FEBRUARY 2020 HIGHLIGHTS

Congressional Testimony

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

Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testified at a February 5, 2020, hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations and Women Veterans Task Force. The hearing examined how VA supports survivors of military sexual trauma (MST). Dr. Kroviak's testimony discussed the results of the Office of Inspector General's (OIG) fiscal year 2019 Comprehensive Healthcare Inspection Program, which in part evaluated VA medical facilities' compliance with selected Veterans Health Administration (VHA) requirements related to MST. These included processes carried out by MST coordinators, the provision of care to patients after positive screening, and mandatory staff training. Dr. Kroviak discussed that, while VHA had high compliance with several of the selected requirements, the OIG noted opportunities for improvement such as ensuring MST coordinators communicate issues concerning MST services and initiatives with local leaders, making facility staff aware of MST issues, and ensuring that new staff receive required training. Dr. Kroviak also provided updated information on the status of recommendations contained in the Office of Audits and Evaluations' 2018 report "Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma."

Criminal Investigations Involving Health Care

Former VA Prosthetics Vendor Ordered to Pay Restitution to VA

A former VA prosthetics vendor was ordered to pay restitution of almost $480,000 to VA. The vendor was previously sentenced in the Eastern District of California to 60 months' imprisonment and 36 months' supervised release after being convicted by a federal jury of healthcare fraud and conspiracy to commit healthcare fraud. An investigation by the VA OIG, Homeland Security Investigations, and VA Police Service resulted in charges that between March 2008 and February 2015, the vendor and the former chief of podiatry for the Sacramento, California, VA Medical Center engaged in a scheme to defraud VA by billing for custom prescription footwear containing carbon graphite plates but instead providing veterans with inferior footwear containing preinstalled components. It is alleged the vendor, the chief, and a former employee of the vendor who separately pleaded guilty in December 2016 agreed to make materially false statements to VA regarding the manufacturing location of their shoes while applying for a national VA contract worth over $11 million per year.

Former Miami, Florida, VA Medical Center Employee and Two Vendors Plead Guilty in Connection with Bribery Scheme

A now former VA employee pleaded guilty to bribery and two vendors pleaded guilty to conspiracy to commit healthcare fraud in the Southern District of Florida. A VA OIG investigation that was initiated based on a hotline complaint resulted in charges that the defendants and 12 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the West Palm Beach and Miami VA medical centers. The investigation revealed that 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, and 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 to be designated as a service-disabled veteran-owned small business, which resulted in further business transactions with VA.

Defendant Sentenced for Fraud Scheme Related to VA's Supportive Services for Veteran Families Program

An individual who operated a nonprofit that received funds under VA's Supportive Services for Veteran Families program was sentenced in the Kings County Supreme Court of New York to 10 to 21.5 years' imprisonment. The nonprofit received supportive services funds for the purpose of placing veterans experiencing homelessness into housing. An investigation by the VA OIG and New York State Attorney General's Office resulted in charges alleging the defendant received the funds but failed to use them to cover rent payments for veterans. Instead, the defendant used the funds for his personal gain. As a result, several veterans were evicted and had to obtain alternative housing. The defendant was previously convicted in this case of grand larceny and committing a scheme to defraud. The loss to VA is approximately $80,000.

VA Boston Healthcare System Inventory Management Specialist Charged with Embezzlement

A now former VA employee was arrested after being charged in the District of Massachusetts with embezzling nearly $70,000 from the Brockton Campus of the VA Boston Healthcare System. A VA OIG investigation resulted in charges alleging that from 2016 to 2019 the defendant used his VA-issued purchase card to make numerous fraudulent transactions to a company he created using a mobile payment company for items VA never received. The defendant then routed the proceeds to his personal bank account. To conceal the embezzlement, the defendant made the purchases appear as if they were from a large plumbing supply company frequently used by the Brockton Campus for legitimate business. It is further alleged the defendant attempted to hide his actions by falsely annotating within the VA's accountability system that the items were received.

Veteran Sentenced for Making Threats Against VA Employees

A veteran was sentenced in the Northern District of California to 28 months' imprisonment. An investigation by the VA OIG, FBI, and VA Police Service revealed the defendant threatened to kill five employees at the VA medical centers in Palo Alto and San Francisco, California. The defendant was already serving a 92-month sentence in California State Prison for threatening to harm US Congresswomen Jackie Speier and her staff. During the transfer from state to federal custody for legal proceedings, the defendant physically assaulted and threatened to kill a VA OIG agent. The defendant will serve his federal sentence and then be remanded back to the custody of the California Department of Corrections and Rehabilitation to serve the remainder of his state sentence.

Criminal Investigations Involving Benefits

Five Individuals Charged with Bank Fraud and Money Laundering Conspiracy

Two former bank employees and three coconspirators were arrested after being charged in the Eastern District of New York with bank fraud conspiracy and money laundering conspiracy. An investigation by the VA OIG, Social Security Administration (SSA) OIG, US Postal Inspection Service, Internal Revenue Service Criminal Investigation, Manhattan District Attorney's Office, New York City Police Department, and Homeland Security Investigations resulted in charges alleging the defendants embezzled funds from deceased or elderly account holders at a major financial institution. Many of the affected account holders were SSA and VA beneficiaries. With the assistance of an accountant, the bank employees allegedly laundered the stolen funds to relatives, associates, or shell companies owned by relatives and associates. The subjects allegedly misappropriated more than $7.6 million from the bank account holders. The total loss to VA is still being calculated.

VA Fiduciary Pleads Guilty to Mail Fraud

A VA fiduciary pleaded guilty in the District of Nevada to mail fraud. A VA OIG and FBI investigation revealed that, while claiming to offer home healthcare and fiduciary services to veterans and surviving spouses, the defendant submitted fraudulent applications for pension, survivor's pension, and aid and attendance benefits to VA on behalf of 35 elderly veterans. The defendant then had the benefits paid to bank accounts that she controlled without the knowledge or consent of the victims. The defendant also altered medical records to ensure that the victims' physical and mental conditions rendered them eligible for the benefits. The total loss to VA is about $1.8 million.

Veteran Indicted for Compensation Benefits Fraud Scheme

A veteran was arrested after being indicted in the Western District of Texas for theft of government funds, healthcare fraud, social security disability fraud, false claims to VA, and false statements related to a healthcare matter. A VA OIG and SSA OIG investigation resulted in charges alleging that the defendant misled VA and SSA about his ability to walk. As a result, the defendant received 100 percent service-connected disability benefits for the loss of the use of both feet since October 2010 and Social

Security Disability Insurance benefits since 2008. The total loss to the government is approximately $594,000 and the loss to VA is roughly $434,000.

Veteran Indicted for Theft of Government Funds and False Statements

A veteran was arrested after being indicted in the Middle District of Florida for theft of government funds and false statements. A VA OIG investigation resulted in charges alleging that the defendant fraudulently led VA to believe he was blind. As a result, the veteran had been receiving 100 percent service-connected disability benefits since June 2011. It is alleged that the defendant possessed a valid driver's license with a motorcycle endorsement and drove on a routine basis. The loss to VA is over $390,000.

Former VA Fiduciary Sentenced for Misappropriation Scheme

A former VA fiduciary was sentenced in the Northern District of California to three years' probation and ordered to pay over $84,000 in restitution to VA and a fine of $3,000. A VA OIG investigation revealed that the defendant misappropriated the funds of eight severely disabled VA beneficiaries to pay for his personal living expenses.

Former Contract Physician Sentenced for Sexual Assault

A physician previously under contract with VA was sentenced in San Diego County, California, to 36 months' imprisonment (all of which were suspended) and 36 months' probation after pleading guilty to the sexual assault of five female patients who were referred to him by VA. Additionally, the defendant was ordered to surrender his medical license and register as a sex offender. A VA OIG and Medical Board of California investigation revealed the defendant engaged in inappropriate acts while conducting compensation and pension examinations. In support of this investigation, a VA physician determined through an independent review that the defendant conducted examinations that exceeded standard practices, to include unnecessary pelvic examinations.

Criminal Investigations Involving Other Matters

Three Individuals Plead Guilty in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

Three individuals, including one veteran, pleaded guilty in the District of Massachusetts to conspiracy to defraud the United States and mail fraud. In addition, each defendant agreed to forfeit $300,000. An investigation by the VA OIG, General Services Administration OIG, and Army Criminal Investigation Command revealed that the defendants defrauded VA's and the Department of Defense's set-aside programs for service-disabled veteran-owned small businesses and Historically Underutilized Business Zone-certified businesses. The defendants allegedly used a veteran-owned small business to apply for and receive set-aside contracts through which a nonveteran-owned business completed most, if not all, of the work. The value of these set-aside contracts totaled approximately $10 million for VA and $6.4 million for the Department of Defense.

Two Defendants Charged in Compounding Pharmacy Scheme

Two defendants were charged in the Northern District of Texas with conspiracy to solicit and receive illegal kickbacks related to healthcare fraud. An investigation by the VA OIG, Department of Labor OIG, US Postal Service OIG, Defense Criminal Investigative Service, Department of Health and Human Services OIG, and FBI resulted in charges alleging the defendants received kickbacks disguised as salary from a compounding pharmacy. The kickbacks were then disbursed to other coconspirators through shell companies that were controlled by the defendants. The approximate loss to the government is $7 million and the loss to VA is approximately $850,000.

Individual Sentenced in Kickback Scheme

The president of a government subcontracting company was sentenced in the District of the Virgin Islands to 18 months' incarceration as well as three years' supervised release and ordered to pay restitution of $218,000 and a fine of $4,000. This defendant previously pleaded guilty to paying over $200,000 in kickbacks to a senior project manager whose company was awarded a large General Services Administration 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 canceled prior to award by VA due to findings from this investigation. This investigation was conducted by VA OIG, Naval Criminal Investigative Service, Department of Agriculture OIG, Coast Guard Investigative Service, and General Services Administration OIG.

Audits and Reviews

Veterans Received Inaccurate Disability Benefit Payments After Reserve or National Guard Drill Pay Adjustments

The OIG examined whether disability benefit adjustments were calculated accurately for veterans who served in the Reserve or National Guard. These veterans may be eligible for military training pay, or "drill pay." However, they are not entitled to receive drill pay and disability benefits in the same fiscal year. The Veterans Benefits Administration (VBA) asks the veteran to choose between drill pay and disability benefits and adjusts payment accordingly. Furthermore, VBA must adjust the payment for any days the veteran was on active duty and ineligible for disability benefits. The review team found that VBA inaccurately processed about 11 percent of adjustments in fiscal year 2016, resulting in an estimated $14.2 million in overpayments and underpayments to veterans. The OIG made four recommendations to VBA to review fiscal year 2016 adjustments and take corrective action as needed, as well as provide training for staff who process drill pay adjustments.

Telehealth Public-Use Questionnaires Were Used Improperly to Determine Disability Benefits

The OIG conducted this review to investigate whether evidence supporting veterans' claims for disability benefits was being submitted on public-use questionnaires without care providers seeing the veterans in person. VBA prohibits the use of telehealth for benefit rating purposes. The OIG found

claims processors improperly used benefits questionnaires to make determinations without ensuring an in-person examination was conducted. For example, VBA made improper determinations in 41 of 81 claims the OIG reviewed, amounting to about $613,000 in benefit payments. VBA did not provide consistent staff guidance, adequately monitor use of telehealth questionnaires, or modify forms to reflect prohibited uses. VBA's internal controls were inadequate to prevent the inherent potential for fraud when relying on publicly available questionnaires, despite VBA's risk-mitigation efforts. The OIG recommended the under secretary for benefits consider whether to discontinue using publicly available questionnaires or, if used, to improve fraud safeguards and notices of prohibited uses.

Review of Regional Procurement Office East's Contract Closeout Compliance

The OIG reviewed whether Regional Procurement Office East followed Federal Acquisition Regulation and VHA requirements when closing out contracts. Noncompliance increases financial and legal risks, and resulting excess funds may not be effectively directed for other uses that benefit veterans. The review team examined a random sample of 40 closed contracts worth $500,000 or more from fiscal year 2018 to determine whether closeout procedures were followed. The team also reviewed an open obligations report to identify contracts with remaining excess funds. The OIG found contracting officers did not consistently close out contracts on time and did not fully document requirements. The review team also identified about $6.8 million in unreleased excess funds. The OIG recommended the VHA procurement executive director establish quality assurance reviews for contracts to ensure closeout requirements are met and ensure all contracting officers are retrained on procedures.

Healthcare Inspections

Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction

A facility urologist performed extracorporeal shock wave lithotripsy (ESWL) on a patient who died 25 days later. However, the patient did not have significant risk factors and was a suitable candidate for ESWL. A non-urologist provider failed to address an abnormal blood smear result. The associate chief of staff for Acute Care Services was associated with the same private practice as urologists hired by the facility; however, the associate chief of staff did not sign the request to recruit the urologists. The OIG was unable to determine if an increase in ESWL procedures was due to the urologists' ownership interest in a company associated with ESWL rental equipment. The Office of General Counsel found "no actual conflict of interest," however, facts given to the General Counsel may have contained inaccurate statements. The OIG made two recommendations related to abnormal blood tests and conflicts of interest.

Review of Veterans Health Administration Community Living Centers and Corresponding Star Ratings

In response to a congressional request, the OIG examined the Community Living Center (CLC) rating system (Compare), the rating system's limitations, and what information from the system can reasonably

be used to understand the long-term care delivered at CLCs. The OIG found star ratings provided only a limited look at care delivered in CLCs. Despite the limitations associated with using CLC Compare, problematic evaluations still raise concerns about quality of care. It is incumbent on VA to determine whether such evaluations reflect shortcomings in the rating system or the care delivered. Three recommendations were made to the under secretary for health related to supplementing CLC Compare with adjustment measures to address CLC and Center for Medicare and Medicaid Services comparison challenges, developing measures with more rigorous risk adjustment for CLC staffing and quality performance, and creating a resource that provides an understandable narrative for all.

Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio

An inspection was initiated regarding a patient who died after transfer from the facility's CLC to the emergency department. Deficiencies were identified in an emergency department physician's medical decision-making, provision of care, and handoff communication. Also, an emergency department registered nurse failed to adequately monitor the patient. Deficits in the physician's practices were not limited to this case and the physician's privileges were revoked. However, while the VA Disciplinary Appeals Board overturned the physician's removal, the physician then resigned. The OIG did not substantiate that the registered nurse under review was involved in additional patient deaths or that emergency department staffing was inadequate. Thirteen recommendations were made that addressed the above and other findings including provider and peer review training, transitions of care policies, standing orders, critically ill patient care, Peer Review Committee documentation, leaders' responses to care concerns, supplies, bar code medication administration compliance, and document management procedures.

Alleged Issues in the Cardiology Department at the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana

A healthcare inspection was conducted at the facility to evaluate allegations concerning delays in interpreting and reporting patient cardiology tests and scheduling patients for cardiology procedures, deficiencies in pacemaker data recordkeeping, and supervisory concerns in the Device Clinic. The OIG did not substantiate that electrocardiogram or cardiac event tracings reports were not interpreted timely, that patients requiring cardiac surgery procedures were not scheduled for over a year, or that there was improper supervision of the Device Clinic. The facility's cardiologist turnover rate was high, and Cardiology and Surgery Services staff did not use the VHA's consult process and maintained an unauthorized wait list for a procedure. The OIG did not find evidence of adverse clinical outcomes related to these issues. The OIG made four recommendations related to cardiologist turnover, staff understanding of authorized and unauthorized patient wait lists, and the training of staff on consult process and wait list policies.

Special Review

Alleged Improper Locality Pay for Teleworking Employee

The OIG investigated an allegation that an employee was approved to change duty stations from Pittsburgh to Altoona, Pennsylvania, but continued to improperly receive the higher locality pay for the Pittsburgh area. The OIG substantiated that the employee's telework agreement did not comply with applicable regulations requiring employees to report to the official worksite twice per pay period when the employee is not in a permanent telework arrangement. Although temporary exceptions can be granted, there is no discretion to grant a permanent exception. The OIG determined that the employee and the employee's supervisors took appropriate corrective action once the issue became known, prior to OIG's investigation. The OIG did not identify any evidence to suggest that maintaining higher locality pay was intentional. Accordingly, the OIG did not substantiate misconduct. The OIG made one recommendation to clarify the authority and obligations of telework-approving supervisors within the Office of General Counsel.

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