DECEMBER 2020 HIGHLIGHTS

Criminal Investigations Involving Health Care

Former West Palm Beach VA Medical Center Employee Sentenced in Connection with Bribery Scheme

A terminated employee of the West Palm Beach VA Medical Center in Florida was sentenced to 27 months' incarceration, 24 months' probation, and restitution of $1.4 million. A VA Office of Inspector General (OIG) investigation, which was based on a hotline complaint, resulted in charges alleging that this defendant and 17 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach, Florida; Miami, Florida; and Philadelphia, Pennsylvania. 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. The defendant worked as an inventory management specialist, where he placed over $1.4 million in orders with the vendors charged in this case in exchange for cash kickbacks. The defendant also recruited other VA employees and vendors to participate in the scheme. To date, 15 individuals have pleaded guilty in connection with this investigation.

Former Transportation Assistant at The Villages, Florida, VA Outpatient Clinic Sentenced in Connection with Fraud Scheme

A former transportation assistant at VA's Outpatient Clinic in The Villages, Florida, was sentenced to 18 months' incarceration and forfeiture of $382,254. A VA OIG investigation revealed that the former transportation assistant, who had the authority to award transportation assignments to vendors, conspired with his daughter and ex-wife to create and control two companies to which he steered VA transportation assignments. As a result, VA paid a total of $305,673 to these companies. The former transportation assistant also solicited and received approximately $76,000 in kickbacks from two other transportation vendors. The former transportation assistant's ex-wife and daughter were also criminally prosecuted in connection with this investigation.

Physician Sentenced for Obstruction of a Healthcare Investigation

A physician was sentenced in the Eastern District of Arkansas to three years' probation, a fine of $180,000, and restitution of $33,150. A VA OIG, Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service (DCIS), and Department of Health and Human Services (HHS) OIG investigation revealed that the defendant used telemedicine to fraudulently prescribe compounded medication that resulted in over $5 million paid by government healthcare insurance programs, to include VA's Civilian Health and Medical Program. The investigation further revealed that the defendant did not speak to many of the patients for whom she wrote prescriptions. The defendant also

misled agents during an interview that was conducted in connection with this investigation. The loss to VA is $305,430.

Criminal Investigations Involving Benefits

Home Healthcare Company Owner Sentenced for Fiduciary Fraud

The owner of a home healthcare company was sentenced in the District of Nevada to 41 months' incarceration, three years' supervised release, restitution of approximately $1.7 million and forfeiture of approximately $1.7 million. 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 elderly veterans and surviving spouses. On the applications, the defendant included inflated home healthcare expenses that were not actually paid. The home healthcare expenses reduced the veterans' and surviving spouses' incomes to make it appear as if they qualified for the benefits. The defendant also altered medical records so that the beneficiaries would appear to be eligible for the benefits. Without informing the beneficiaries, the defendant then fraudulently directed their benefit payments to bank accounts that she controlled.

Veteran Indicted in Connection with Compensation Benefits Fraud Scheme

A veteran was indicted in the Western District of North Carolina on charges of theft of government funds, false statements, and false claims. A VA OIG investigation resulted in charges alleging that the veteran fraudulently received VA compensation benefits for blindness. The defendant was rated as having "light perception only" and a visual acuity of 5/200 for approximately 30 years upon his discharge from the U. S. Army. It is alleged that the defendant maintained a driver's license in multiple states while claiming blindness. It is further alleged that during a 15-year period, the defendant and his wife purchased approximately 33 automobiles that he routinely drove, including on long-distance trips, to perform errands, and to VA medical appointments. The loss to VA is approximately $978,000.

Veteran Sentenced in Connection with Compensation Benefits Fraud Scheme

A veteran was sentenced in the Western District of Texas to 366 days' incarceration, three years' probation, and $198,907 in restitution after pleading guilty to theft of government property. A VA OIG investigation, which was based upon a hotline complaint, revealed the defendant lied to VA to obtain a 100 percent service-connected disability rating related to partial leg and arm paralysis and other neurological ailments. The investigation revealed that the defendant maintained a physically active lifestyle, to include running, participating in daily vigorous exercise classes at her gym, and mowing her lawn. The loss to VA is approximately $198,900.

Veteran Indicted for Theft of Government Funds

A veteran was indicted in the Eastern District of Missouri for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant received approximately $118,000 in benefits

to which he was not entitled after failing to notify VA that he was no longer enrolled in continuing education.

Criminal Investigations Involving Other Matters

Construction Company Owner Pleads Guilty in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

The owner of a construction company pleaded guilty in the Western District of Texas to conspiracy to defraud the United States. A VA OIG, General Services Administration (GSA) OIG, Army Criminal Investigation Command (CID), Small Business Administration (SBA) OIG, and DCIS investigation resulted in this charge that alleged the defendant and two other individuals conspired to defraud VA by fraudulently obtaining a service-disabled veteran-owned small business (SDVOSB) set-aside construction contract valued at more than $20 million.

Two Nonveterans Plead Guilty in Connection with SDVOSB Fraud Scheme

Two nonveterans pleaded guilty in the District of Utah in connection with an SDVOSB fraud scheme. A multiagency investigation resulted in charges alleging the two defendants falsely claimed that a joint venture was eligible to receive SDVOSB set-aside contracts from the government. The total value of these set-aside government contracts is approximately $16.1 million. Of this amount, the total value of the VA set-aside contracts is approximately $4.3 million. This case was investigated by the VA OIG, Air Force Office of Special Investigations, Department of Transportation OIG, Department of Agriculture OIG, SBA OIG, Army CID, GSA OIG, and FBI.

Furniture Vendor Agrees to Pay $7.1 Million to Resolve False Claims Act Allegations

A GSA-contracted furniture vendor entered into a settlement agreement with the U.S. Attorney's Office for the Northern District of California and the Department of Justice's Civil Division's Consumer Litigation Branch to resolve allegations that the company violated the False Claims Act. A VA OIG, Department of State OIG, Defense Contract Audit Agency, GSA OIG, and DCIS investigation resolved allegations that the company provided false information to GSA about their commercial pricing practices during contract negotiations. The settlement also resolves allegations that the company did not extend lower prices to government customers as required by the GSA contract's price reduction clause. Pursuant to the settlement, the company will pay $7.1 million to the United States. Of this amount, VA will receive approximately $560,000.

Durable Medical Equipment Manufacturer Agrees to Pay $1.5 Million to Resolve False Claims Act Allegations

A manufacturer of range-of-motion therapy devices entered into a settlement agreement with the U.S. Attorney's Office for the District of Massachusetts to resolve allegations that the company violated the False Claims Act by improperly charging the government for custom fabricated orthotics. A VA OIG and HHS OIG investigation resolved allegations that the company overcharged VA for its devices under

the terms of their contract. This contract required the company to sell its devices to VA at a substantially better price than was offered to any commercial customer. Despite the contract's terms, the company did not disclose to VA that it continued to offer much deeper discounts to certain customers. As a result, the company charged VA medical centers nationwide up to 300 percent more for its devices than the contract required. Pursuant to the settlement, the company will pay $1.5 million, of which $797,267 is restitution. Of this restitution amount, VA will receive $452,553.

Administrative Investigation

Senior VA Officials' Response to a Veteran's Sexual Assault Allegations

To address congressional requests, the OIG investigated VA's response to a veteran's complaint that she was sexually assaulted at the Washington DC VA Medical Center, including whether the VA Secretary or other senior officials investigated or sought to undermine the veteran's credibility. The OIG lacked conclusive evidence to reconcile conflicting testimony regarding whether Secretary Wilkie investigated or asked others to investigate the veteran. Six senior officials testified, however, that the Secretary stated the veteran had made, or may have made, prior similar complaints—which some understood meant prior complaints were unfounded. Officials questioning the veteran's credibility affected responses, including VA police conducting a background check first on the veteran and public affairs staff's engaging media to scrutinize the veteran. Despite the inspector general confirming VA could take action, leaders failed to follow up on available information regarding the individual the veteran accused or to address inhospitable conditions at the facility.

Audits and Reviews

Management and Oversight of the Electronic Wait List for Healthcare Services

The OIG substantiated allegations that the Veterans Health Administration (VHA) data on VA's website regarding the electronic wait list for patient appointments was inconsistent with internal data sources. The audit team confirmed the website data did not include entries older than two years or administrative entries, such as patients requesting care at a different facility. Because VHA addressed these issues, the OIG did not make related recommendations. The team did find that patients were not removed from the wait list when appropriate, indicating that VHA employees did not review entries daily and supervisors did not validate the list weekly. This lack of oversight increases the risk that patients will not receive care in a timely manner or at their preferred facility and could lead to the appearance that veterans waited longer than they did for care. Although VHA advanced its wait list management, the OIG provided three recommendations for improvement.

Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement

To decide that a veteran is eligible for disability benefits, VA claim processors must establish a connection between the disability and the veteran's military service. The OIG examined whether claim

processors followed VA regulations and procedures when determining service connection for posttraumatic stress disorder (PTSD) claims that were not related to military sexual trauma. The review team found that claims processors inaccurately processed about 18,300 of 118,000 PTSD claims (16 percent) completed in fiscal year (FY) 2019. Most errors occurred because claims processors did not verify or ask veterans to provide the disorder's cause, known as an in-service stressor. The OIG recommended that the Veterans Benefits Administration determine the actions needed to ensure staff understand requirements for gathering evidence and verifying stressors for PTSD claims and whether the adjudication procedures manual needs to be reorganized and amended to help staff process PTSD claims more accurately.

Audit of VA's Financial Statements for Fiscal Years 2020 and 2019

To fulfill an annual legislative requirement, the OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to audit VA's financial statements. CLA provided an unmodified opinion on VA's FYs 2020 and 2019 financial statements. It identified five material weaknesses in internal control in the following areas: (1) controls over significant accounting estimates; (2) obligations, undelivered orders, and accrued expenses; (3) financial systems and reporting; (4) information technology security controls; and (5) entity level controls including chief financial officer organizational structure. The information technology security controls material weakness has been reported for more than 10 years. VA also did not substantially comply with certain requirements of the Federal Financial Management Improvement Act due to its disjointed legacy financial management system architecture that no longer supports stringent financial management and reporting requirements. CLA made recommendations for addressing these material weaknesses and is responsible for its November 2020 audit report and conclusions.

Added Measures Could Reduce Veterans' Risk of COVID-19 Exposure in Transitional Housing

The OIG reviewed measures taken by VHA's Homeless Program Office, medical facilities, and community service providers to mitigate COVID-19 risks in transitional housing programs for veterans experiencing homelessness. The review team found that transitional housing service providers at the 14 assessed facilities successfully implemented four of six specific Centers for Disease Control and Prevention (CDC) measures but could have strengthened implementation of two others. They involved communicating precautions to high-risk veterans and social distancing. VHA and service provider staff said the Homeless Program Office allowed them the flexibility to isolate vulnerable veterans, facilitate telehealth exams, and coordinate the provision of medical care in the community. Some service providers and VA medical facilities also developed their own best practices for reducing risks. The OIG made four recommendations to the under secretary for health regarding additional measures to strengthen the implementation of CDC guidelines at the service providers' facilities.

National Healthcare Review

Review of Veterans Health Administration's Emergency Department and Urgent Care Center Operations During the COVID-19 Pandemic

The OIG conducted a review of VHA's response to anticipated demand of emergency department and urgent care center services during the COVID-19 pandemic. The team deployed a survey and interviewed 63 emergency department and urgent care center directors. Identified issues included a small number of negative pressure rooms and small waiting rooms making it difficult to isolate patients. Twenty-three directors reported a loss of staff due to providers testing positive, transfers, or retirements. Testing was generally available. Some directors reported a lack of or need to ration certain items of personal protective equipment. Data related to supplies, clinical treatment, COVID-19 epidemiology, and hospital utilization were helpful for decision making. The respondents closely monitored staff for burnout. Lessons learned included rethinking how emergency or urgent care can be delivered in a pandemic and continuing to provide care to non-COVID-19 patients while attending to the special care needs of patients with COVID-19.

Healthcare Inspection

Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, Georgia

This healthcare inspection assessed allegations that deficiencies in care coordination between facility staff and remote telemedicine intensive care unit (tele-ICU) staff resulted in deaths, injuries, or poor outcomes for patients in the critical care unit after general surgery residents were withdrawn. While the OIG was unable to determine the withdrawal resulted in poor patient outcomes, the OIG found a misunderstanding of the tele-ICU program and lack of engagement between facility and tele-ICU staff contributed to challenging and impaired communication processes, including the reporting of patient safety events. The OIG made six recommendations to the facility director related to communication and coordination, on-call processes, medicine and surgery staff responsibilities, patient safety reporting training, quality review collaboration processes, and orientation and competency training. Two recommendations made to the Veterans Integrated Service Network 10 Tele-ICU Medical Director related to patient safety reporting training and coordination of patient care reviews.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reports 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

Recently published CHIP reports include:

William Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina

Charlie Norwood VA Medical Center in Augusta, Georgia

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