



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

JANUARY 2020 HIGHLIGHTS

Congressional Testimony

Deputy Assistant Inspector General for Healthcare Inspections Testifies before the House Veterans' Affairs Committee

Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testified at a January 29, 2020, hearing before the House Committee on Veterans' Affairs on "Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach." Dr. Kroviak's testimony was drawn from nearly two dozen VA Office of Inspector General (OIG) reports, such as *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2018*, *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, and *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida*, and two reports discussing veteran deaths by suicide at the Minneapolis VA Medical Center. In these reports, the OIG found inadequate coordination of care to be an underlying theme in many of the suicides. During questioning, Dr. Kroviak reiterated OIG findings that the root causes for poorly implemented Veterans Health Administration (VHA) policies include staffing shortages, inadequate training, and leadership failures.

Criminal Investigations Involving Health Care

Ex-Employee at The Villages, Florida, VA Outpatient Clinic and Two Relatives Indicted in Conspiracy Scheme

A former transportation assistant at VA's outpatient clinic in The Villages, Florida, along with two of his family members, were arrested after being indicted in the Middle District of Florida for conspiracy, soliciting and receiving kickbacks, and false statements. A VA OIG investigation resulted in charges alleging the former employee created and controlled two companies to whom he steered VA transportation assignments. As a result, VA paid \$305,673 to these companies. This individual also allegedly solicited and received approximately \$76,800 in kickbacks from two other transportation vendors.

Former Memphis, Tennessee, VA Medical Center Police and Security Service Sergeant Sentenced for Conflict of Interest

A defendant who was previously employed as a police and security service sergeant at the Memphis VA Medical Center in Tennessee was sentenced in the Western District of Tennessee to three years' supervised probation and ordered to pay \$118,000 in restitution to VA after pleading guilty to conflict of interest. A VA OIG investigation revealed that the defendant created a shell security company, which she then paid using her government purchase card for purported security services rendered at VA facilities throughout the Memphis area. The payments were laundered through an account with a third-

party processor that was opened by the defendant in the name of the shell company and subsequently deposited into the defendant's personal bank account.

Defendant Sentenced for Assault on a Federal Officer

A nonveteran was sentenced in the Western District of Washington to 20 months' imprisonment and 36 months' supervised release for assault on a federal officer. An investigation by the VA OIG, VA Police Service, and the FBI revealed that the defendant was involved in a hit-and-run collision with VA Police Service officers at the American Lake VA Medical Center in Tacoma, Washington. The collision caused injury to one of the officers.

Former Florissant, Missouri, Community Based Outpatient Clinic Nurse Practitioner Charged with Sodomy and Sexual Abuse

A now former VA nurse practitioner was charged in the Circuit Court of St. Louis County, Missouri, with felony sodomy and misdemeanor sexual abuse. A VA OIG and VA Police Service investigation resulted in charges alleging that the defendant sexually assaulted a veteran at the Florissant, Missouri, Community Based Outpatient Clinic during an acupuncture appointment.

Ex-Pharmacist of Shreveport, Louisiana, VA Medical Center Convicted of Acquiring Controlled Substances by Fraud

A pharmacist formerly employed by the Overton Brooks VA Medical Center was convicted by a federal jury in the Western District of Louisiana of acquiring controlled substances by fraud. A VA OIG investigation resulted in charges alleging the defendant diverted pills from outpatient prescriptions that were being prepared to be mailed to veterans. When performing final verifications, the defendant allegedly diverted between one and five pills before sealing the packages and placing them in the outgoing mail.

North Las Vegas, Nevada, VA Medical Center Intermediate Health Technician Charged in Connection with Hoax That Impaired Facility Operations

A North Las Vegas, Nevada, VA Medical Center intermediate health technician was charged in the District of Nevada with furnishing false information and perpetuating a hoax related to purported biological and chemical weapons. The defendant was subsequently arrested and is being detained pending trial. A VA OIG, Las Vegas Metropolitan Police Department, and VA Police Service investigation resulted in charges alleging the defendant left two envelopes containing an unknown white powder on two coworkers' desks in the facility's podiatry department. This resulted in the quarantine of three VA healthcare providers, a six-hour partial shutdown of the facility, and more than 150 canceled appointments.

Criminal Investigations Involving Benefits

Veteran Sentenced for Compensation Benefits Fraud

A veteran was sentenced in the Eastern District of Missouri to 12 months' and one day imprisonment, three years' probation, and was ordered to pay \$1,036,170 in restitution to VA. An investigation by the VA OIG revealed that the defendant fraudulently led VA to believe he had suffered from blindness since 1969. The defendant filed for, and received, disability compensation benefits at the 100 percent rate beginning in July 1991. The investigation determined that although the defendant was discharged from military service in 1969 for vision issues, he was in possession of a valid driver's license that he had obtained by passing the vision test with 20/40 acuity in both eyes. The investigation also determined the defendant drove on a routine basis and performed other activities that were not consistent with blindness.

Veteran Indicted for Theft of Government Funds

A veteran was arrested after being indicted in the Southern District of Florida for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant lied about his military history to receive VA compensation and healthcare benefits. The loss to VA is \$318,423.

Veteran Sentenced for Theft of Government Funds

A veteran was sentenced in the Eastern District of North Carolina to six months' incarceration and three years' supervised release and was also ordered to pay \$312,807 in restitution after pleading guilty to theft of government funds. A VA OIG investigation revealed that for more than 17 years, the defendant made false statements to VA about his disabilities. As a result of his claimed injuries to his neck, back, shoulders, arms, and hips, the veteran was rated permanently and totally disabled. Surveillance video footage showed the defendant powerlifting several times per week at gyms located on military installations. In addition, the defendant posted powerlifting competition videos of himself on Facebook.

Former VA Fiduciary Pled Guilty to Theft of Government Funds

A former VA-appointed fiduciary pled guilty in the Western District of North Carolina to theft of government funds. A VA OIG investigation revealed that the defendant misused \$103,126 in funds intended for her veteran father for her personal benefit. The defendant used the money while the veteran was hospitalized. The veteran passed away prior to the adjudication of this case.

Criminal Investigations Involving Other Matters

Former Construction Company Executive Sentenced for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme

A former construction company executive was sentenced in the Eastern District of Wisconsin to 78 months' imprisonment and two years' supervised release and was also ordered to forfeit assets worth nearly \$4 million. A multiagency investigation involving the VA OIG, Defense Criminal Investigative

Service, General Services Administration OIG, Small Business Administration OIG, and the FBI revealed the defendant led a 12-year fraud scheme involving over \$260 million in government-funded contracts intended to benefit small businesses, including those owned by service-disabled veterans. The scheme involved the purported operation of three construction companies by “straw” owners who qualified either as a disadvantaged individual or a service-disabled veteran, but who did not actually control the companies. A certified public accountant was also convicted by a jury of conspiracy to commit wire and mail fraud for his role in this scheme.

Three Individuals Charged for Roles in Service-Disabled Veteran-Owned Small Business Fraud Scheme

Three individuals, including one veteran, were charged in the District of Massachusetts with conspiracy to defraud the United States and mail fraud. A VA OIG, Army Criminal Investigation Command, and General Services Administration OIG investigation resulted in charges alleging the defendants defrauded both VA’s and the Department of Defense’s Service-Disabled Veteran-Owned Small Business programs as well as the Small Business Administration’s Historically Underutilized Business Zone program. The defendants allegedly used a veteran-owned small business to apply for and receive set-aside contracts and then passed through most, if not all, of the work to a business not owned by a veteran. The value of these set-aside contracts totaled approximately \$10 million for VA and \$6.4 million for the Department of Defense.

Former Pharmaceutical Executives Sentenced for RICO Act Conspiracy

Eight former pharmaceutical company executives, including the founder and majority owner, chief executive officer, and vice president of sales, were sentenced in the District of Massachusetts for their roles in a Racketeer Influenced and Corrupt Organizations (RICO) Act conspiracy. Each defendant received a custodial sentence with incarceration time ranging from 12 to 66 months. The investigation revealed the pharmaceutical company’s executives led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe their drug, a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. Through the creation of a reimbursement center, the defendants also conspired to mislead and defraud health insurance providers by using a variety of fraudulent reimbursement schemes to obtain payment authorizations from insurers. VA’s Civilian Health and Medical Program (CHAMPVA) paid the company approximately \$3.3 million for this drug. This case was investigated by the VA OIG, Department of Labor (DOL) OIG, U.S. Postal Service OIG, Health and Human Services (HHS) OIG, U.S. Postal Inspection Service, Food and Drug Administration Office of Criminal Investigations, Drug Enforcement Administration, Office of Personnel Management OIG, FBI, and Defense Criminal Investigation Service.

University Agrees to Civil Settlement

A New Jersey university's board of trustees and the U.S. Attorney's Office for the District of New Jersey agreed to a civil settlement whereby the university will pay \$4,883,000, of which \$2,441,500 is restitution to VA. An investigation by the VA OIG, Department of Education OIG, and FBI revealed that between 2011 and 2013, the university conspired with a private business to fraudulently obtain millions of dollars in tuition assistance and other education-related benefits under the Post-9/11 GI Bill. This case previously resulted in the arrest and convictions of a former dean as well as the owner and a senior executive of the private business. The three were ordered to pay \$24,024,465 in restitution.

Political Consulting Business Owner Sentenced in Connection with Fraud Scheme

The owner of a political consulting business was sentenced in the Eastern District of Pennsylvania to 12 months' imprisonment and 36 months' supervised release and ordered to forfeit \$973,807. This investigation revealed that the defendant participated in a conspiracy to unjustly enrich himself and others through a nonprofit organization that contracted with VA to provide substance abuse counseling and housing services for veterans. The defendants allegedly used the nonprofit's funds for political contributions, excessive lobbying, and political advocacy, and paid themselves through a system of kickbacks that disguised the nature and source of the payments. The conspirators allegedly caused the nonprofit to seek out and obtain additional sources of revenue, including federal program funds, through "political outreach" that violated both law and public policy. From 2010 to 2016, the nonprofit had revenues of approximately \$837 million, to include \$1.7 million contributed by VA. This investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation, Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, Medicaid Fraud Control Unit of the Missouri Attorney General's Office, HHS OIG, DOL OIG, and FBI.

Eye Surgeon and Forty-Six Current and Former Eye Center Employees Indicted in Fraud Scheme

An eye surgeon and 46 current and former employees of an eye center were indicted in Yavapai County Superior Court in Arizona on various fraud related charges. An investigation by the VA OIG, Arizona Attorney General's Office Special Investigations Section, Arizona Health Care Cost Containment System, and HHS OIG resulted in charges alleging the employees falsified patients' medical records to induce government agencies and third-party insurers to pay for cataract and other eye surgeries between 2009 and 2018. The indictment alleges that some patients possibly underwent cataract surgeries that were not medically necessary. It is further alleged the eye surgeon did not have the specific equipment necessary to perform the tests billed to VA. The loss to VA is approximately \$1.3 million.

Four Defendants Charged in Compounding Pharmacy Scheme

Four defendants were indicted in the Northern District of Texas on various charges to include conspiracy to solicit and receive illegal kickbacks related to healthcare fraud. An investigation resulted in charges alleging that the defendants received kickbacks from a compounding pharmacy in exchange for referring patient prescriptions that were covered under federal health programs. One of the

defendants allegedly received kickbacks that were disguised as a salary from this compounding pharmacy. It is further alleged that this defendant subsequently disbursed portions of the kickbacks to multiple shell entities that were controlled by the other defendants. The approximate loss to the government is \$7 million and the loss to VA is approximately \$850,000. This investigation was conducted by the VA OIG, FBI, DOL OIG, U.S. Postal Service OIG, Defense Criminal Investigation Service, and HHS OIG.

Health Clinic Owner Indicted in Workers' Compensation Fraud Scheme

The owner of a health clinic was arrested after being indicted in the Middle District of Florida for healthcare fraud and aggravated identity theft. An investigation by the VA OIG, Department of Homeland Security OIG, DOL OIG, and U.S. Postal Service OIG resulted in charges alleging the defendant, a former VA nurse, submitted fraudulent claims to DOL's Office of Workers' Compensation Programs on behalf of VA and other federal agencies. The defendant allegedly used the names and signatures of other physicians to make it appear as if those doctors performed or supervised examinations and treatments when, in fact, they had not. The loss to VA is approximately \$688,000.

Owner of Two Firearms Instruction Schools Agrees to Settle Fraud Allegations

The owner of two firearms instruction schools and the U.S. Attorney's Office for the Eastern District of Louisiana agreed to a civil settlement agreement under which he agreed to pay \$700,000 to VA to settle False Claims Act allegations. A VA OIG investigation revealed that the schools submitted false course enrollments for VA students. In addition, the schools did not notify VA when students failed to attend or dropped a course. The school also failed to reimburse VA for any resulting overpayments.

Defendant Arrested for Defrauding VA's Civilian Health and Medical Program

A defendant in a nationwide healthcare fraud scheme involving the use of durable medical equipment, telemedicine doctors, and telemarketers was arrested after being charged in the District of New Jersey with conspiracy to violate the Anti-Kickback Statute. An investigation by the VA OIG, Internal Revenue Service Criminal Investigation, HHS OIG, and FBI resulted in charges alleging that the defendant was a participant in a scheme which solicited durable medical equipment to patients and used telemedicine doctors to certify medical necessity. The telemedicine doctors did not have a relationship with the patients, and the telemarketers sold the completed orders to the durable medical equipment companies. Many of the target companies identified in the scheme impacted VA through billing disbursements from the CHAMPVA program. The total loss to the government exceeds \$1 billion. Of this amount, VA's loss from this scheme is approximately \$330,000.

Audits and Reviews

Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes

The OIG conducted this audit to determine if VHA efficiently manages positive airway pressure devices and supplies for veterans diagnosed with sleep apnea. The number of veterans who receive devices and supplies increased dramatically in five years, increasing VA's financial risk. VHA did not efficiently manage devices and associated supplies—almost half of the 250,000 veterans issued a device from October 2016 through May 2018 used it less than half the time. VHA could save up to \$39.9 million annually with alternative processes such as loaning devices rather than purchasing them. A loan program could save up to an additional \$12.4 million annually by not purchasing device supplies for veterans who do not use their devices. The OIG made three recommendations to the under secretary for health regarding management of sleep apnea devices including looking at staffing levels, ways to better monitor device use, and alternatives to purchasing devices.

Improvements Are Needed in the Community Care Consult Process at Veterans Integrated Service Network 8 Facilities

The OIG conducted this audit to determine whether facilities in Veterans Integrated Service Network (VISN) 8 were appropriately staffed and structured to manage the community care needs of veterans. The audit team found that during fiscal year 2018, patients experienced delays receiving community care in VISN 8 due to insufficient staffing and the consult-processing structure at community care departments. These departments review, authorize, and schedule requests from a VA facility service for a patient to receive care from a non-VA provider. The OIG made five recommendations to the VISN 8 director to improve the timeliness of community care consults and address staffing deficiencies. The recommendations included implementing a mechanism to identify and routinely exchange wait time data. This exchange would ensure patients understand potential wait times and would help staff monitor the timeliness of each processing stage.

Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Cincinnati Education and Research for Veterans Foundation

The OIG evaluated the merits of a 2018 hotline complaint alleging the executive director of the Cincinnati Education and Research for Veterans Foundation (CERV), a VA-affiliated nonprofit corporation, used the CERV credit card inappropriately for personal expenses. In addition, the OIG broadly examined whether CERV had adequate controls in place for ensuring proper expenditures and whether the CERV board of directors provided adequate oversight of CERV expenditures. The audit team did not substantiate the allegation that the CERV executive director used the CERV credit card inappropriately. However, the team identified some financial controls that were inadequate or absent. In addition, the audit team found that the Cincinnati VA Medical Center did not comply with VA internal

controls to ensure services were performed in accordance with the agreement before approving invoices for payment. The OIG made four recommendations to CERV and the Cincinnati VA Medical Center.

Little Rock VA Regional Office Employee Inaccurately Established and Decided Claims

The OIG substantiated an anonymous allegation that an employee at the VA Regional Office in Little Rock, Arkansas, inaccurately established and decided claims for disability benefits. As a result, the Veterans Benefits Administration made nearly \$311,000 in improper beneficiary payments. The review team did not find the decisions benefited the employee financially. The allegation also noted a potential conflict of interest in the employee's website for his nonprofit organization, but the review team found the site was not used to assist veterans on claims the employee processed. The employee subsequently resigned from his VA position to work in a different field. The OIG recommended the Little Rock VA Regional Office director review and correct the employee's rating decisions. The director should also ensure that the proper authority approves rating decisions that are intended to resolve errors, and that rating veterans service representatives cannot establish claims in VA's electronic system.

Healthcare Inspections

Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington

The OIG conducted a healthcare inspection and found that although seven providers left the facility from early June through mid-July, the losses were due to a combination of internal transfers, planned retirements, and resignations. The OIG found that access to some outpatient care started to decline around May 2019. The facility formed a team to analyze the potential of closing the intensive care unit due to low utilization. The facility used one of its two operating rooms and temporarily reduced its procedures and services to decrease the volume of items requiring sterile processing. The chief of dental service was detailed to the acting chief of radiology position based on previous leadership experience and qualifications. The OIG made two recommendations related to access to care and continued corrective actions identified during a visit from the National Program Office for Sterile Processing for the Sterile Processing Service.

Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota

A healthcare inspection was conducted to review the care of an inpatient who died by suicide. emergency department staff failed to report the patient's suicidal ideation to the suicide prevention coordinator. Three other staff members failed to involve clinicians when the patient verbalized suicidal thoughts. The facility's root cause analysis team did not interview relevant clinical staff. While the team identified lessons learned, VHA does not provide formal guidance on distinguishing lessons learned from root causes. An institutional disclosure to the patient's next of kin was not conducted. Patient Safety Committee and Quality Management Council meeting minutes lacked required documentation. A recommendation was made to the under secretary for health related to lessons learned. Six

recommendations were made to the facility director related to suicide prevention coordinator notification, a review of the patient's care, consult results, institutional disclosure, the root cause analysis process, and documentation of meeting minutes.

A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York

A healthcare inspection team assessed allegations of delays in providing patient test results, communication issues between providers and paramedics related to transporting patients to a community hospital emergency department, violations of the Emergency Medical Treatment and Labor Act, and quality of care concerns resulting from paramedic care at the facility. The OIG substantiated a surrogate provider failed to follow test notification policies; however, the delay did not result in an adverse event. The OIG substantiated a paramedic failed to comply with the facility's standard operating procedure by transporting a patient to a different hospital than instructed by the provider. The OIG noted that the facility's policy for paramedic transfers was unclear. The OIG did not substantiate that the paramedics violated the intent of the law or provided poor quality of care.

Alleged Deficiencies in a Hospitalist's Interactions with a Patient at the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas

The OIG evaluated allegations regarding a hospitalist's interactions with a patient and family when obtaining consent for do-not-resuscitate (DNR) status and determining discharge plans at the facility. The OIG was unable to determine whether the hospitalist demonstrated inappropriate and unprofessional behavior with the patient and family. The hospitalist followed policy when determining the patient's decision-making capacity and obtaining consent for a DNR status. The facility coordinated the patient's discharge and addressed medication and nutrition needs and aspiration precautions. After discharge, the family requested, and the patient received, home hospice services and a nasogastric tube. The OIG evaluated three additional cases involving the hospitalist's determination of patients' DNR status and noted that the hospitalist's interactions lacked evidence of discussions of patients' preferences and quality of life. The facility had processes to provide oversight of physician behavior. The OIG made no recommendations.

Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System

The OIG conducted a healthcare inspection to evaluate concerns related to deficiencies in the Women Veterans Health Program, quality management in patient safety and resuscitation attempts, and leaders' responses to recommendations from oversight bodies at the facility. The facility had an insufficient number of women's health primary care providers available to provide gender specific comprehensive primary care for women veterans. Resources needed to support comprehensive women veterans' healthcare were insufficient. Community Care results were not consistently tracked. The facility's quality management performance measurement and evaluation processes did not ensure awareness of quality of care concerns to inform facility leaders' of required institutional disclosures and adverse event

decision-making. The resuscitation committee did not capture and review all resuscitation attempts, nor take corrective actions to identify the causes surrounding these events. The OIG made 18 recommendations related to staffing, appointment times, current and future resources, community care, and quality management processes.

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:

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| (1) Leadership and Organizational Risks | (6) Mental Health Care |
| (2) Quality, Safety, and Value | (7) Geriatric Care |
| (3) Credentialing and Privileging | (8) Women's Health |
| (4) Environment of Care | (9) High-Risk Processes |
| (5) Medication Management | |

Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington

Veterans Integrated Service Network 4: VA Healthcare, Pittsburgh, Pennsylvania

VA Western New York Healthcare System, Buffalo, New York

Canandaigua VA Medical Center, New York

VA Maryland Health Care System, Baltimore, Maryland

Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts

VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts

Richard L. Roudebush VA Medical Center, Indianapolis, Indiana

Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network, Arlington, Texas

West Texas VA Health Care System, Big Spring, Texas

Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana

Alaska VA Healthcare System, Anchorage, Alaska

Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts

To listen to the podcast on the OIG's January 2020 activity highlights, go to www.va.gov/oig/podcasts.