Department of Veterans Affairs
Office of Inspector General
January 2017 Highlights

OFFICE OF INSPECTOR GENERAL REPORTS

Review of the Implementation of the Veterans Choice Program

The Office of Inspector General (OIG) conducted this review at the request of Senator Johnny Isakson, Chairman of the Senate Committee on Veterans' Affairs, who expressed concerns about the implementation of the Veterans Choice Program (Choice) and the barriers facing veterans trying to access it. OIG's review focused on whether veterans were experiencing barriers accessing Choice during its first year of implementation. Choice, as part of the Patient Centered Community Care Program, provides care for eligible veterans when the local Veterans Health Administration (VHA) medical facilities lack available specialists, have long wait times, or are geographically inaccessible. OIG reviewed monthly reports to identify average wait times for multiple stages of the Choice process, including the authorization of care, scheduling, and the delivery of health care to veterans. OIG determined several barriers exist in accessing care through Choice, to include cumbersome authorization and scheduling procedures, inadequate provider networks, and potential veteran liability for treatment costs. After being scheduled with a Choice provider, on average the veteran waited about 13 days to receive care. VHA identified approximately 1.2 million instances in which veterans could not receive VHA appointments from November 1, 2014 through September 30, 2015. During this period, approximately 283,500 eligible veterans opted into Choice, and 149,000 of these received an appointment with a Choice provider. OIG calculated a 13 percent rate of Choice utilization (based on appointments provided compared to veterans eligible to receive care). OIG was unable to determine why the other 87 percent did not access Choice. OIG recommended the Under Secretary for Health (USH) streamline procedures for accessing care, develop accurate forecasts of demand for care in the community, reduce providers' administrative burdens, ensure veterans are not liable for authorized care, and ensure provider payments are made in a timely manner. The USH concurred with OIG's findings and recommendations.
[Click here to access report.]

Audit of VA's Recruitment, Relocation, and Retention Incentives

OIG assessed how VA used recruitment, relocation, and retention (3R) incentives to develop and maintain its workforce in fiscal year (FY) 2014. OIG conducted this audit following a complaint alleging VA awarded its Senior Executive Service (SES) employees recruitment and relocation incentives without adequate justification and retention incentives without determining the employee's intent to leave VA. OIG substantiated part of the allegation, finding VA's Office of Corporate Senior Executive Management did not ensure SES recruitment and relocation incentives were properly authorized before making award recommendations to VA. OIG did not substantiate that VA awarded SES employees retention incentives without determining the employee's intent to leave. VHA didn't properly authorize 33 percent of the recruitment and 64 percent of the relocation incentives awarded to non-SES employees. Most retention incentives awarded to SES employees and non-SES VHA employees and half of

retention incentives awarded to non-SES VA Central Office (VACO) employees lacked adequate workforce and succession plans. VA needs to improve efforts to recoup payments when employees do not meet the recruitment or relocation service agreement terms. VA's inadequate controls over its 3R incentives represent an estimated $158.7 million in unsupported spending and approximately $3.9 million in repayment liabilities projected for FYs 2015 through 2019. OIG recommended the Assistant Secretary for Human Resources and Administration review and update procedures for VA Administrations to ensure recruitment and relocation incentives are justified and properly authorized and develop internal controls for VA Administrations to monitor facilities' compliance with developing succession plans to reduce VA's reliance on retention incentives. [Click here to access report.]

Review of Alleged Waste of Funds on a Cloud Brokerage Service Contract
In January 2015, OIG received an anonymous Hotline complaint alleging that the Office of Information and Technology (OIT) spent over $2 million on a cloud brokerage service contract that provided only limited brokerage functionality and that VA's actions did not ensure adequate system performance or return on investment. Substantiating the allegations, OIG determined total project costs exceeded $5 million, that the system's limited brokerage service functionality prevented it from being used in a production environment, and that VA's actions did not ensure adequate system performance or return on investment. The project manager did not ensure that formal testing and acceptance were conducted on project deliverables. Project management was not performed in accordance with established procedures and the Project Management Accountability System was not used to hold project managers accountable for meeting project goals. These deficiencies occurred because of a lack of executive oversight and ineffective project management. Without enforcement of oversight controls, project leadership cannot ensure the value of contract deliverables or demonstrate an adequate return on investment for the project. OIG recommended that the Assistant Secretary for OIT implement improved controls to ensure effective oversight of IT projects and compliance with IT project management procedures. Additionally, the Assistant Secretary should enforce the use of the Veteran-focused Integration Process on all software development projects and ensure all VA developed software costs are funded with IT systems appropriations. [Click here to access report.]

Review of Alleged Human Resources Delays at the Atlanta VA Medical Center
OIG received and substantiated allegations that the Atlanta VA Medical Center (VAMC) had a backlog of over 300 unadjudicated background investigations and that mandatory drug testing of new hires did not occur for 6 months. VA officials confirmed the VAMC had a backlog of unadjudicated background investigations by mid FY 2015. The Director of VACO's Personnel Security and Suitability Service said the VAMC had a backlog of approximately 200 of these investigations as of July 2015. Atlanta Human Resources (HR) personnel acknowledged a backlog dating as far back as 2012. Even though the lack of available records limited OIG's ability to quantify the extent of the backlog, OIG substantiated that backlogs were occurring by determining that the average adjudication processing time at the VAMC was about 170 days. OIG also substantiated that the Drug Free Workplace Program (DFWP) was not administered

from November 2014 to May 2015. These lapses occurred because records within the personnel security program were inadequate, policies were not implemented as required, and HR staff were not adequately trained. VAMC management did not ensure the continuity of the DFWP when the former coordinator left the position in September 2014. Without proper controls over these functions, the VAMC cannot reliably attest to the suitability of its staff, exposing veterans and employees to individuals who have not been properly vetted. The facility lacks assurance that employees in Testing Designated Positions remain suitable for employment. OIG recommended the Medical Center Director assess the HR program and ensure staff receive appropriate background investigations, provide training on the requirements of the personnel security program, and monitor the DFWP. The Director concurred with OIG's recommendations. OIG considers the corrective action plans the facility submitted acceptable and will follow up on their implementation. [Click here to access report.]

Combined Assessment Program Review
In January 2017, OIG published one Combined Assessment Program (CAP) follow-up review containing OIG findings for the facility listed below. The purpose of the CAP review was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following two activities:

(1) Environment of Care
(2) Mental Health Residential Rehabilitation Treatment Program

VA St. Louis Health Care System, St. Louis, Missouri

CRIMINAL INVESTIGATIONS
Alexandria, Louisiana, Nursing Assistant Indicted for Negligent Homicide
An Alexandria, LA, nursing assistant was indicted for negligent homicide. The indictment alleges that the defendant assaulted an inpatient veteran by slamming the veteran's head into a wall while the veteran was in a special observation day room. The veteran died several weeks later. According to the forensic report, the death was the result of blunt force trauma to the head.

***False Claims Act* Settlement Agreement**
A VA OIG, Federal Bureau of Investigation, Health and Human Services (HHS) OIG, and Defense Criminal Investigative Service (DCIS) investigation of an alleged illegal medical product marketing scheme, which relied on gratuity payments to VA and Medicare physicians, resulted in a $350 million civil *False Claims Act* settlement agreement. The medical product was a biological skin substitute for the treatment of diabetic foot ulcers. The investigation determined that Advanced BioHealing (ABH), Inc. sales representatives provided a variety of financial inducements to VA physicians to include honorarium payments, concert tickets, and all-expense paid vacations in an effort to increase sales of their product to VA facilities. ABH sales to VA during the time the gratuities were paid to VA clinicians totaled approximately $147 million. To date,

this settlement is the largest *False Claims Act* recovery by the U.S. involving a medical device.

Civil Settlement in Medical Products Case
The Department of Justice announced that a Government contractor based in St. Louis, MO, signed a civil settlement agreement and paid $4 million to resolve allegations that they submitted false claims for medical items sold to VA and the Department of Defense (DoD). The civil settlement was the result of a VA OIG, General Services Administration (GSA) OIG, and DCIS investigation and resolved allegations that the contractor made false disclosures to VA and DoD regarding the discounts and prices it was providing to other commercial customers for assorted medical products. The agreement also resolves allegations that the contractor made false statements to VA and DoD about the country of origin for some products, and as a result, sold products that were not from approved countries as required by the Trade Agreements Act. VA's portion of the settlement is approximately $2.1 million.

Former St. Louis, Missouri, VAMC Supervisor and a VA Vendor Indicted for Conspiracy to Steal Government Funds
A former St. Louis, MO, VAMC supervisor and a VA vendor were indicted for conspiracy to steal Government funds. A VA OIG and Federal Deposit Insurance Corporation OIG investigation determined that from April 2014 to April 2015 the supervisor issued purchase card payments totaling $125,549 to the vendor for unnecessary maintenance work. During this time, the vendor kicked back approximately $39,000 to the supervisor and approximately $20,800 to his stepfather, who was also a VA employee at the time. The stepfather previously pled guilty to conspiracy to steal Government funds. This investigation is ongoing and there is an anticipated loss of $451,853.

Former Physician Pleads Guilty to Health Care Fraud
A former physician, who had previously lost his medical license, pled guilty to health care fraud after being charged for his part in a health care fraud scheme. The defendant was employed as a medical consultant at a Kansas City, MO, clinic that was subcontracted by a VA contractor to provide VA disability examinations for local veterans. The examinations were performed in violation of the prime contractor's contract with VA, which required that the examinations be conducted by a licensed and credentialed provider who has a clear and unrestricted license and has not been excluded from participating in Federal health care programs. The investigation revealed that a total of 209 examinations were submitted for 53 veterans utilizing another doctor's name and license without his permission. The investigation is ongoing.

Ohio Home Health Care Provider and Son Convicted of Health Care Fraud and Conspiracy to Commit Health Care Fraud
The owner of a northeast Ohio home health care provider and her son were convicted at trial of health care fraud and conspiracy to commit health care fraud. The owner was also convicted of money laundering. A multi-agency health care fraud task force investigation revealed that the defendants submitted fraudulent billings to Medicare, Medicaid, and VA as well as false information or stolen identities on every annual

provider agreement approved by the Cleveland, OH, VAMC. Five defendants were originally charged; however, one died and the other two previously pled guilty. The State and Federal loss is approximately $7 million, to include a loss to VA of approximately $429,600.

Former Portland, Oregon, VA Social Worker Sentenced for Attempted Coercion and Initiating a False Police Report

A former Portland, OR, VA social worker was sentenced to 2 days' incarceration and 24 months' probation and was ordered to receive mental health counseling and pay $16,536 in restitution after pleading guilty to attempted coercion and initiating a false police report. The defendant falsely reported that her veteran patient had threatened to kill her. This threat prompted the medical center to shut down the mental health clinic for the remainder of the day. Further investigation revealed that the defendant engaged in a personal relationship with the veteran who was 100 percent service-connected and rated incompetent by VA. The defendant exchanged over 4,000 personal text messages with the veteran asking him to marry her, raise an adoptive child, and spend personal time together outside of their therapy sessions. The defendant also threatened to report the veteran to VA police as dangerous and to have him arrested if he reported their personal relationship.

Former Pharmaceutical Executive Arrested

As the result of a multi-agency investigation, a pharmaceutical executive formerly employed by Insys Therapeutics, Inc., was arrested after re-entering the country. The defendant had previously been charged as a co-conspirator in an alleged nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe a fentanyl-based pain medication and defraud health care insurers. The medication, called "Subsys," is a powerful narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for bribes and kickbacks, the practitioners allegedly wrote large numbers of prescriptions for the patients, most of who were not diagnosed with cancer. VA's CHAMPVA paid the company approximately $3.3 million for Subsys.

Northport, New York, VAMC Employee and Former Union President Arrested for Grand Larceny in the Third Degree

A Northport VAMC employee and former union president were arrested for grand larceny in the third degree. An OIG, Department of Labor Office of Labor Management Standards, and NY Attorney General's Office investigation resulted in the defendant being charged with embezzling approximately $45,000 from the union's bank account and using the funds for personal expenditures.

Former Salt Lake City, Utah, VAMC Associate Chief of Pharmacy Sentenced for Drug Diversion

A former Salt Lake City, UT, VAMC associate chief of pharmacy was sentenced to 3 years' probation after pleading guilty to acquiring possession of a controlled substance by fraud. An OIG investigation revealed that between October 2011 and March 2015 the defendant diverted approximately 25,000 pills of oxycodone, hydromorphone, Adderall, buprenorphine, Ritalin, and tramadol from the inpatient

pharmacy. The defendant admitted to diverting the drugs for personal use and subsequently resigned from his position at the medical center.

Veteran Convicted of Theft of Government Funds and False Statements
A veteran was found guilty at trial of theft of Government funds and false statements. A VA OIG, Social Security Administration (SSA) OIG, and HHS OIG investigation revealed that the defendant fraudulently applied for and received VA, SSA, and HHS disability benefits, claiming loss of use of her right hand since January 2009 when in fact she had full use of both hands. During the course of the investigation, the defendant also provided false statements to VHA and SSA medical staff regarding the extent of her disabilities. The loss to the Government is over $300,000, to include a loss to VA of $187,656.

Daughter of Deceased VA Beneficiary Convicted of Theft of Government Funds
The daughter of a deceased VA beneficiary was convicted at trial of theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in January 2007. The loss to VA is $101,459.

Kansas City, Missouri, Construction Company and Former Owners Indicted on Charges Related to Service-Disabled Veteran-Owned Small Business Fraud
A Kansas City, MO, construction company and two of its former owners were indicted for various charges to include wire fraud conspiracy, major program fraud, wire fraud, and money laundering. A VA OIG investigation, with assistance from GSA OIG, resulted in the indictment that alleges that the defendants obtained $13.8 million in Federal Government contracts for work in nine states by using a veteran's service-disabled veteran (SDV) status to create a "pass-through" company for the purpose of obtaining 20 set-aside veteran-owned small business and service-disabled veteran-owned small business (SDVOSB) contracts. The work was then allegedly subcontracted to a non-SDV-owned company. The SDV owner maintained full-time work as a Government employee and did not control the day-to-day management, daily operation, or long-term decision making of the SDVOSB. Warrants have led to the seizure of $2.5 million from various financial accounts associated with this scheme.

Civil Complaint Alleging SDVOSB Fraud Filed Against Construction Companies and Officers
A U.S. Attorney's Office filed a civil complaint against a construction company contracted by VA as an SDVOSB, its three officers, and another construction company as the result of a VA OIG and Small Business Administration OIG investigation. The civil action was based on an SDVOSB fraud allegation that involved several VA construction contracts at VA facilities in New Jersey. The amounts of the contracts totaled over $7 million, most of which were funded by the *American Recovery and Reinvestment Act*. The complaint seeks monetary damages for violations of the *False Claims Act*, fraud, and other deceptive actions allegedly committed by the subjects. The construction company contracted by VA was allegedly created to act as a

pass-through SDVOSB company for a non-SDVOSB company so it could qualify and bid on set-aside contracts.

Two Defendants Found Guilty of Major Fraud Against the United States
Two non-veteran defendants were found guilty of major fraud against the United States. Additionally, one of the defendants was also found guilty of conspiracy and wire fraud. A VA OIG, Housing and Urban Development OIG, United States Postal Inspection Service, and North Carolina Department of Insurance investigation revealed an interstate fraudulent construction bond scheme, affecting multiple Federal agencies over the course of several years. The loss to VA is approximately $4 million.

Veteran Sentenced for Mail Fraud and Structuring Currency Transactions
A veteran was sentenced to 18 months' incarceration, 3 years' probation, and was ordered to pay restitution of $525,521 after pleading guilty to mail fraud and structuring currency transactions. An OIG and Internal Revenue Service Criminal Investigation Division investigation determined that the defendant fraudulently posed as a representative of VA and took payments from 16 veterans with the promise of getting the veterans VA compensation benefits at a 100 percent rating. The payments made to the defendant were to be used to pay an attorney to do research and file the veterans' claims. The defendant subsequently stole the payments from his victims and never filed a single claim on their behalf.

Former Tucson, Arizona, Consolidated Mail Outpatient Pharmacy Chief IT Specialist Pleads Guilty to Possession of Child Pornography
The former Tucson, AZ, Consolidated Mail Outpatient Pharmacy chief IT specialist pled guilty to possession of child pornography. Department of Homeland Security agents executed a search warrant at the VA employee's residence which resulted in the seizure of approximately 40 GB of child pornography video from the employee's personal computer. Subsequently, OIG seized the employee's VA-issued laptop, which was sent to the OIG Forensic Laboratory. The result of their examination revealed pornographic images as well as internet word searches associated with child pornography. The VA employee resigned from VA while under investigation.

East Orange, New Jersey, VAMC Employee Charged With Assault and Possession of Weapons
An East Orange, NJ, VAMC employee was charged with assault and possession of weapons. An OIG and VA Police Service investigation resulted in the defendant being charged after allegedly attacking and assaulting his VA supervisor with a wooden "billy" club at the medical center. Consensual searches of the employee's locker and car yielded three illegal knives. The altercation was sparked by a prior incident in which the supervisor allegedly sexually assaulted the employee. OIG is currently investigating the allegation of sexual assault.

Veteran Arrested for Assaulting a Lyons, New Jersey, VAMC Physician
A veteran was arrested for assaulting a Lyons, NJ, VAMC physician. An OIG and VA Police Service investigation disclosed that the defendant allegedly assaulted his VA

physician by throwing a cup of hot coffee at her face and throwing a water pitcher at her back after he was told he was going to be discharged from the medical center. The VA physician sustained injuries, including burns to her face and an injury to her eye.

Veteran Involuntarily Committed After Assaulting Phoenix, Arizona, VAMC Employee
A Federal judge involuntarily committed a veteran indefinitely to the permanent care and custody of the Federal Government at the Federal Medical Center in Butner, NC. The court determined that the defendant's release to the public would create a substantial risk of bodily injury to another person. An OIG investigation determined that the defendant physically assaulted and attempted to sexually assault a VA employee at the Phoenix, AZ, VAMC. During the assault, the defendant stripped off his clothing and barricaded himself and the victim in an office.

Veteran Sentenced for Assault of Topeka, Kansas, VAMC Police Chief
A veteran was sentenced to 48 months' supervised probation after pleading guilty to assaulting a Federal law enforcement officer. An OIG investigation resulted in the defendant being charged with assaulting the VA chief of police at the Topeka, KS, VAMC. After responding to an emergency call by VA medical staff due to the defendant making threats, the chief was assaulted by the defendant and suffered minor injuries.

Veteran Arrested for Firearm Violations
A veteran was arrested for unlawful possession of a firearm by a felon, possession of a firearm on Federal property, and false statements. An OIG; Bureau of Alcohol, Tobacco, Firearms, and Explosives; and VA Police Service investigation revealed that the defendant was a felon in possession of a firearm who allegedly committed an armed robbery of another veteran while at a West Palm Beach, FL, VAMC. Additionally, on a different date, the defendant displayed a firearm to another veteran and made threatening statements that he was going to blow up VA with a grenade because VA owed the defendant money. OIG obtained voluntary consent to search the defendant's home after the defendant denied possessing firearms. A loaded .45 caliber pistol, UZI carbine, and ammunition were found and seized from the defendant's home.

Veteran Pleads No Contest to Making Threats to the Palo Alto, California, VAMC
A veteran pled no contest to making threats to commit a crime resulting in death or great bodily injury. As part of the plea, the veteran was sentenced to 1 year incarceration and 3 years' probation. An OIG and VA Police Service investigation revealed that the veteran made several threats, both telephonic and via text message, indicating that he had purchased a gun and that there would be a mass shooting at the Palo Alto, CA, VAMC. The veteran also threatened one specific VA employee indicating that he had a gun and that she was on his "hit list."

ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may

result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership. Administrative advisories are issued if allegations are substantiated but no recommendations are made or are unsubstantiated during the course of the investigation and there is a need to notify VA leadership of the investigative results.

A major component of OIG's vision is an unwavering commitment to being a transparent organization. In keeping with this vision, OIG is maintaining transparency with veterans, Congress, and the public by releasing administrative investigation advisories issued by OIG. As other administrative investigation advisories are completed, they will be available on our website if they are not prohibited from public disclosure.

You may view and download these administrative investigation advisories and closure memoranda by clicking on the links below on our webpage.

https://www.va.gov/oig/publications/administrative-investigation-advisories.asp

Administrative Investigation Advisories (January 2017)	
Advisory Number	**Title**
14-04097-139	Administrative Investigation – Alleged Improper Use of Relocation Program and Incentives, VHA
14-04690-140	Administrative Investigation – Alleged Improper Telework and Ineffective Supervision, Nebraska-Western Iowa Health Care System, Omaha, Nebraska
14-01418-141	Administrative Investigation – Alleged Preferential Treatment in Hiring, Veterans Health Care System of the Ozarks, Fayetteville, Arkansas

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