APRIL 2020 HIGHLIGHTS

Criminal Investigations Involving Health Care

Defendant Arrested in Connection with an Alleged Multimillion Dollar COVID-19 Scam

A defendant was arrested after being charged in the District of Columbia with wire fraud in connection with an alleged COVID-19 scam. An investigation by the VA Office of Inspector General (OIG) and Homeland Security Investigations (HSI) resulted in charges alleging the defendant made a series of fraudulent misrepresentations in an attempt to secure orders from VA for 125 million face masks and other personal protective equipment (PPE) that would have totaled over $750 million. The defendant allegedly promised that he could obtain millions of genuine 3M masks from domestic factories when he knew that fulfilling the orders would not be possible. The defendant also allegedly made similar false representations in an effort to enter into other fraudulent agreements to sell PPE to state governments.

Former Beckley, West Virginia, VA Medical Center Doctor Charged with Civil Rights Offense

A former Beckley, West Virginia, VA medical center doctor specializing in Osteopathic Manipulation Therapy was arrested after being charged in the Southern District of West Virginia with deprivation of rights under the color of law (civil rights). The investigation by the VA OIG, Federal Bureau of Investigation (FBI), and VA Police Service resulted in charges alleging the defendant sexually molested a patient during an examination at the facility.

Former Miami, Florida, VA Medical Center Employee Sentenced in Connection with Bribery Scheme

A former Miami, Florida, VA medical center employee was sentenced in the Southern District of Florida to nine months' imprisonment and three months' supervised release and was also ordered to pay restitution of $120,505. Another employee of the medical center also pleaded guilty to bribery. The VA OIG investigation based on a hotline complaint resulted in charges that these defendants and 14 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 charges allege that VA employees placed supply orders in exchange for cash bribes and kickbacks. In many instances, the prices of supplies were grossly inflated, or 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.

Former Brockton, Massachusetts, VA Medical Center Inventory Management Specialist Pleads Guilty to Embezzlement Scheme

A former Brockton, Massachusetts, VA Medical Center inventory management specialist pleaded guilty after being charged in the District of Massachusetts with embezzling nearly $70,000 in VA funds. A VA OIG investigation revealed that from 2016 to 2019, the defendant used his VA-issued purchase card to

conduct numerous fraudulent transactions for items that were never actually received by VA. The defendant then routed the proceeds of these fraudulent transactions 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 medical center for legitimate business. However, the purchases were made through a company that the defendant created using a mobile payment company. The defendant then attempted to hide his actions by falsely annotating within the VA's accountability system that the items were received.

Criminal Investigations Involving Benefits

Two Defendants Arrested in Connection with Fraud Scheme

A former VA-appointed professional fiduciary, who was part owner of a nonprofit organization, and a former nonprofit employee were arrested pursuant to bench warrants after both defendants failed to appear for sentencing in the District of New Mexico. The defendants previously pleaded guilty to conspiracy, mail fraud, aggravated identity theft, money laundering, and conspiracy to commit money laundering. The investigation by the VA OIG, Social Security Administration (SSA) OIG, Internal Revenue Service Criminal Investigation, and FBI was initiated based on a hotline complaint and revealed that the defendants engaged in a sophisticated scheme along with two other defendants to use their nonprofit organization to defraud victims of their VA and SSA beneficiary funds. The defendants unlawfully transferred money from their clients' accounts to their own business accounts and then used the comingled funds to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately $3.3 million.

Defendant Sentenced in Connection with Scheme to Steal Monthly VA Benefit Payments

A Jamaican national was sentenced in the Eastern District of New York to 11 months' imprisonment (time served), one year of supervised release, and restitution of $48,139 (of which $45,855 will be paid to VA). The defendant was subsequently released into the custody of the US Immigration and Customs Enforcement for deportation proceedings. The investigation by the VA OIG, Department of the Treasury OIG, and HSI resulted in charges alleging that suspects in Jamaica stole VA and SSA benefit payments by unlawfully redirecting debit cards containing the payments to another defendant in the United States. The US-based individual subsequently withdrew the funds, kept a portion for herself, and transferred the remainder back to the other coconspirators in Jamaica. The investigation also revealed the defendant was allegedly involved in lottery scams that targeted elderly, vulnerable victims. This New York-based investigation has resulted in eight arrests to date and began as a proactive, nationwide effort to combat the growing problem of veterans' benefits being unlawfully redirected to other individuals.

Criminal Investigations Involving Other Matters

Residential Mortgage Company Agrees to Pay $15 Million to Civil Allegations

A residential mortgage company entered into a civil agreement with the US Attorney's Office for the Northern District of New York and the Department of Justice Civil Division's Commercial Litigation Branch, under which the company agreed to pay more than $15 million to resolve allegations that it violated the False Claims Act and the Financial Institutions Reform, Recovery, and Enforcement Act of 1989. The investigation by the VA OIG and Department of Housing and Urban Development (HUD) OIG resolved allegations that the company knowingly originated and underwrote mortgage loans insured by the Federal Housing Administration, HUD, and VA that did not meet critical program requirements. In particular, it was alleged that the company knowingly failed to comply with material program rules that require lenders to maintain quality control programs to prevent and correct underwriting deficiencies, self-report any materially deficient loans, and ensure that the underwriting process is free from conflicts of interest. The amount attributed to VA loans is $698,787 in damages and penalties, of which $420,956 will be returned to VA and the remainder to the Department of the Treasury.

Biopharmaceutical Manufacturer Agrees to Pay $6.5 Million to Resolve False Claims Act Allegations

A biopharmaceutical manufacturer entered into a civil agreement with the US Attorney's Office for the District of Minnesota and the Department of Justice Civil Division's Commercial Litigation Branch, under which the company agreed to pay $6.5 million to resolve allegations that it violated the False Claims Act by knowingly submitting false commercial pricing disclosures to VA. A VA OIG investigation resolved allegations that, since at least 2013, the company defrauded the government in the sale of human tissue grafts through the VA Multiple Award Schedule. In particular, it was alleged that the company submitted false statements and disclosures to VA regarding their commercial pricing practices, which enabled the company to charge inflated prices to VA for their human tissue graft products.

Audits and Reviews

Independent Review of VA's Special Disabilities Capacity Reports for Fiscal Years 2017 and 2018

The OIG conducted an independent review of VA's reports on special disabilities capacity for fiscal years 2017 and 2018. These annual reports document VA's capacity to meet the specialized treatment and rehabilitative needs of disabled veterans. VA is required to submit the reports to Congress, and the OIG is required to report to Congress on report accuracy. The OIG found nothing that caused it to believe the capacity reports were not fairly stated and accurate in all material respects, with exceptions noted in the OIG report. The OIG believes VA can no longer meet the requirement to compare current

capacity to 1996 levels because of changes in areas such as diagnoses and information technology. However, the OIG also believes Congress can better assess VA's capacity by requiring reports annually or more frequently, and by considering the extent to which VA can meet disabled veterans' needs for health care and services.

Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System

This audit examined whether VA's infrastructure-readiness efforts were on schedule for the initial deployment of its new electronic health records (EHR) system at the Mann-Grandstaff VA Medical Center in Spokane, Washington. The OIG found that critical physical and information technology infrastructure upgrades had not been completed at the site, jeopardizing the initially planned deployment on March 28, 2020. VA subsequently postponed going live. The lack of important upgrades jeopardizes proper deployment of the new system and increases risks of overall implementation delays. VA originally committed to a deployment date without needed information on the state of the medical center's infrastructure. Also found were security vulnerabilities in the physical infrastructure at Mann-Grandstaff that created a risk of damage from unauthorized access. The OIG made eight recommendations, including reassessing the deployment schedule to ensure projected milestones are realistic and securing the electronic health records infrastructure.

Healthcare Inspections

Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington

This review examined the first facility to transition to VA's new EHR to determine how the new EHR's capabilities could affect patients' access to care. Facility leaders lacked written guidance on handling an anticipated 30 percent drop in productivity that could affect patients' access to care. Although primary care access was addressed, understaffing (48.5 of 108 staff needed for EHR support) and a backlog of 21,155 community care referrals remained in January 2020. Staff needed to enact 84 mitigations for 62 moderate or high-risk systems to address gaps at the go-live date. Workarounds for VA's removal of an online prescription refill process and going live with fewer capabilities present risks to patient safety. The OIG made four recommendations regarding productivity and capabilities to VA leaders, with two recommendations on facility support and two recommendations to the facility's director related to community care referrals and timely medication refills.

Manipulation of Radiology Reports and Leadership Failures in the Medical Imaging Service at the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin

This inspection reviewed a radiologist's alleged errors with treatment delays and misleading addenda placement, leaders' tolerance of this practice, and leaders' response to an OIG query. The radiology manager manipulated an EHR by deleting a radiologist's interpretation. Facility leaders failed to manage

ongoing interpersonal conflicts within the radiology service. The OIG did not substantiate the radiologist added addenda to cover errors causing treatment delays that contributed to patients' adverse clinical outcomes. However, the OIG determined leaders failed to conduct a thorough, impartial oversight review. The OIG made eight recommendations, including two under secretary for health recommendations regarding new EHR addenda formatting and the manager's imaging report deletion; two veterans integrated service network director recommendations regarding image archiving and communication system practices as well as OIG Hotline case referral oversight; and four facility director recommendations regarding an erroneous imaging study correction, radiology service oversight and management, radiology service's workplace culture, and workplace intimidation training and employees' reporting process.

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