FEBRUARY 2022 HIGHLIGHTS

Congressional Testimony

Deputy AIG for Healthcare Inspections Testifies on the Vet Center Inspection Program Before the House Veterans Affairs' Subcommittee on Health

On February 3, 2022, Dr. Julie Kroviak, the deputy assistant general for Healthcare Inspections, testified before the House Veterans Affairs' Subcommittee on Health. Her testimony focused on the findings and recommendations from the OIG's five published vet center inspection reports. She emphasized the need for improved collaboration between vet centers and VHA facilities for high-risk veterans with complex mental health conditions. The reports identified a need for continued VA leadership engagement at all levels and greater attention to training, internal controls, and oversight. In response to questions, Dr. Kroviak discussed the need for better documentation of vet center processes and an improved record-keeping system. This will ensure vet center leaders and oversight bodies can verify that required training, client assessments, and internal reviews are being completed in a timely manner. Dr. Kroviak also stressed that vet centers should prioritize addressing any deficiencies in their suicide prevention activities.

Healthcare Investigations

New Jersey Man Sentenced for Theft of HIV Medication

An investigation by the VA OIG, FBI, and VA Police Service revealed that a New Jersey man conspired with a former pharmacy technician employed at the East Orange VA Medical Center to steal prescription human immunodeficiency virus (HIV) medication from the facility for several years. The former pharmacy technician ordered large quantities of HIV prescription medication, which she stole and then sold to the defendant, who in turn resold the medication for a profit. The defendant was sentenced in the District of New Jersey to 42 months of incarceration, three years of supervised release, and ordered to pay restitution of $8.2 million. The former pharmacy technician previously pleaded guilty to theft of government property. The loss to VA is approximately $8.2 million.

New Jersey Man Pleaded Guilty for Role in Healthcare Fraud Scheme

From 2014 through 2016, a New Jersey man conspired to commit healthcare fraud against the government by unnecessarily prescribing and billing for compound medication through a VA vendor and a coconspirator pharmacy. The pharmacy received over $8 million in reimbursements through federal healthcare programs. Of this amount, CHAMPVA paid approximately $493,000. The VA OIG, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), and FBI conducted the investigation.

Six Defendants Pleaded Guilty for Healthcare Kickbacks

A multiagency investigation revealed that two laboratories engaged in a kickback scheme with marketers and physicians. The laboratories provided kickbacks to marketers based upon a percentage of their referrals for clinical testing. These referrals resulted in billings for expensive testing services that were not medically necessary. Claims submitted to all federal programs totaled approximately $300 million. Of this amount, VA paid claims of about $165,000. Six defendants pleaded guilty in the Northern District of Texas to conspiracy to pay and receive healthcare kickbacks. The investigation was conducted by the VA OIG, HHS OIG, DCIS, and FBI.

Business Owner Sentenced for Two Consecutive Healthcare Fraud Conspiracies

The owner of a telemarketing company and multiple durable medical equipment (DME) supply companies was sentenced in the Middle District of Florida to 15 years in prison for his role in two consecutive conspiracies to commit healthcare fraud. From January 2018 to April 2019, the defendant and his coconspirators generated medically unnecessary physicians' orders via a telemarketing operation for DME. Through the telemarketing operation, the personal and medical information of Medicare beneficiaries was harvested to create the unnecessary DME orders. The orders were then forwarded to purported "telemedicine" vendors that, in exchange for a fee, paid illegal bribes to physicians to sign the orders, often without ever contacting the beneficiaries. The orders were then used as support for millions of dollars in false and fraudulent claims submitted to the Medicare program. To avoid Medicare scrutiny, the defendant spread the fraudulent claims across five DME storefronts operated under his ownership and control. The scheme led to about $25 million in fraudulent DME claims submitted to Medicare, resulting in approximately $12 million in payments. In April 2019, the storefronts were subject to search warrants and a civil action under which, among other ramifications, enjoined the defendant and his five storefronts from engaging in any further healthcare fraud conduct. Undeterred, he and other conspirators carried out a similar conspiracy using three new DME storefronts and different "telemedicine" vendors. This second conspiracy caused approximately $12 million in additional fraudulent DME claims to be submitted to Medicare, resulting in approximately $6.3 million in payments. In addition to his prison sentence, the defendant was sentenced to three years of supervised release and restitution of $18 million to Medicare and more than $20,000 to CHAMPVA. The court also issued a final order of forfeiture against the defendant for $10 million. This investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation (IRS CI), FBI, and HHS OIG.

Veteran Sentenced for Making Threats

A VA OIG investigation determined that a veteran sent a threatening text message to his VA social worker's government-issued cell phone after he was discharged from housing provided through the US Department of Housing and Urban Development–VA Supportive Housing Program due to misconduct. The defendant threatened to kill the social worker's family members because he blamed the social worker for his removal from the program. The defendant was sentenced in the Northern District of Ohio

to 12 months in prison and three years of supervised release after previously pleading guilty to influencing, impeding, or retaliating against a federal employee by threatening a family member.

Veteran Pleaded Guilty to Assault with a Deadly Weapon

An investigation by the VA OIG and Las Vegas Metropolitan Police Department revealed that on multiple occasions, a veteran threatened to kill himself and VA employees during calls to the VA Hotline, White House VA Hotline, and VA Crisis Line. On one occasion, the veteran said he possessed weapons, had the knowledge to build chemical weapons, and established a timeline to start killing people. He pleaded guilty in the District Court for Clark County, Nevada, to assault with a deadly weapon.

Benefits Investigations

Defendant Sentenced for Identity Theft and Other Charges Targeting the Elderly

According to a multiagency investigation, multiple individuals in Jamaica engaged in a scheme that involved redirecting the monthly benefit payments of veterans and Social Security recipients to alternate bank accounts. The stolen funds were then allegedly loaded onto prepaid credit cards and mailed to coconspirators in the Miami and Atlanta areas. These individuals also participated in telemarketing scams that targeted elderly US citizens, including veterans. One defendant was sentenced in the Southern District of Florida to 24 months of incarceration, four years of supervised release, and restitution of over $48,000. The VA OIG, Homeland Security Investigations (HSI), and US Postal Inspection Service (USPIS) conducted the investigation. To date, 18 coconspirators have been indicted in connection with this scheme, 15 of whom have been arrested and convicted, with 14 being sentenced to a combined 559 months of incarceration, 456 months of supervised release, 36 months of probation, and over $3.9 million in restitution. The loss to VA is more than $7 million.

Individual Sentenced for Embezzlement

A multiagency investigation resulted in charges alleging that an individual, with the assistance of four coconspirators, embezzled funds from deceased or elderly bank account holders at a major financial institution. The defendant allegedly laundered the stolen funds through relatives, associates, or shell companies owned by relatives and associates, misappropriating more than $6.9 million in funds from the bank account holders. Many of the affected account holders were VA and Social Security Administration (SSA) beneficiaries. The defendant was sentenced in the Eastern District of New York to 48 months of incarceration, 48 months of supervised release, and restitution of almost $1.4 million. Three of his coconspirators previously pleaded guilty in connection with this investigation, which was conducted by the VA OIG, Manhattan District Attorney's Office, New York City Police Department, HSI, IRS CI, USPIS, and SSA OIG.

Veteran Pleaded Guilty to Theft of Government Property

A VA OIG proactive investigation revealed that a veteran who maintained a valid Missouri driver's license was rated as 100 percent service-connected disabled for bilateral blindness since 2000. During the investigation, the veteran was observed driving routinely and mowing his lawn. He pleaded guilty in the Eastern District of Missouri to theft of government property. The loss to VA is more than $671,000.

Ex-wife of Deceased VA Beneficiary Sentenced for Theft of Government Funds

A VA OIG investigation revealed that the ex-wife of a deceased VA beneficiary was awarded VA Dependency and Indemnity Compensation benefits based upon multiple false documents that she submitted to VA. Despite being divorced at the time of the beneficiary's death, she provided an amended death certificate that falsely indicated that she was the deceased VA beneficiary's widow. She was sentenced in the Western District of Missouri to one year and one day of incarceration, three years of supervised release, and restitution of more than $100,000 to VA.

Investigations Involving Other Matters

Food Service Equipment Company to Pay Record Settlement for Service-Disabled Veteran-Owned Fraud Allegations

A company based in Mansfield, Massachusetts, that provides kitchen and food service equipment to federal customers has agreed to pay $48.5 million to resolve allegations that its fraudulent actions led to federal agencies improperly awarding small business set-aside contracts to three small business with which the company worked. The settlement constitutes the largest-ever False Claims Act recovery based on allegations of small business contracting fraud. Between 2011 and 2021, the company identified federal set-aside contract opportunities for the small businesses to bid on using their set-aside status; instructed them on how to prepare their bids and what prices to propose; "ghostwrote" emails for those companies to send to government officials to make it appear as though the small businesses were performing work; and affirmatively concealed its involvement in the contract. The case began in May 2019, when a whistleblower filed a *qui tam* complaint under seal in the US District Court for the Northern District of New York. Per the False Claims Act, such complaints require the United States to investigate the allegations and elect whether to intervene and take over the action. In this case, the United States elected to intervene in the action in December 2021 and subsequently reached the $48.5 million settlement, of which VA will receive over $10 million. The investigation was conducted by the VA OIG, US Attorney's Offices for the Northern District of New York and Eastern District of Washington, General Services Administration OIG, Small Business Administration OIG, Department of Homeland Security OIG, US Army Criminal Investigation Division, US Air Force Office of Special Investigations, Naval Criminal Investigative Service, and DCIS.

Audits and Reviews

Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2020

VA must report annually to Congress on its capacity in five areas: (1) spinal cord injuries and disorders, (2) traumatic brain injury, (3) blindness, (4) prosthetics, and (5) mental health issues. The requirement was established to ensure that VA's capacity to serve disabled veterans does not fall below 1996 levels. The OIG is required to report to Congress on the accuracy of VA's report. This OIG report identified minor errors, omissions, and inconsistencies in the FY 2020 capacity report that have persisted from the OIG's FY 2019 review. However, VA issued its FY 2020 report before the OIG released its FY 2019 review and therefore could not correct some of the identified issues. As the OIG previously reported, VA cannot compare current mental health capacity data with 1996 capacity because of changes in diagnosis and treatment, service provision, and data collection. The OIG believes that by modernizing the reporting metrics, Congress would be better positioned to assess VA's capacity to provide care for today's veterans with disabilities.

First-Party Billing Address Management Needs Improvement to Ensure Veteran Debt Notification before Collection Actions

The OIG reviewed a complaint that employees at the Central Plains Consolidated Patient Account Center mismanaged veterans' billing addresses at the Minneapolis VA Health Care System. The complainant claimed bills were mailed to outdated addresses, returned, and then referred to debt collection without veterans' knowledge. The OIG found VA mailed bills using outdated addresses from one file while newer information was available from another file in the same record system. Some accounts were previously referred to debt collection, but the OIG could not establish whether this was because veterans did not receive the bills. VHA lacked defined processes for managing returned bills and correcting addresses. Veterans may face unanticipated financial demands if bills are sent to outdated addresses and accounts are referred to collection without notice. The OIG recommended VHA review and correct address data for first-party bills and improve policies detailing responsibilities and procedures for remediating returned bills and updating addresses.

Healthcare Inspections

Lack of Care Coordination and Hepatocellular Carcinoma Surveillance of a Patient at the VA Eastern Colorado Health Care System in Aurora

The inspection team assessed allegations that lack of care coordination and surveillance led to a delay in a patient being diagnosed with hepatocellular carcinoma (HCC), which is a common type of primary liver cancer. The OIG substantiated the lack of care coordination due to providers' failure to communicate important information during patient hand-offs. In addition, facility providers failed to properly document the patient's problem list. The patient did not receive the necessary HCC surveillance or varices (blood vessel) monitoring, leading to a delay in the diagnosis of HCC. The OIG

reviewed additional cases and determined that facility providers did not consistently comply with recommended HCC surveillance guidelines or consistently update patient problem lists for patients with a similar diagnosis. Ultimately, this could result in missed opportunities for identifying needed HCC surveillance. The OIG made six recommendations.

Care in the Community Consult Management during the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia

The OIG received allegations of a failure to schedule a Care in the Community (CITC) COVID Priority 1 consult (referral) within VHA requirements, and inadequate staffing caused scheduling delays. The OIG substantiated that the consult was not scheduled within 30 days of the clinically indicated date (when a healthcare provider deems an appointment is clinically appropriate). The facility had a backlog of unscheduled CITC consults but did not have plans to address the backlog, maximize use of available reports, or conduct clinical reviews of unscheduled consults. The facility also lacked a process to review potential adverse events due to delayed consults and workarounds were created by other departments to avoid patient care delays. Inadequate CITC staffing did cause delays in consult scheduling. Reported contributing factors included frequent staff turnover, outdated local processes, lack of training, and staffing challenges during the pandemic. The OIG made eight recommendations.

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:

- Leadership and organizational risks
- COVID-19 pandemic readiness and response
- Quality, safety, and value
- Medical staff credentialing
- Environment of care
- Mental health (focusing on suicide prevention)
- Care coordination (targeting interfacility transfers)
- Women's health (examining comprehensive care)

Recently published CHIP reports include:

VA Hudson Valley Health Care System in Montrose, New York

Durham VA Health Care System in North Carolina

The following reports are part of the series of Comprehensive Healthcare Inspection Summary Reports published during this reporting period that aggregate findings from FY 2020 facility reports.

Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020

This report evaluates selected mental health program requirements for VHA facilities, focusing on suicide prevention coordinator processes, provision of suicide prevention care, and suicide prevention training. The report describes mental health–related findings from healthcare inspections that were initiated at 36 VHA medical facilities from November 4, 2019, through September 21, 2020, and electronic health record reviews at five additional facilities. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the FY 2020 OIG reviews. The OIG found general compliance with many of the selected requirements; however, the OIG identified weaknesses in various key mental health–related processes, including the completion of follow-up visits within the required time frame, appropriate follow-up with veterans who have a "high risk for suicide" patient record flag and who fail to attend mental health appointments, and the completion of monthly outreach activities. The OIG issued four recommendations.

Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2020

The CHIP team reported on selected requirements and guidelines for care coordination for VHA facilities, targeting compliance with program requirements related to life-sustaining treatment decisions for hospice patients. The report describes care coordination findings again from all FY 2020 inspected facilities, and electronic health record reviews at five additional facilities. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes. During the time frame of this retrospective review, VHA policy required certain elements of "goals of care" conversations to be documented in patients' electronic health records. However, in March 2020, VHA revised its policy to require fewer elements. The OIG observed general compliance with the selected requirements after these rules were updated during the review period. However, under the original VHA requirements in place when patients received their care, the OIG estimated that providers did not consistently identify a surrogate should the patient lose decision-making capacity; address previous advance directives, state-authorized portable orders, and/or life-sustaining treatment plans; or address the patient's or surrogate's understanding of the patient's condition. The OIG did not issue recommendations but developed this summary report for leaders to consider when improving operations and clinical care at VHA facilities.

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