



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## AUGUST 2020 HIGHLIGHTS

### Cash Rewards Program Payment

#### **Reward for Report of Service-Disabled Veteran-Owned Small Business Fraud**

VA's Office of Inspector General (OIG) presented a reward to a confidential complainant who submitted two separate allegations, which involved fraud against VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) program. VA OIG subsequently conducted investigations revealing that, in both instances, the two unrelated construction companies falsely represented that they were owned and controlled by service-disabled veterans. As a result of these false representations, the two construction companies obtained over \$65 million in set-aside contracts from VA. The two construction companies and their principal owners entered into separate civil agreements under which they agreed to pay a total of almost \$2.6 million to the federal government.

### Criminal Investigations Involving Health Care

#### **Defendant Indicted in Connection with Compounding Pharmacy Scheme**

A defendant was indicted in the Northern District of Texas on charges of soliciting and receiving healthcare kickbacks and conspiracy to pay and receive healthcare kickbacks. A multiagency investigation resulted in charges alleging the defendant received over \$60 million in kickbacks from a compounding pharmacy for fraudulent prescriptions written by doctors that he recruited. The compounding pharmacy, and their subsidiaries, billed private and government healthcare insurance programs an estimated \$700 million. In total, VA's Civilian Health and Medical Program and its Office of Workers' Compensation Program were billed more than \$16.8 million. Of this amount, VA paid over \$1.9 million. This investigation was conducted by the VA OIG, Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service (DCIS), U.S. Postal Service Inspection Service, Department of Health and Human Services OIG, Office of Personnel Management OIG, Food and Drug Administration Office of Criminal Investigations, Internal Revenue Service Criminal Investigation, and Drug Enforcement Administration.

#### **Defendant Sentenced in Connection with Bribery Scheme**

A former employee of the Bruce W. Carter VA Medical Center in Miami, Florida, was sentenced in the Southern District of Florida to 36 months' incarceration, three years' supervised release, and restitution of \$592,717. Additionally, a former employee of the West Palm Beach VA Medical Center, also in Florida, also pleaded guilty in the Southern District of Florida to conspiracy to commit healthcare fraud. A VA OIG investigation that was based on a hotline complaint resulted in charges alleging that 16 defendants engaged in a bribery and kickback scheme involving multiple vendors and employees of the two VA medical centers. The charges allege that VA employees placed orders for supplies in exchange for cash bribes and kickbacks from the vendors. 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.

### **VA Puget Sound Healthcare System Employee Indicted for Theft of Government Property**

A suspended employee of the VA Puget Sound Healthcare System in Seattle, Washington, was indicted in the Western District of Washington for theft of government property. A VA OIG investigation resulted in charges alleging that the defendant stole several pieces of medical equipment, including ventilators and bronchoscopes, and then sold the items on eBay. The approximate value of the stolen items is \$181,000.

### **Former Clarksburg, West Virginia, VA Medical Center Registered Nurse Pleads Guilty to Drug Diversion**

A former registered nurse at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, pleaded guilty in the Northern District of West Virginia to acquiring controlled substances by misrepresentation, fraud, deception, and subterfuge. A VA OIG and FBI investigation revealed that over a two-month period, the defendant diverted hydromorphone from the facility's Pyxis automated medication management machines for her own personal use on 110 occasions.

## Criminal Investigations Involving Benefits

### **Veteran Sentenced in Connection with Fraud Scheme**

A veteran was sentenced in the District of South Carolina to 15 months' incarceration, three years' supervised release, and restitution of \$1,043,150 after previously pleading guilty to conspiracy to commit theft of government funds. A VA OIG proactive investigation revealed that for more than 20 years, the defendant fraudulently received approximately \$9,000 per month from VA for the loss of use of his limbs and hearing problems with associated vertigo. This investigation determined that the defendant was able to ambulate without difficulty and did not require the assistance that he claimed to VA was necessary.

### **Former Buffalo, New York, VA Regional Office Employee Pleads Guilty to Threatening Fellow Employee**

A former employee of the Buffalo VA Regional Office in New York pleaded guilty in the Western District of New York to intentionally opposing, impeding, intimidating, and interfering with a VA employee. A VA OIG investigation revealed that over a 13-month period, the defendant left several voicemails for a coworker at the regional office in which he threatened to rape and/or kill the employee's family members and to kill the employee.

## Criminal Investigations Involving Other Matters

### **Certified Public Accountant Sentenced for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme**

A certified public accountant was sentenced in the Eastern District of Wisconsin to three months' imprisonment; three years' supervised release; 100 hours of community service to a SDVOSB, minority-owned business, or a disadvantaged business enterprise; and a fine of \$7,500. The defendant was previously found guilty of conspiracy to commit wire and mail fraud following a jury trial. A multiagency investigation resulted in charges alleging the defendant provided accounting services to the leader of a 12-year fraud scheme, which involved over \$260 million in government-funded contracts intended to benefit small businesses including SDVOSBs. The alleged 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. The defendant allegedly advised the scheme's participants to hide their common ownership and affiliations, wrote letters attesting to their independence that were later submitted to the controlling government agencies, and lied to federal investigators when interviewed. This case was investigated by the VA OIG, General Services Administration OIG, Small Business Administration OIG, DCIS, and FBI.

### **Cemetery Co-Owner Sentenced for Conspiracy to Commit Mail Fraud**

A co-owner of a cemetery was sentenced in the Middle District of Pennsylvania to 12 months' and one day of imprisonment (to run concurrently with a previously imposed state sentence), two years' supervised release, and joint restitution of approximately \$495,000 after previously pleading guilty to conspiracy to commit mail fraud. A VA OIG, Northern York County Regional Police Department, and FBI investigation revealed the defendant and a codefendant defrauded at least 223 customers out of approximately \$495,000. Instead of applying customers' monies to prepaid cemetery services and products, the defendants embezzled the money for their own personal gain. VA's National Cemetery Administration provided grave markers for veterans buried at the cemetery, many of which were never found, and the burial sites of several veterans could not be confirmed. The codefendant was previously sentenced to 13 months' imprisonment, two years' supervised release, and joint restitution of approximately \$495,000.

## Administrative Investigation

### **Alleged Conflict of Interest by a VA Medical Center Chief of Staff**

The OIG investigated allegations that the chief of staff at a VA medical center engaged in a conflict of interest by performing work for a private company that provides education services and misused his official position by recruiting VA physicians to work for that same company in 2017 and 2018. The OIG did not substantiate either alleged violation. The OIG did, however, identify a related misuse of government resources. The OIG identified email threads exchanged between the chief of staff and the

VA physicians in support of the outside business activities associated with the education company. When presented with these emails, the chief of staff apologized and expressed surprise. The two VA physicians indicated they believed (incorrectly) that the use of VA resources to conduct activities related to the company was permissible if it was done outside working hours. The OIG made no recommendations.

## Audits and Reviews

### **Accuracy of Disability Benefit Evaluations for Veterans' Service-Connected Heart Diseases**

The OIG examined whether Veterans Benefits Administration (VBA) decision makers accurately completed disability evaluations for veterans' service-connected heart disease. The OIG estimated that decision makers incorrectly evaluated about 12 percent of claims for heart disease between November 1, 2018, and April 30, 2019. Of those, about 870 resulted in improper payments totaling at least \$5.6 million. The OIG determined that the disability benefits questionnaire format prompted inappropriate evaluations of veterans' heart conditions. VBA decision makers did not consistently ask for the clarification they needed to accurately determine disability. The OIG made three recommendations for improving the handling of disability benefits questionnaires for heart diseases to ensure they are properly filled out and the information is unambiguous and consistent.

### **Site Visit Program Can Do More to Improve Nationwide Claims Processing**

VBA program operations staff conduct site visits to regional offices to ensure that veterans service centers follow requirements for disability compensation benefits. The OIG determined whether program operations staff conducted site visits and identified deficiencies at regional offices, and if managers took sufficient follow-up action on frequently identified errors to improve disability claims processing. The OIG found that program operations staff generally identified deficiencies during site visits and communicated results to the relevant offices, which addressed those deficiencies. However, VBA did not fully use the information to achieve nationwide improvements because it did not have a written policy for addressing frequently identified errors. The OIG recommended an annual report on all recurring deficiencies and action items, a plan to address them, and a follow-up process to monitor compliance and hold regional office managers accountable for corrections and action items.

## National Healthcare Review

### **Improving VA and Select Community Care Health Information Exchanges**

The OIG reviewed how VA facilities and community providers use health information exchanges in their respective communities to share information and coordinate care for veterans enrolled at VA facilities and identify any barriers that may be preventing optimum exchange of healthcare information. VA shares information with the community through two methods, VA Exchange and VA Direct. The OIG conducted a survey and interviewed Veterans Health Administration (VHA) facilities with

complexity levels of 2 or 3, for a total of 48 sites. Additionally, the OIG interviewed staff from the offices of Veterans Health Information Exchange, Information Technology, Community Care, Rural Health, two state health information exchanges, and Cerner. The most commonly cited challenges included training, the need for more community partners, use of contract community coordinators, and technology. The OIG made four recommendations.

## Healthcare Inspections

### **Alleged Deficiencies in Pharmacy Service Procedures at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia**

This healthcare inspection reviewed deficiencies in pharmacist orientation and training, IV admixture compounding, and staff's annual competencies. Allegations of pharmacy management's noncompliance with controlled substance policies was also reviewed. The OIG did not substantiate deficiencies in pharmacist orientation and training and a lack of pharmacist oversight in IV admixtures. The staff's annual competencies were current; however, the orientation checklists and competencies lacked a tracking mechanism. Pharmacy managers complied with VHA's controlled substance directive. Facility leaders reported a suspected controlled substance diversion incident to the VA police and the OIG, but not to the required VHA email group. On one occasion, testosterone was not added to inventory records or secured. The OIG made three recommendations related to developing a tracking process for orientation and competencies of pharmacy staff, ensuring facility leaders are trained on current drug diversion reporting requirements, and conducting a review of the testosterone misplacement.

### **Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center in Louisville, Kentucky**

The OIG substantiated an allegation that providers permitted a patient's neighbor, who had no legal authority, to make medical decisions for the patient. The patient had a three-week hospitalization that was marked by repeated episodes of confusion and agitation, was transferred to hospice care, and died five days later. Facility staff did not take the required steps to identify and confirm the eligibility of the patient's surrogate, such as reviewing other VA records, due to staff's varied understanding of the procedures and requirements. The OIG noted additional clinical and patient rights deficiencies and reviewed the facility leaders' evaluation of the deficiencies in the patient's care. The OIG made 15 recommendations to the facility director focusing on the patient's decision-making capacity, surrogate identification, medical assessments, medication management, a review of the patient's hospice admission, patients' rights, and quality management processes.

### **Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds**

The inspection was conducted, in response to a referral from Senator Elizabeth Warren and a complaint, to assess mental health staffing, lengths of stay, medical assessments, prescribing practices, nurse

staffing methodology, health programming, and facility levels of care. Inpatient psychiatry staffing was below expected levels but did not contribute to increased lengths of stay. The OIG was unable to determine if medical provider staffing was inadequate. All required utilization management reviews were not completed. The OIG did not substantiate that patients remained on the acute inpatient mental health unit to treat medical issues or inappropriate prescribing practices. Nurse staffing methodology was not completed and required health programming was not occurring. Facility leaders failed to convert sustained treatment and rehabilitation and posttraumatic stress disorder beds to acute or residential beds. Recommendations were made related to staffing, utilization management reviews, medical assessments, nurse staffing methodology, programming, and levels of care.

### **Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon**

This healthcare inspection evaluated the management of staff exposure to a patient with COVID-19. This was the facility's first patient diagnosed with COVID-19. The OIG did not substantiate that emergency department staff failed to notify imaging department staff before transferring a patient with COVID-19, that supervisors failed to promptly notify staff about exposure to a patient with COVID-19, or that leaders failed to take appropriate action following staff exposure to a patient with COVID-19. The OIG identified some missteps in the facility's processes when responding to staff exposure, which affected the accuracy of exposure risk assessments and monitoring for some exposed staff. While missteps were noted, the facility made timely efforts to identify exposed staff and respond according to Centers for Disease Control and Prevention guidance. The OIG made five recommendations to the facility director related to communicating infection control precautions, managing staff exposed to high-consequence infections, and implementing a detailed staff exposure management processes in facility policies.

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

(9) High-Risk Processes

**William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin**

**VA St. Louis Health Care System in Missouri**

**Jesse Brown VA Medical Center in Chicago, Illinois**

**Robert J. Dole VA Medical Center in Wichita, Kansas**

**Veterans Integrated Service Network 15: VA Heartland Network in Kansas City, Missouri**

**Edward Hines, Jr. VA Hospital in Hines, Illinois**

**Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin**

**Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois**

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