Congressional Testimony

**Inspector General Testifies before the House Veterans’ Affairs Committee on the VISN Structure and Lessons from the DC VA Medical Center Report**

Inspector General Missal testified before the US House of Representatives Committee on Veterans’ Affairs on May 22nd. Although the hearing primarily focused on the Veterans Integrated Service Network (VISN) functions, Mr. Missal discussed the importance of leadership and governance at all levels of VA—from individual medical centers to regional VISNs and up through the VA Central Office. Drawing from the findings in the OIG’s report, *Critical Deficiencies at the Washington, DC VA Medical Center*, he presented the documented failures in oversight and accountability as a case study for VA leaders across the nation. He discussed the role of VISNs and how unstable or ineffective leadership plays a considerable role in what the OIG sees as persistent problems that result in the same findings being reported, sometimes repeatedly over many years, despite the efforts of line-level staff to overcome significant problems.

**Deputy Assistant Inspector General for Audits and Evaluations Testifies before the House Veterans’ Affairs Subcommittee on Oversight and Investigations**

Mr. Nick Dahl, Deputy Assistant Inspector General for Audits and Evaluations, testified before the House Committee on Veterans’ Affairs Subcommittee on Oversight and Investigations on May 8, 2018. The subcommittee members were interested in determining if VA should continue to invest in the Real Time Location System (RTLS), which uses multiple technologies for locating and tracking medical equipment, given the issues with contracting, cost overruns, and implementation that VA has experienced. Mr. Dahl’s testimony included information from the OIG’s December 2017 report on the *Review of Alleged Real Time Location System Project Management*. He emphasized that OIG’s review of RTLS indicated VA needs enhanced discipline, oversight, and resource management to support successful IT development. He was accompanied by Mr. Michael Bowman, Director of OIG’s Information Technology and Security Audits Division.

Criminal Investigations for Health Care

**VA Choice Contractor Paid $40.8 Million in Reimbursements for Overpayments**

A contractor that acted as a third party payer for the VA Choice Program (one of the community healthcare programs) reimbursed VA more than $40 million for overpayments that it received as a result of improperly submitting duplicate invoices. An OIG and VA investigation revealed that errors in the contractor’s billing practices led to multiple overpayments. This contractor conceded that at least a portion of the overpayments were accurately identified by VA and reimbursed for that amount.
Three Former Greenville, South Carolina, VA Community Based Outpatient Clinic Employees Indicted for Bribery, Conflict of Interest, Healthcare Fraud, and Conspiracy

An OIG investigation resulted in charges alleging that the defendants conspired with officials from a medical product company to receive gratuities and payments while employed by VA, and also used large quantities of its skin graft product on VA patients for wound treatment. The OIG Office of Healthcare Inspections staff helped investigators determine that the VA healthcare providers violated Department policy and misused the product in a number of ways for personal gain. VA employees used the product without a Consignment Agreement and stored it in their work spaces, which assisted the company in reporting inflated sales to investors. One defendant, a former VA physician, conducted a published research study using this product, which showed successful wound closure. However, subsequent to the study, this defendant continued to overuse the product on at least one of the research patients as if the patient’s wound was not closed. One of the defendants resigned in lieu of termination and another defendant was fired. The third defendant retired when the investigation began. In addition, a physician and two nurses at the Greenville Community Based Outpatient Clinic (CBOC) each received a one-day suspension. VA spent approximately $153 million worth of this product, with more than approximately $7 million from a South Carolina VA medical center (VAMC) and this CBOC.

Former Bedford, Massachusetts, VA Medical Center Employee Pled Guilty to Distribution of Morphine

The guilty plea in this case was the result of a year-long OIG and Drug Enforcement Administration investigation into the widespread sale of drugs at the Bedford VAMC, which garnered local media and congressional interest. Further investigation identified multiple veterans who purchased drugs from the defendant while receiving addiction treatment at the VAMC. The defendant’s employment was terminated after VA was notified of the conduct.

Veteran Charged with Drug Distribution at the West Haven, Connecticut, VA Medical Center

A veteran was arrested after being charged with drug distribution at the West Haven VAMC. The arrest was based on the results of an OIG and local police investigation that targeted the illegal sale of drugs and drug overdoses at the facility. This ongoing investigation has identified multiple defendants involved in the alleged distribution of illicit drugs and controlled pharmaceuticals at the VAMC. One defendant was previously arrested during the execution of a state arrest and search warrant.

Veteran Pled Guilty to Receiving Visual Depictions of Minors Engaging in Sexually Explicit Conduct

Based upon a tip from the National Center for Missing and Exploited Children, an investigation involving the OIG, Homeland Security Investigations, and Texas Department of Public Safety revealed that the defendant used a VA network to access a Google account containing child pornography while residing at the Big Spring, Texas, VAMC. The defendant subsequently admitted to possessing and viewing child pornography.
Nonveteran Charged with Assault on a Federal Officer at the American Lake, Washington, VA Medical Center

A grand jury indicted a nonveteran on charges of assault on a federal officer and being a felon in possession of a firearm. An OIG, Federal Bureau of Investigation (FBI), and VA Police Service investigation resulted in charges that allege the defendant, who is a convicted felon, was involved in a hit-and-run collision with VA Police Service officers at the American Lake VAMC in Tacoma, Washington. One of the officers was injured in the collision. The suspect possessed a handgun at the time of the incident.

Criminal Investigations for Benefits

Veteran Sentenced for Healthcare Fraud

A veteran was sentenced to six months’ imprisonment, followed by six months of electronic monitoring during home detention, and three years’ probation. The defendant also was ordered to pay restitution of over $244,000 to VA after previously pleading guilty to healthcare fraud. An OIG and FBI investigation revealed that the defendant used an altered DD-214 to report that he had 23 years of military service, to include serving in combat during the Gulf War and Operation Iraqi Freedom. The investigation revealed that the defendant never left the United States during his two brief enlistments in the US Army Reserves. The defendant falsely claimed to various VA healthcare professionals that while serving in Iraq he was exposed to gunfire, witnessed other soldiers die, and was injured by an improvised explosive device. The defendant was subsequently awarded an 80-percent service-connected disability rating for multiple conditions, including Posttraumatic Stress Disorder, but was paid at 100 percent due to Individual Unemployability. The defendant’s former spouse was also paid over $40,000 in VA Caregiver Support Program payments.

Criminal Investigations for Other Matters

Parking Services Company Owner Pled Guilty to Wire Fraud and Conspiracy to Commit Bribery and Major Fraud against the United States

An OIG, Internal Revenue Service Criminal Investigation Division (IRS CID), and FBI investigation revealed that the defendant bribed a VA Contracting Officer (CO) with over $286,000 in cash in order to defraud VA of more than $13 million between 2003 and 2017. The defendant had entered into a sharing agreement with VA that required the defendant to pay 60 percent of the collected gross parking revenue to VA. The defendant instead paid bribes to the CO in order to continue the conspiracy even after the CO retired from VA. The defendant also underreported income and overreported improvements to VA. The defendant and his wife agreed to forfeit three condominiums in Santa Monica, with a cumulative estimated value of approximately $7.5 million; numerous high-end collectible cars, including several classic Corvettes and three Ferrari automobiles; a Cigarette “Top Gun” racing boat; bank and brokerage accounts containing more than $1 million; and over $213,000 cash seized from the defendant’s residence.
Business Owner Pled Guilty to False Statements Related to VA’s Service-Disabled Veteran-Owned Small Business Program

An OIG investigation resulted in charges that allege a veteran and another defendant conspired to defraud the government by forming a joint venture and falsely representing that the venture and another company qualified as Service-Disabled Veteran-Owned Small Businesses (SDVOSBs). The defendants fraudulently obtained approximately $11 million in VA-funded SDVOSB set-aside construction contracts or task orders. Four separate federal search warrants executed at various business locations yielded vital documents and information supporting the indictment of these defendants. As part of the guilty plea, the veteran and the government agreed to a 24-month deferment of judgment, 24 months’ supervised release, and a payment of approximately $24,400, which is the amount the veteran claimed on his tax returns as payments he received from the government contracts. The veteran also agreed not to contest any administrative action, to include suspension or debarment.

Thirty-Eight Individuals Charged in Educational Benefits Conspiracy Scheme

Five principals of a trucking school were charged with conspiracy, grand theft, identity theft, forgery, false and fraudulent claims, preparing false evidence, and engaging in criminal profiteering activity for their roles in fraudulently enrolling at least 108 veterans who never attended or received training at the school. In addition, 33 veterans were charged with conspiracy, grand theft, and false and fraudulent claims. A VA OIG, FBI, and Department of Justice OIG investigation resulted in charges that allege the school officials and veterans conspired to defraud VA of over $4.3 million between 2011 and 2015. The school received inflated, unearned tuition and fees ranging from $5,000 to $13,000 per course, while the veterans received a housing allowance and a books-and-supplies stipend totaling over $2,000 per month.

Nonveteran Business Owner Sentenced for Wire Fraud and Money Laundering Scheme Related to VA’s Service-Disabled Veteran-Owned Small Business Program

A nonveteran business owner who previously pled guilty to wire fraud and money laundering was sentenced to 24 months’ imprisonment, 36 months’ supervised release, and ordered to forfeit $640,000. A VA OIG investigation involving FBI, IRS CID, Defense Criminal Investigative Service, General Services Administration OIG, Small Business Administration OIG, US Army CID, and Naval Criminal Investigative Service revealed that the defendant recruited his service-disabled veteran father-in-law to falsely claim majority ownership in his construction company in order to fraudulently obtain SDVOSB status. As a result, this Utah-based company unlawfully obtained 11 SDVOSB set-aside contracts worth over $16.5 million, to include $1.9 million in VA contracts that the business was not entitled to receive.

Houston Business Owner Pled Guilty in Conspiracy Scheme Related to VA’s SDVOSB Program

An OIG investigation revealed that the defendant recruited a service-disabled veteran to falsely claim majority ownership in his small business in order to fraudulently obtain SDVOSB status. As a result, the defendant’s Houston-based company unlawfully obtained 12 VA set-aside contracts valued at $1.64 million.
Audits and Reviews

VA’s Compliance with the Improper Payments Elimination and Recovery Act for FY 2017
The OIG determined that VA met four of six Improper Payments Elimination and Recovery Act (IPERA) requirements for FY 2017 by publishing the Agency Financial Report (AFR), performing risk assessments, reporting improper payment estimates, and providing information on corrective action plans. VA did not fully comply with two IPERA reporting requirements as specified by the Office of Management and Budget. Specifically, VA did not report a gross improper payment rate of less than 10 percent for seven of 13 programs and activities that had an improper payment estimate in its FY 2017 AFR, and VA did not meet annual reduction targets for seven programs and activities. The OIG recommended the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) implement steps to reduce improper payments for applicable programs and activities.

The Beneficiary Travel Program, Special Mode of Transportation Eligibility and Payment Controls
The OIG assessed whether the VHA Beneficiary Travel Program authorized Special Mode of Transportation (SMT) services only for eligible beneficiaries and processed SMT vendor payments in accordance with law and policy. The OIG found VAMCs authorized SMT services for some ineligible beneficiaries, did not adequately validate some SMT vendor invoices prior to authorizing payment, and allowed some beneficiaries that used SMT services to improperly receive mileage reimbursements for the same appointments. VHA also missed an opportunity to reduce program expenditures on ambulance services by paying more than rates authorized by law for SMT services. The OIG recommended the Under Secretary for Health implement additional and more effective controls to ensure compliance with VHA policy concerning SMT eligibility determinations and improper payments, as well as implement policy to use Centers for Medicare and Medicaid Services rates, when applicable, in order to reduce unnecessary SMT expenditures.

Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact
The OIG reviewed allegations that the VBA Office of Transition, Employment, and Economic Impact (OTEEI) authorized printing services that were out of scope, resulting in an unauthorized commitment. The OIG also reviewed allegations that OTEEI misused the General Operating Expense Appropriations (GOE) to develop and maintain a dashboard and purchase IT equipment and software. The OIG made three recommendations to include taking action to remedy the unauthorized commitment, obtaining appropriate funding for all future IT costs, and making account adjustments to debit the IT account and credit the GOE account.
Healthcare Inspections

Colorectal Cancer Screening, Timely Colonoscopies, and Physician Coverage in the Intensive Care Unit at the James H. Quillen VA Medical Center

The OIG reviewed allegations of inadequate colorectal cancer screening resulting in patient deaths, timely colonoscopies, and Intensive Care Unit (ICU) physician coverage. The OIG did not substantiate that veterans were dying due to fecal immunochemical tests (FIT) rather than screening with colonoscopies and could not substantiate that a specific delay impacted a particular patient’s care. OIG staff did, however, identify deficiencies with the facility’s FIT specimen labeling, tracking, and monitoring processes. Although the OIG substantiated a lack of attending physician coverage in the ICU between March and September 2016, temporary physicians provided coverage and inconsistent coverage was resolved in February 2017. The OIG made seven recommendations related to clinical patient reviews/disclosures, tracking patients’ surveillance colonoscopies, tracking follow-up of positive FIT patients, ensuring availability of non-VA colonoscopy reports, providing a diagnostic colonoscopy after patients’ positive FITs, notifying patients to resubmit FIT specimens, and tracking the distribution of patients’ FIT kits.

Clinical and Administrative Concerns Related to the Podiatry Department at the Lexington VA Medical Center Kentucky

The OIG evaluated allegations that a podiatrist did not perform adequate examinations or provide comprehensive care; misrepresented patients’ clinical statuses; “disappeared” from the clinic and did not see patients timely; and called out on sick leave the day before clinic, inconveniencing patients and staff. The OIG did not or could not substantiate any of the allegations but made one recommendation to develop a clear action plan to resolve noted Podiatry Department work environment issues and monitor compliance to ensure patient safety.

Follow-up to Clinical and Administrative Concerns at the Cincinnati VA Medical Center

The OIG examined the adequacy of policies and practices in several areas, including the separation of clean and dirty materials in storage areas, reporting and follow-up of reusable medical equipment (RME) reprocessing errors, identification and management of Methicillin-resistant Staphylococcus aureus (MRSA) healthcare-associated infections, and recruitment and retention of nurses. The storage areas that the OIG inspected were generally clean, with clean and dirty materials stored separately. Although the facility did not have a written policy for reporting RME reprocessing errors, an appropriate process was in place. The facility’s MRSA surveillance and prevention activities appeared to be improving, as the facility did not report any new infections during the second half of FY 2017. The facility was taking reasonable steps to ensure patient care and safety when Intensive Care Unit nurse staffing was not optimal, and to improve nurse recruitment and retention through pay parity efforts. The OIG made no recommendations.
Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews are one element of the OIG's overall efforts to ensure that our 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) Long-Term Care;
(8) Women’s Health; and
(9) High-Risk Processes.

In the month of May, CHIP reviews were published for the following sites:

**VA Sierra Nevada Health Care System, Reno, Nevada**

**Cincinnati VA Medical Center, Ohio**

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

**VA Puget Sound Health Care System, Seattle, Washington**