MARCH 2021 HIGHLIGHTS

Congressional Testimony

Inspector General Missal Testifies Before House Veterans' Affairs Oversight and Investigations Subcommittee on VA's Supply Chain in the Pandemic and Modernization Efforts

Inspector General Missal testified before the House Veterans Affairs Committee's Subcommittee on Oversight and Investigations on March 24, 2021. The hearing focused on VA's medical and surgical supply chain during the pandemic as well as oversight conducted by the Office of the Inspector General (OIG) and the Government Accountability Office. Mr. Missal discussed how OIG staff have worked to report promptly on VA's logistics during the pandemic and develop impactful recommendations. The testimony also discussed recent reports that focus on long-standing VA supply chain issues and modernization efforts, illustrating prior programmatic weaknesses. In response to questions, Mr. Missal discussed an OIG review of mismanagement of equipment and supplies at the Hampton VA Medical Center in Virginia, the OIG's need for testimonial subpoena authority, and the common themes that underlie many OIG oversight reports such as poor governance structures, poor information technology systems, and lack of steady leadership.

Deputy Assistant Inspector General for Audits and Evaluations Testifies Before the House Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs

Deputy Assistant Inspector General for Audits and Evaluations Brent Arronte testified at a hearing on March 23, 2021, regarding the increase in VA's disability exam inventory caused by the pandemic. Because VA canceled in-person disability exams as a protective measure, a backlog of exams mounted quickly. In addition, some claims were improperly denied due to canceled appointments during the pandemic. Mr. Arronte's testimony discussed these and other issues drawn from the OIG's November 2020 report *Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams*. The OIG's findings focused on VBA's failure to create a documented plan to reduce the exam inventory to pre-pandemic levels.

Investigations Involving Health Care

Defendant Sentenced for Drug Distribution

A VA OIG and Drug Enforcement Administration investigation revealed that the defendant sold fentanyl to the friend of a veteran. The friend later provided the fentanyl to the veteran, who fatally overdosed at a VA residential facility in Lowell, Massachusetts. During the investigation, the defendant sold over 100 grams of fentanyl to an undercover agent. An individual was sentenced in the District of Massachusetts to 10 years' incarceration and eight years' supervised release after previously pleading

guilty to the distribution of fentanyl, the distribution of 40 grams or more of fentanyl, and possession with intent to distribute 28 grams or more of crack cocaine.

Former Pharmacy Technician at the East Orange VA Medical Center in New Jersey Charged with Theft of Government Medical Products

A former pharmacy technician at the VA Medical Center in East Orange was arrested after being charged with theft of government medical products. A VA OIG, FBI, and VA Police Service investigation resulted in charges alleging the defendant stole prescription HIV medication from the facility for several years. The loss to VA is approximately $8.2 million. The defendant was charged in the District of New Jersey.

Former Cleveland, Ohio, VA Medical Center Surgical Service Supervisor Pleads Guilty in Connection with Fraud Scheme

A former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center pleaded guilty to theft of government property, "honest services" wire fraud, wire fraud, and false statements relating to healthcare matters. A VA OIG and FBI investigation resulted in charges alleging the defendant received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor. It is alleged that to justify the purchase of implants from the vendor, the defendant falsified some patient records to make it appear as if patients had implants that did not correlate to any actual surgical or medical procedure. The defendant is accused of defrauding VA of nearly $2.2 million. It is alleged that in a separate scheme, the defendant fraudulently used his VA-issued purchase card and facilitated the use of other VA employees' purchase cards to make purchases from a company that he controlled for an additional loss of over $1 million. The defendant pleaded guilty in the Northern District of Ohio.

Investigation Involving Benefits

Defendant Sentenced for Theft of Public Funds

A nonveteran was sentenced in the Western District of Washington to three years' probation after previously pleading guilty to theft of public funds. The defendant previously paid restitution of $58,044 to the court, which can now be released to VA. A VA OIG investigation revealed that the defendant stole approximately $58,398 in VA funds from the bank account of a deceased VA beneficiary. The defendant withdrew the funds by conducting 173 ATM withdrawals during an eight-year period.

Investigations Involving Other Matters

Defendant Pleads Guilty in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

A nonveteran pleaded guilty in the Western District of Texas to conspiracy to defraud the United States. A VA OIG, Small Business Administration OIG, General Services Administration OIG, Defense

Criminal Investigation Service, and Army Criminal Investigation Command investigation resulted in this charge, which alleged the defendant and two other individuals conspired to defraud VA by fraudulently obtaining a service-disabled veteran-owned small business set-aside construction contract valued at more than $20 million.

Construction Company Agrees to Pay $561,411 to Resolve False Claims Act Allegations

A Virginia-based construction company entered into a settlement agreement with the U.S. Attorney's Office for the Eastern District of Pennsylvania to resolve allegations that the company violated the False Claims Act. A VA OIG and Department of Labor OIG investigation resolved allegations that the company submitted falsified payroll records pertaining to two construction projects at the VA Medical Center in Coatesville, Pennsylvania. The company was awarded subcontracts to perform work on the two VA projects under a prime contractor. The company was required by federal law to pay their workers prevailing wages because the construction work was performed for VA. It is alleged that the company paid their workers significantly less than the prevailing wage but submitted falsified payroll records to make it seem as if the prevailing wage had been paid. Unaware of the falsifications, the prime contractor submitted the payroll records to VA for payment. Pursuant to the settlement, the company will pay $561,411. Of this amount, VA will receive approximately $181,523.

Administrative Investigation

Alleged Irregularities Regarding Physician Incentive Compensation Were Not Substantiated

The OIG simultaneously investigated two unrelated complaints of potential irregularities regarding incentive compensation earned by VA physicians and dentists at two different healthcare facilities. The first complainant alleged that the director of a cardiac catheterization lab misused his government position for personal gain by restricting other cardiologists' access to the lab to satisfy a new productivity incentive; however, an OIG analysis of physician productivity did not substantiate the allegation. The second complainant alleged that the medical center dental service chief inappropriately miscoded numerous patient encounters to increase his performance pay. The OIG determined that, while the dental service chief incorrectly coded several patient encounters, the coding errors were due to his inexperience with coding procedures and had an insignificant impact on his overall performance pay. The OIG recommended an audit of the performance pay received to ensure the errors did not result in any improper payments.

Audits and Reviews

Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing

The OIG conducted this audit to assess VA's oversight of the Medical/Surgical Prime Vendor-Next Generation Program, under which prime vendors maintain inventories of medical and surgical supplies

and restock medical facilities when needed. The OIG found VA controls were insufficient to ensure medical facility staff accurately reviewed, verified, or certified distribution fee invoices for the program. VA also did not ensure staff at medical facilities accurately established and applied the on-site representative rates and paid fees based on annual facility purchases. The Medical/Surgical Prime Vendor pricing schedule establishes fee rates for on-site representatives based on annual facility purchase amounts. VA establishing a flat fee rate will help mitigate on-site representative fee rate disparities, but in the interim VA still needs to ensure facilities reconcile rate disparities that have occurred and continue to occur. The OIG made 10 recommendations designed to improve oversight of verification and certification of distribution fee invoices and ensure the accuracy of on-site representative fees.

Handling Administrative Errors at the Chicago VA Regional Benefits Office in Illinois

The OIG reviewed a March 2019 allegation that employees at the VA regional benefits office were not following VBA procedures for correcting administrative errors. The OIG substantiated the allegation based on procedures in place at the time each error was corrected. VBA modified its procedures for correcting administrative errors three times after the review team began its work in October 2019. Claims processors did not properly correct administrative errors in 88 percent of cases reviewed. Those errors resulted in improper underpayments of about $59,100 to six veterans, improper overpayments of $18,900 to two veterans, and $5,900 in debts VA had inappropriately collected from eight veterans through January 2020. The OIG recommended the director of the Chicago VA regional office ensure the errors identified by the review team are corrected, monitor the effectiveness of actions taken to improve the accuracy of corrections, and determine whether additional measures are needed.

VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors

This review examined how effectively VBA managers fulfilled the plan VA was required to submit to Congress for a skills certification program for claims processors, which includes a required test to ensure they have the skills, knowledge, and abilities for accurately carrying out their tasks. The OIG found VBA did not meet the plan requirements during fiscal years 2016 through 2019. VBA needs to make improvements in assessing claims processors, providing remedial training to those who need it, retesting those who failed tests, and taking personnel actions against employees who failed consecutive tests after receiving remedial training. The OIG's recommendations included creating written guidelines, a tracking mechanism, updates to Congress on the positions subject to testing, plans to train and retrain staff who failed tests, and notifying Congress of plans to take personnel actions against individuals who fail consecutive tests after remediation, as required by law.

The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor

The OIG conducted this audit to determine whether VHA contractor's employees accurately processed claims for non-VA care. VA authorizes care from non-VA providers based on eligibility requirements,

availability of VA care, and the circumstances of individual veterans. VA contracted with Signature Performance to help process claims for such care, but the contract did not require Signature employees to follow VA's claims-processing guidance. It also did not include standardized criteria to use when processing claims. The OIG found 13 percent of the contractor's claims decisions did not align with Office of Community Care's (OCC) guidance, increasing the risk that veterans are unnecessarily billed. VA agreed that oversight of the contractor's performance was not robust. OIG recommendations to the under secretary included providing additional training and guidance, enhancing quality surveillance, and ensuring contract requirements specify that contractor employees must follow OCC's guidance for processing non-VA care claims.

National Healthcare Reviews

Colonoscope Reprocessing at Multispecialty Community-Based Outpatient Clinics

An Office of Healthcare Inspections team conducted a national review to evaluate specific elements of colonoscope reprocessing at 10 multispecialty community-based outpatient clinics (CBOCs) that performed colonoscopies on site. The OIG reviewed training oversight and documentation, colonoscope reprocessing, and environmental monitoring in sterile processing areas. The OIG determined that CBOC sterile processing services (SPS) staff reprocessed and tracked colonoscopes according to VHA requirements and met requirements for environmental monitoring. The OIG found that 50 percent of SPS employees who were required to complete initial training within 90 days did not complete it in the required time frame. Service chiefs at 70 percent of the CBOCs did not ensure that training documentation was complete, and supervisors did not make certain that SPS staff received continuing education at 20 percent of the sites. The OIG made two recommendations to the under secretary for health related to initial SPS training and continuing education.

Quality of Colonoscopies in Multispecialty Community-Based Outpatient Clinics

The OIG also conducted a second national colonoscopy project that reviewed colonoscopies performed in VHA multispecialty CBOCs, focusing on the CBOC colonoscopy providers' professional practice evaluations, national quality assurance monitoring, colonoscopy quality monitoring, and emergency care preparations. The OIG determined that (1) VHA, facility, and CBOC leaders lacked standardized monitoring processes preventing them from identifying colonoscopy quality gaps; (2) CBOC colonoscopy quality indicator data was not comprehensively monitored; (3) VHA's colorectal cancer screening directive lacked colonoscopy quality indicator compliance monitoring requirements; (4) lack of consistency in endoscopy software and variations in data collection limited the VHA National Gastroenterology Program Office's ability to monitor quality assurance; and (5) CBOC staff monitored patients during colonoscopies, managed potential risks, and had policies for managing after-hours medical emergencies. The OIG made three recommendations to the under secretary for health related to colonoscopy provider professional practice evaluations, colonoscopy quality assurance monitoring, and standardization of endoscopy software.

Healthcare Inspections

Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona

This inspection assessed concerns regarding mental health care provided to a patient who died by suicide. While the patient awaited psychological diagnostic testing, facility staff failed to offer mental health treatment, and a social worker relied on an eight-month prior suicide risk assessment. The social worker did not document that a voicemail message provided notification of the patient's death, and a suicide prevention coordinator failed to complete timely family outreach documentation. A mental health delegate did not timely approve the patient's consult, and a third-party administrator scheduled the patient for therapy rather than testing. Primary care scheduling staff did not complete required missed appointment outreach, and the suicide prevention coordinator did not promptly complete a behavioral health autopsy. The OIG made seven recommendations related to the patient's care, suicide risk assessment, documentation, timely community care authorization, missed appointment procedures, community care scheduling, and prompt behavioral health autopsies.

View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery

This inspection was conducted in response to allegations that significant failures related to the management of "view alert notifications" placed patients at risk. A view alert is an automated notification to providers of abnormal test results. The OIG substantiated that nine of 12 reviewed providers had each accumulated more than 5,000 view alerts at some point between July 23 and December 2, 2019. The OIG substantiated that of the patients reviewed, some of their care was compromised because abnormal laboratory and imaging results were either not managed or not managed within the required timeframe. Some patients were at risk for delayed cancer diagnoses because of the lack of timely provider follow-up. The OIG also found ordering providers did not consistently take appropriate actions to edit and resubmit canceled consults. The OIG made one recommendation to the under secretary for health, one to the VA Southeast Network director, and nine to the system director.

Review of VHA's Virtual Primary Care Response to the COVID-19 Pandemic

The OIG conducted a review to assess VHA's virtual primary care response to the COVID-19 pandemic between February 7 and June 16, 2020. One strategy initiated by VHA, in accordance with the Centers for Disease Control and Prevention recommendation to social distance, was the expansion of virtual care. Virtual care options during the pandemic included video conferencing through the VA Video Connect (VVC) and third-party applications as well as telephone appointments. Face-to-face primary care encounters decreased by 75 percent and virtual encounters increased, with contact by telephone representing 81 percent of all primary care encounters. Additionally, primary care providers reported via questionnaire that virtual care scheduling was challenging and that VVC training and support was

lacking for veterans, as was equipment and internet connectivity. The OIG made two recommendations to the under secretary for health related to access, equipment, and VVC training and support.

Comprehensive Healthcare Inspections

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 inspections 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:

Veterans Integrated Service Network 7: VA Southeast Network in Duluth, Georgia

Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20

Additional Publications

Post-9/11 GI Bill Non-College Degree Entitlement Calculations Lead to Differences in Housing Allowance Payments

The OIG analyzed data on housing allowances for Post-9/11 GI Bill students attending non-college degree schools. These schools offer training programs, such as those for truck drivers and emergency medical technicians. Generally, the education program entitlement for these schools is 36 months. However, the VBA could allocate students from less than one month to almost six years of housing allowance because of how it is required to calculate the amounts. The OIG's management advisory memorandum provided details on the calculations and the team's analysis of housing allowances during a five-year period. VBA's response indicated it will use this analysis to help determine whether to request a legislative change to how entitlements and housing allowance payments are calculated for Post-9/11 GI Bill benefits. The OIG requested that VBA inform the OIG of any actions taken in response to the memorandum and the outcome of those actions.

Potential Risks Associated with Expedited Hiring in Response to COVID-19

This management advisory memorandum identifies potential risks associated with VHA's efforts to quickly add new staff to meet increased demand for healthcare services caused by the COVID-19 pandemic. The OIG recognizes the tremendous pressure to quickly hire staff to meet unprecedented needs. To achieve VHA's goal of bringing all new employees on duty within three days of making a tentative offer, VHA has been modifying or deferring tasks such as fingerprinting, background investigations, drug testing, credentialing, and preplacement physicals. Because the associated risks, if realized, could damage the trust veterans have in VA keeping their information secure and ensuring care providers are suitably qualified, this memorandum raises issues for VHA to consider in determining whether vulnerabilities and related processes warrant further review. These include possible changes to centralize governance of deferred actions to improve oversight.

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