, such as expired or missing personal protective equipment and incomplete documentation on cache activations. The OIG made three recommendations to the under secretary for health to improve the use and oversight of the emergency caches.

In an audit, the OIG evaluated whether VA's community care staff accurately uploaded records for non-VA medical care to veterans' electronic health records. These records enable continuity of care by Veterans Health Administration providers and inform treatment decisions. The audit team found that the VHA medical facilities reviewed, which used community care staff to index non-VA medical records, did not comply sufficiently with VHA requirements. Errors included using ambiguous or incorrect document titles, indexing records for non-VA care to the wrong referral or veteran, and entering

duplicate records. These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, and a lack of facility-level policies. The OIG made two recommendations to the under secretary for health to address the issues identified.

The OIG also audited the National Cemetery Administration's governance and oversight of the Veterans Cemetery Grants Program and whether critical noncompliance issues at two Hawaii state cemeteries were addressed. Program staff did not prioritize some grants as regulations required, but generally ensured cemeteries used grants for their intended purpose. However, the administration did not ensure cemeteries with grants met all national shrine standards for markers, maintenance, and safety. The audit team observed noncompliance issues at eight state cemeteries. As a result, the National Cemetery Administration lacks assurance that veterans and family members buried in those cemeteries have been appropriately honored. The OIG made 11 recommendations to the under secretary for memorial affairs to ensure better management of state cemetery grants and veterans cemeteries.

A review of 58 Veterans Health Administration outpatient clinics' emergency preparedness evaluated the delivery of telemental health care as of November 1, 2019. The review focused on clinic-specific emergency procedures, defined emergency procedure roles and responsibilities, staff emergency contact information, and patient safety reporting methods. Five recommendations were made.

A healthcare inspection assessed and substantiated allegations that former pathologist, Dr. Robert Levy, misdiagnosed specimens and altered quality data. Pursuant to a criminal investigation by the OIG, Dr. Levy was sentenced to 20 years in prison. After reviewing Dr. Levy's almost 34,000 cases, clinicians identified more than 3,000 errors including 34 that required disclosure to patients. Errors occurred because Dr. Levy, a self-admitted alcoholic, subverted quality processes that facility leaders did not detect, signs of impairment were unaddressed, and facility culture did not support reporting impaired behaviors. Ten recommendations were made to the under secretary for health related to competency and pathology quality processes, pathology reports, and consulting with external pathologists.

Finally, the OIG published three Comprehensive Healthcare Inspection Program or CHIP reports on VA medical centers located in Marion, Indiana and in Battle Creek and Detroit, Michigan. CHIP reports ensure our nation's veterans receive high-quality and timely healthcare and are performed every three years. Inspections focus on variety of issues like mental health, medication management, and safety.

Find summaries of all VA OIG reports online at our website. Thank you for listening to the monthly highlights for June 2021.

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