DECEMBER 2019 HIGHLIGHTS

Criminal Investigations Involving Health Care

Fifteen Defendants Charged in Connection with Bribery Scheme

Fifteen defendants, which included vendors and current and former VA employees, were charged in the Southern District of Florida with bribery, conspiracy to commit healthcare fraud, healthcare fraud, false statements, theft of government funds, and falsification of records. A VA Office of Inspector General (OIG) investigation resulted in charges alleging the vendors engaged in a bribery and kickback scheme with employees of the West Palm Beach and Miami VA medical centers in Florida. The charges allege the VA employees placed supply orders with the vendors in exchange for cash bribes and kickbacks. In many instances, the prices of supplies were grossly inflated. In other instances, the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts. Another aspect of this investigation involved one vendor who allegedly submitted false statements in an application to VA in order to be designated as a service-disabled veteran-owned small business, which resulted in further business transactions with VA.

Nonveteran Arrested for Healthcare Fraud and Theft of Government Funds

A nonveteran was arrested in the Central District of California for healthcare fraud and theft of government funds. A VA OIG investigation resulted in charges alleging that from approximately February 1992 to November 2016 the defendant used the identity of a deceased veteran to fraudulently obtain VA compensation benefits and healthcare benefits. The loss to VA is $111,567.

Criminal Investigations Involving Benefits

Husband and Wife Sentenced for Theft of Government Funds

A husband and wife were sentenced in the Northern District of Mississippi after pleading guilty to theft of government funds. A VA OIG and Social Security Administration (SSA) OIG investigation revealed that from December 2005 to August 2018 the defendants accessed a deceased veteran's bank account in order to steal his VA and SSA benefits. The husband was sentenced to 18 months' incarceration and three years' supervised release. The wife was sentenced to 21 months' incarceration and three years' supervised release. The defendants were also ordered to pay restitution of $239,127 to VA.

Veteran Indicted for Compensation Benefits Fraud

A veteran was arrested after being indicted in the District of Massachusetts for theft of government funds and false statements. A VA OIG and SSA OIG investigation resulted in charges alleging the defendant stole more than $420,000 from VA and SSA by falsely claiming he was unable to work due to a disability while simultaneously owning and operating an insurance company. The loss to VA is approximately $165,000.

Friend of Deceased VA Beneficiary Sentenced for Theft of Government Funds

The friend of a deceased veteran was sentenced in the District of New Mexico to three years' supervised probation, 40 hours of community service, and ordered to participate in a 500-hour drug treatment program and a gambling addiction program. The defendant was also ordered to pay restitution of $162,741 to VA and $62,748 to SSA. A VA OIG and SSA OIG investigation revealed the defendant continued to draw VA disability pension benefits and SSA retirement funds intended for the veteran who died in September 2004.

For-Profit College and General Manager to Pay Over $120,000 to Resolve False Claims Act Liability

A non-college degree information technology training institution and the school's general manager executed a settlement agreement with the U.S. Attorney's Office for the Eastern District of Washington. Under the terms of the settlement agreement, the institution will pay $100,000 and the general manager will pay $20,950. A VA OIG proactive investigation resulted in this settlement agreement under which the school and the general manager admitted that between 2015 and 2018 the school failed to comply with the "Last Payer Rule," which requires the amount of G.I. Bill reimbursement to be reduced by the amount of any discounts, rebates, or other financial incentive provided to veterans. The settlement also included a statement of fact that explained how the school received guidance from its corporate parent, which facilitated these violations.

Former Buffalo, New York, VA Regional Office Employee Arrested for Making Threats

A former Buffalo, New York, VA Regional Office employee made his initial appearance in the Western District of New York following his arrest for making threatening telephone calls. A VA OIG investigation resulted in charges alleging that the defendant left numerous voicemails for a current Buffalo, New York, VA Regional Office employee in which he threatened to rape and/or kill the employee's family members and to kill the employee.

Criminal Investigations Involving Other Matters

Medical Office Administrator Convicted for Role in Workers' Compensation Fraud Scheme

A medical office administrator was found guilty of healthcare fraud by a federal jury in the Northern District of Texas. A VA OIG, U.S. Postal Service OIG, Department of Labor OIG, Department of Justice OIG, and Army Criminal Investigation Command-Major Procurement Fraud Unit investigation resulted in charges alleging the defendant submitted false claims to the Department of Labor's Office of Workers' Compensation Program on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, allegedly assigned inaccurate billing codes to increase the practice's Office of Workers' Compensation Program reimbursement payments. According to the evidence at trial, some of the medical procedures were medically unnecessary, while others were not

even performed. One other defendant previously pled guilty in the case and will be sentenced in March 2020. The loss to VA is approximately $2.9 million.

Workers' Compensation Clinic Owner Sentenced for Fraud Scheme

The owner of a workers' compensation clinic was sentenced in the Western District of Texas to seven years' imprisonment, three years' supervised release, and ordered to pay restitution of $6,032,126 to the government. A VA OIG, Federal Bureau of Investigation, Department of Labor OIG, and U.S. Postal Service OIG investigation resulted in charges alleging that between October 2012 and December 2016 the defendant charged multiple federal agencies for fraudulent claims and for services not rendered. The defendant also allegedly used the name and physical therapy license number of another person without their knowledge to further the scheme. In June 2019, the defendant was found guilty by a federal jury of health care fraud, wire fraud, and aggravated identity theft. The total loss to VA is $506,986.

Audits and Reviews

Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers

This audit examined whether VA effectively monitored Medical/Surgical Prime Vendor-Next Generation Program (MSPV-NG) order fulfillment and vendor performance. It focused on VA medical centers serviced by American Medical Depot. MSPV-NG is VA's national program for procuring medical or surgical supplies across the Veterans Health Administration (VHA). Inaccurate or unavailable supplies due to ordering errors can affect patient care. The audit team found that VA did not have adequate staff and processes to ensure effective management and oversight of American Medical Depot's services. Delivery orders and invoice pricing did not match approved costs, products were obtained from unapproved suppliers, and staff obligated funds without proper authority. VA medical centers received incorrect orders about 60 percent of the time. The OIG estimated that, without correction, VA would improperly pay American Medical Depot about $84 million over the next five years. OIG recommended increased performance monitoring and developing formal processes to ensure contract compliance.

Insufficient Oversight of VA's Undelivered Orders

This audit examined whether VA's management of undelivered orders ensured the most effective use of appropriated funds. Undelivered orders are items or services ordered that have not been received, and their value represents legal financial commitments. The OIG found that VA did not effectively ensure appropriated funds that were no longer needed were identified and deobligated. Undelivered orders management lapses identified were related to VA issuing conflicting guidance and not properly monitoring and reconciling excess funds or providing supporting documentation. The audit team estimated that VA had not deobligated at least $132.6 million of $3.5 billion in excess funds in a timely manner, as required by VA policy. The OIG recommended that VHA leaders make certain that obligation policy includes timeframes for internal communication to identify funds for deobligation.

Other recommendations focused on compliance with policies related for reviewing, adjusting, and maintaining documentary evidence for obligations.

Delays and Deficiencies in Management of Selected Radiology and Nuclear Medicine Outpatient Exams

The OIG conducted this review to determine if VHA completed radiology and nuclear medicine exam requests and follow-up care in a timely manner. The audit team also determined if VHA managed canceled requests appropriately. The audit team estimated that 17 percent of routine exams and 25 percent of urgent exams were not completed within the time frames required by VHA policy. Reasons included staff and equipment shortages, issues with staff allocation, and insufficient monitoring of the scheduling process. Most follow-up care was completed appropriately, but facility staff did not consistently cancel obsolete exam requests correctly. The audit team also substantiated two hotline allegations of inappropriate exam cancellations at the James A. Haley and Iowa City VA medical centers. The OIG made several recommendations to the Under Secretary of Health for improving radiology and nuclear medicine oversight at the facility and regional levels.

Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Boston VA Research Institute

The OIG conducted this audit in response to allegations that the Boston VA Healthcare System violated law and VA policy by making inappropriate payments to Boston VA Research Institute, a VA-affiliated nonprofit corporation. The OIG found lapses in oversight and weak internal controls allowed for inappropriate payments to the Boston VA Research Institute. VA Boston Healthcare System officials authorized about $1.6 million in inappropriate payments to the Boston VA Research Institute for administrative fees, reimbursing salaries and benefits of administrative positions, and duplicate retirement contributions because they did not follow VA policy. The healthcare system made an estimated $22.8 million in improper payments because employees did not verify services were performed before making payments, as VA policy requires. The OIG made seven recommendations, including that the Under Secretary for Health confer with the VA Office of General Counsel and human resources officials about whether administrative actions should be taken against officials responsible for inappropriate payments.

Healthcare Inspections

Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in Veterans Integrated Service Network 15

The OIG evaluated staff's adherence to the facility's psychosocial distress screening standard operating procedure (SOP) and facility leaders' response to the root cause analyses following two patient deaths. Facility oncology service staff demonstrated compliance with psychosocial distress screening SOPs. However, a mental health evaluation, which may have identified additional risk factors and provided opportunity for suicide prevention interventions, was not completed prior to one patient leaving the

clinic. Facility oncology service nursing staff administered the psychosocial distress thermometer at every visit, which exceeded SOP requirements. The alignment of the SOP with current practice is critical to ensure clear guidance to staff. The facility's Patient Safety Manager did not monitor progress toward root cause analysis action item completion. After a patient's death by suicide in 2017, the Acting Suicide Prevention Coordinator did not complete documentation required by VHA. The OIG made four recommendations related to mental health evaluation coverage, alignment of SOPs for psychosocial distress screening with the National Comprehensive Cancer Network's ideal standards, tracking of action items to completion, and the completion of Suicide Behavior and Overdose Reports and Behavioral Health Autopsies.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program 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) Leadership and Organizational Risks
(2) Quality, Safety, and Value
(3) Medical Staff Privileging
(4) Environment of Care
(5) Medication Management
(6) Mental Health
(7) Geriatric Care
(8) Women's Health
(9) High-Risk Processes

VA Greater Los Angeles Healthcare System, California

Sioux Falls VA Health Care System, South Dakota

VA Pacific Islands Health Care System, Honolulu, Hawaii

Northern Arizona VA Health Care System, Prescott, Arizona

VA Butler Health Care Center, Pennsylvania

VA Manila Outpatient Clinic, Pasay City, Philippines

Kansas City VA Medical Center, Missouri

Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio

Coatesville VA Medical Center, Pennsylvania

St. Cloud VA Health Care System, Minnesota

VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
Louis Stokes Cleveland VA Medical Center, Ohio

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