



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

OCTOBER 2019 HIGHLIGHTS

Congressional Testimony

Inspector General Testifies Before the House Committee on Veterans' Affairs About the Office of Inspector General's Review of VA's Office of Accountability and Whistleblower Protection

Inspector General Michael Missal [testified](#) at a hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on October 29, 2019. The hearing focused on the Office of Inspector General (OIG) report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*. Inspector General Missal provided an overview of the report's six findings, which noted how leadership failures undermined the Office of Accountability and Whistleblower Protection's (OAWP's) core mission and diminished the confidence of whistleblowers and other potential complainants in the operations of the office. The report also included 22 recommendations to improve VA processes that increase employee accountability and whistleblower protection.

Assistant Inspector General for Healthcare Inspections Testifies on Oversight and Investigations

Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections, [testified](#) at a hearing before the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations, regarding the challenges facing the Veterans Health Administration (VHA) Credentialing and Privileging programs. Dr. Daigh's testimony was drawn from numerous OIG reports, including the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2018*; *Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility*; and *Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center Asheville, North Carolina*. He discussed the OIG's findings, explained VHA's failure to implement policies appropriately, and urged VHA to look at appointing national practice leaders to strengthen oversight over credentialing and privileging functions, including conducting more hands-on skills checks of new providers.

Criminal Investigations Involving Health Care

Medical Billing Company Owner Pled Guilty to Defrauding VA's Civilian Health and Medical Program

The owner of a medical billing company conspired with the owner of three clinics to bill government healthcare programs, including VA's Civilian Health and Medical Program (CHAMPVA), for office visits, tests, and services that were rendered by prohibited providers. As a result, the billing company owner pled guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. The loss to

VA is approximately \$180,000. The investigation was conducted by the VA OIG, Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service (DCIS), and Health and Human Services OIG.

Six Former VA Office of Community Care Employees Prosecuted for Roles in Overtime Fraud Scheme

A VA OIG investigation revealed the defendants allegedly collected overtime compensation totaling more than \$178,000 for hours that were not worked. Five former VA Office of Community Care (OCC) employees pled guilty in the Northern District of Ohio to theft of government property, and a sixth former VA OCC employee was indicted on charges of theft of government property, wire fraud, and false statements.

Former San Diego, California, VA Medical Center Medical Support Assistant Sentenced for Drug Distribution

A VA OIG, Drug Enforcement Administration (DEA), and VA Police Service investigation revealed that a former VA medical center medical support assistant sold methamphetamine and cocaine at the medical center during normal duty hours. The defendant was sentenced in the Southern District of California to 24 months' imprisonment and three years' supervised release. Also, as a result of this investigation, a former San Diego VA medical center canteen service barber previously pled guilty to the distribution of methamphetamine and was sentenced to 22 months' imprisonment and three years' supervised release.

Two Defendants Pled Guilty to Drug Distribution at the Cleveland, Ohio, VA Medical Center

A VA OIG and FBI investigation discovered that three defendants allegedly sold a substance containing heroin, fentanyl, carfentanil (one of the most potent synthetic opioids), and acetylfentanyl (another potent synthetic opioid) to an inpatient veteran while on the property of the Cleveland, Ohio, VA Medical Center. The veteran injected the substance directly into her peripherally inserted central catheter (or PICC line, a form of intravenous access), which resulted in a nonfatal overdose. As a result of the investigation, two defendants pled guilty in the Northern District of Ohio to drug distribution resulting in serious bodily injury and conspiracy to distribute heroin. The third defendant was indicted in the Cuyahoga County Court of Common Pleas on charges of corrupting another with drugs and permitting drug abuse.

Former Des Moines, Iowa, VA Medical Center Registered Nurse Indicted for Drug Diversion

A former VA medical center registered nurse was indicted in the Southern District of Iowa for acquiring controlled substances by misrepresentation, fraud, deception, and subterfuge. A VA OIG and VA Police Service investigation resulted in charges alleging the defendant diverted hydromorphone and other narcotics from the medical center over approximately seven months.

Veteran Pled Guilty to Possession of Fentanyl

A veteran pled guilty in the Western District of New York to a criminal information (a formal charging document) charging him with possession of fentanyl after an investigation revealed that while a resident at the Bath, New York, VA Medical Center, the defendant returned to the facility after a weekend trip home in possession of numerous items of contraband, including approximately 20 plastic bags of a substance later determined to be fentanyl. Four knives, an unspent round of ammunition, three used hypodermic needles, and a bag of unused needles were also recovered. The investigation was conducted by the VA OIG, VA Police Service, and DEA.

Criminal Investigations Involving Benefits

Veteran Charged in Connection with Fraud Scheme

A VA OIG investigation resulted in charges alleging that for more than 20 years, a veteran fraudulently received approximately \$9,000 per month from VA for the loss of use of his limbs and hearing problems with associated vertigo. The investigation examined allegations that the defendant was able to ambulate without difficulty and did not require the assistance he claimed to VA was necessary. The defendant was captured on video driving, walking, bending, and using all his limbs without assistance. During the investigation, the defendant attended two Compensation and Pension examinations in a wheelchair and received assistance from a co-conspirator when attending his medical appointments. Ultimately, the veteran was charged in the District of South Carolina with healthcare fraud and theft of government funds. The loss to VA is nearly \$2 million.

Veteran Convicted for Compensation Benefits Fraud Scheme

A veteran was convicted of healthcare fraud, theft of government money, false statements, and Social Security Disability Insurance fraud by a federal jury in the District of Montana. A VA OIG and Social Security Administration OIG investigation uncovered allegations that the defendant was witnessed driving a Harley-Davidson motorcycle while receiving Aid & Attendance compensation for the loss of the use of his hands and feet. During a Compensation and Pension examination, the defendant was found to have misled the VA examiner about his ability to drive and walk. The loss to VA is over \$617,000.

Son of Deceased VA Beneficiary Arrested for Theft of Government Funds

The son of a deceased VA pension beneficiary was arrested in the Southern District of New York for theft of government funds. A VA OIG investigation resulted in charges alleging the defendant stole monthly VA pension benefits intended for the beneficiary, who died in September 2006. The loss to VA is approximately \$201,000.

Criminal Investigations Involving Other Matters

Two Individuals Pled Guilty in Kickback Scheme

The president of a government subcontracting company pled guilty in the District of Vermont to paying over \$200,000 in kickbacks to a senior project manager whose company was awarded a large General Services Administration (GSA) Energy Savings Performance Contract. This subcontractor previously bid on a VA Energy Savings Performance Contract, which was valued at approximately \$18.5 million, that was cancelled prior to award by VA due to findings from this investigation. The president of a Puerto Rico-based company pled guilty in the District of the Virgin Islands to charges that he paid over \$1.2 million in kickbacks to the aforementioned senior project manager in exchange for federal government subcontracts to perform work on the federal building and courthouse in St. Croix and on Coast Guard facilities in Puerto Rico. Although not part of the charging documents, the subcontractor was awarded a contract at the San Juan, Puerto Rico, VA Medical Center. The senior project manager previously pled guilty to receiving over \$2.5 million in kickbacks from approximately eight subcontractors, to include these defendants. This investigation was conducted by VA OIG, Naval Criminal Investigative Service, Department of Agriculture OIG, Coast Guard Investigative Service, and GSA OIG.

Former Anchorage, Alaska, VA Medical Center Contracting Officer Representative and Business Owner Indicted for Alleged Participation in Bribery Scheme

A former medical center Contracting Officer Representative (COR) and the owner of a general contracting company were indicted in the District of Alaska for false statements, wire fraud, bribery of public officials, conspiracy, and prohibited contracting acts. A VA OIG investigation resulted in charges alleging that the former COR received bribes totaling approximately \$29,000 in connection with purchase card orders and service-disabled veteran-owned small business set-aside housekeeping and snow removal contracts at the Anchorage medical center. The total value of the contracts and purchase card orders awarded by VA was over \$2 million.

Medical Device Company Owner Charged in Connection with Healthcare Fraud Scheme

The owner of a medical device company was charged via criminal information in the District of Oregon with healthcare fraud and tax evasion. An investigation resulted in charges alleging that the defendant used altered invoices to inflate wholesale costs in claims to private insurance and government healthcare programs for durable medical equipment, mainly compression stockings. The overall loss to the government is approximately \$1.9 million. Of this amount, the loss to the CHAMPVA program is almost \$115,000. The joint investigation was conducted by the VA OIG, Office of Personnel Management OIG, Internal Revenue Service Criminal Investigation, Washington State Office of the Insurance Commissioner, FBI, and DCIS.

Audit(s) and Review(s)

Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives

The OIG conducted this review in response to an allegation that veterans' sensitive personal information was stored on shared network drives and was likely accessible to unauthorized users. The OIG team found sensitive personal information was left unprotected on two shared VA enterprise network drives, putting veterans at risk of fraud or identity theft. VA's Office of Information and Technology (OIT) senior representatives said authenticated network users with access to the shared drives could have accessed that information regardless of having a business need. These issues occurred as a result of negligence and lack of oversight. The OIG recommended VA officials provide remedial training to users on the safe handling and storage of sensitive personal information on network drives. The OIG also recommended establishing technical controls and improving oversight procedures to prevent sensitive personal information from being stored on the shared network drives.

VA's Management of Mobile Devices Generally Met Information Security Standards

VA's OIT manages more than 50,000 mobile devices that store and transmit veteran information that must be protected. The OIG conducted this audit to determine whether OIT's policies and procedures provide enough security for that information. The OIG found OIT's security practices for mobile devices generally minimized security weaknesses within VA's network. However, the OIG did find vulnerabilities associated with configuration management. An OIT director said the office decided not to use blacklisting or other configuration management tools because of concerns about workload. The OIG recommended the Assistant Secretary for Information and Technology either enforce blacklisting or formally assess and document whether training would work to prevent users from downloading and using non-VA approved applications. OIT has now awarded a contract to Lookout for a new application vetting tool, but it was not available for OIG review before report publication.

Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017

In response to congressional requests and allegations made to the OIG hotline, the Office of Special Reviews examined aspects of VA's implementation of the Accountability and Whistleblower Protection Act. In particular, the OIG examined OAWP operations and found failures in how OAWP exercised its statutory authority, conducted investigations, and protected whistleblowers. Former OAWP leaders engaged in activities outside its core mission and created a culture that chilled reporting and undercut efforts to build confidence in the office. OAWP misinterpreted its statutory authority, improperly referred matters to other VA offices (without sufficiently protecting whistleblowers' identities or safeguarding against risk of investigatory retaliation), and retained matters for investigation outside its scope. Inadequate guidance contributed to investigations not being thorough or balanced, resulting in the reduction of some recommended disciplinary sanctions. (See related hearing on page 1.)

The Impact of VA Allowing Government Agencies to Be Excluded from Temporary Price Reductions on Federal Supply Schedule Pharmaceutical Contracts

VA is responsible for negotiating Federal Supply Schedule (FSS) prices (volume discounts) for billions of dollars of pharmaceuticals on behalf of all federal agencies. This review examined how VA administers temporary price reductions (TPRs) and the impact on government-wide contract negotiations when VA accepted TPRs offered only to certain government agencies and not all authorized FSS users. VA's National Acquisition Center has been routinely facilitating the award of agency-specific TPRs, which did not benefit all authorized FSS users. The OIG determined taxpayers paid an estimated \$602 million more over two years for pharmaceuticals purchased government-wide than if the lowest price reduction had been offered to all federal agencies. Agency-specific TPRs appeared to have negatively affected the negotiation of FSS prices and were being processed as unilateral modifications. Also, the TPRs were not published as required for FSS prices, potentially reducing competition. VA non-concurred with one of the OIG's four recommendations to develop and implement a policy that prohibits restricted agency-specific TPRs on FSS contracts.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

- (1) Quality, Safety, and Value;
- (2) Medical Staff Privileging;
- (3) Environment of Care;
- (4) Medication Management;
- (5) Mental Health;
- (6) Geriatric Care;
- (7) Women's Health; and
- (8) High-Risk Processes

In October, the following CHIP reports were released:

Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 Texas Valley Coastal Bend Health Care System, Harlingen, Texas

To listen to the podcast on the OIG's October 2019 activity highlights, go to www.va.gov/oig/podcasts.