Congressional Testimony

Inspector General Testifies before the House Veterans’ Affairs Committee on VA Hiring and Recruiting and the Value of OIG’s Staffing Report

Inspector General Missal testified before the US House of Representatives Committee on Veterans’ Affairs on June 21, 2018. The hearing focused on VA’s hiring authority and challenges regarding staff recruitment and retention. Mr. Missal discussed the findings in the June 2018 report, OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages. He explained that for the first time the report reveals the self-reported gaps in both clinical and nonclinical occupations at individual medical centers, which allows users to examine the particular needs of an individual facility as opposed to only national data. He discussed how this year’s reporting regarding nonclinical occupations (such as human resources and custodial personnel) ultimately affect the ability of Veterans Health Administration (VHA) facilities to provide quality and timely patient care in a safe environment. Drawing from the findings in the report, Mr. Missal emphasized the OIG’s repeated recommendation that VHA develop a new staffing model that identifies and prioritizes staffing needs at the national level while supporting flexibility at the facility level. He concluded that without a comprehensive staffing model that gives VHA the ability to analyze accurate data, the Department risks spending significant dollars without any measurable improvement in the quality of healthcare delivery. (See also, Healthcare Inspections section below.)

Criminal Investigations Regarding Health Care

Sales Representative Pled Guilty to Submitting False Claims

A sales representative who previously served the VA Medical Centers (VAMCs) in St. Louis, Missouri, pled guilty to making false, fictitious, or fraudulent claims. An OIG investigation revealed that from July 2012 to August 2017, the defendant submitted 220 false orders to the Jefferson Barracks VAMC that totaled more than $644,000. These orders were for drill bits and other supplies that were never requested nor received by the facility. In fact, the defendant provided false invoices to a VA employee who believed them to be legitimate based on the defendant’s long-standing history and reputation as a sales representative to the VAMC. After the VA employee processed the orders, the defendant kept the items for himself and sold what he could at flea markets. During the investigation, the defendant turned over approximately $30,000 worth of supplies that were located in his garage.
Houston, Texas, VA Medical Center Prosthetics Representative and Business Owner Indicted for Fraud Conspiracy

A Houston, Texas, VAMC Prosthetics Representative was indicted for conspiracy, wire fraud, and theft of government property, and a second defendant was indicted for conspiracy related to her co-ownership of a company that billed services to the facility’s Prosthetics Section. An OIG investigation resulted in charges that allege from January 2011 through December 2014, the defendants conspired to bill VA for false and fraudulent claims for services and then split the proceeds. The overall loss to VA is approximately $499,000.

Former Reno, Nevada, VA Medical Center Physician’s Assistant and Nonveteran Sentenced for Conspiracy to Violate the Uniform Controlled Substance Act

A former Reno, Nevada, VAMC Physician’s Assistant (PA) and a nonveteran pled guilty to conspiracy to violate the Uniform Controlled Substance Act. Both individuals were sentenced to suspended jail sentences of 34 months and 60 months’ probation. A VA OIG, Reno Police Department, and Nevada Department of Public Safety investigation revealed that the former PA used his position at the facility to write more than 100 prescriptions of narcotics for personal use. The nonveteran then assisted with the submission and retrieval of the prescriptions from various commercial pharmacies in northern Nevada.

Veteran Arrested for Making Threats Against VA Employees

A veteran was arrested based upon charges that he allegedly threatened to shoot VA employees and physically damaged government property at the Northern Arizona VA Healthcare System. A VA OIG; Federal Bureau of Investigation (FBI); Bureau of Alcohol, Tobacco, Firearms, and Explosives; and U.S. Marshals Service investigation was initiated after a VA employee reported that the subject uttered, "If I have to go home and get a weapon and come back and shoot everybody, then that is what I am going to do." The subject also allegedly attempted to throw a service kiosk across the room. After the subject departed the facility, VA employees became aware of additional threats by telephone that the subject allegedly left via voicemail.

Long Beach, California, VA Medical Center Registered Nurse Pled Guilty to Elder Abuse and Computer Access Fraud

A Long Beach, California, VAMC registered nurse was sentenced to three years’ probation and a minimum of six months in an inpatient drug treatment program after pleading guilty to elder abuse and computer access fraud. The defendant’s boyfriend pled guilty to identity theft and was sentenced to three years’ probation, six months in an inpatient drug treatment program, and 30 days of California Transportation work. An OIG and VA Police Service investigation revealed the defendant diverted Hydromorphone, Percocet, and Benadryl from the facility. The defendant tampered with at least 23 vials of Hydromorphone from the VAMC’s Omnicell medication dispensers. The FBI Laboratory subsequently found the vials to contain either Benadryl or a water-like substance. The defendant also diverted Percocet and instead gave a patient a vitamin C tablet. The defendant also brought home pharmaceuticals, supplies, and VA patient records which could have been used to commit identity theft.
Two Individuals Arrested in Connection with Drug Investigation at Northampton, Massachusetts, VA Medical Center

Two individuals were arrested for drug possession following an OIG, Drug Enforcement Administration, and Massachusetts State Police investigation into the sale of illicit drugs at and around the Northampton, Massachusetts, VAMC. This investigation was initiated after a veteran died of a suspected heroin overdose on VA property. The investigation uncovered evidence that one of the defendants sold heroin inside the facility on multiple occasions. The investigation into the veteran’s overdose death is ongoing.

Nashville, Tennessee, VA Medical Center Employee Pled Guilty to Assault

A Nashville, Tennessee, VAMC employee pled guilty to assault within the maritime or territorial jurisdiction of the United States. An OIG and VA Police Service investigation revealed that on separate occasions between approximately 2013 and 2017, the defendant inappropriately touched four female coworkers at the facility. The defendant is currently suspended indefinitely from his position at the VAMC.

Criminal Investigations Regarding Benefits

Veteran Convicted of Theft of Government Funds

A veteran was convicted of theft of government funds following a one-week trial. An OIG investigation revealed that over a 14-year time span, the defendant fraudulently received more than $538,000 in service-connected disability benefits for an eye disorder (granular corneal dystrophy). This investigation revealed that the defendant held a valid driver license, frequently drove, operated heavy machinery (tractors), and performed routine tasks such as yard work while in receipt of benefits for bilateral blindness.

Veteran and Spouse Indicted for Compensation Benefits Fraud

A veteran and his spouse were indicted and subsequently arrested for the attempt and conspiracy to commit fraud, mail fraud, and wire fraud. A VA OIG and Social Security Administration (SSA) OIG investigation also resulted in charges that alleged both defendants provided false statements to VA, SSA officials, and medical providers regarding the veteran’s ability to ambulate. The defendants allegedly conspired to lead VA and SSA to believe that the veteran was unable to ambulate without assistance or the use of supportive equipment. The veteran was surveilled on multiple occasions displaying the ability to ambulate with the full use of his lower and upper extremities. The veteran's spouse was also enrolled in the VA’s Caregiver Support Program, for which she was paid more than $500 a month. The overall loss to VA is approximately $200,000.

Nonveteran Pled Guilty to Wire Fraud

An OIG investigation revealed the defendant lived with the victim, who is a veteran, and the veteran’s son. The defendant took on the role of the veteran’s caregiver and helped the veteran apply for VA disability compensation benefits. VA subsequently granted the veteran a service-connection of 100
percent, but the defendant never informed the veteran. The defendant intercepted all mail communication from VA and kept the money for himself. The defendant had forged the veteran’s signature on U.S. Treasury checks, and subsequently switched the payment to direct deposit. The total loss was more than $114,000.

Criminal Investigations of Other Matters

Three Individuals Sentenced for Wire Fraud
The former owner of a private business, a past executive employee of that business, and a prior dean of a New Jersey university were sentenced after each pled guilty to conspiracy to commit wire fraud. A VA OIG, FBI, and Department of Education OIG investigation revealed that the defendants engaged in a conspiracy to defraud VA by fraudulently obtaining tuition assistance and other education-related benefits under the Post 9/11 GI Bill. The owner of the business was sentenced to five years’ imprisonment and three years’ supervised release. The remaining two defendants were both sentenced to three years’ probation. All three were ordered to jointly pay restitution of approximately $24.2 million, which represents the amount VA paid to the school. Both the former business owner and dean had forfeiture judgments levied against them for approximately $700,000 each.

Healthcare Executive Sentenced for Role in Workers’ Compensation Scheme
A healthcare executive was sentenced after being found guilty at trial of conspiracy, healthcare fraud, wire fraud, and money laundering relating to his and his co-defendants’ ownership and operation of multiple Office of Workers’ Compensation Program (OWCP) clinics throughout the United States. The defendant was sentenced to 19 years and five months’ incarceration, three years’ probation, and was ordered to pay restitution of approximately $14.5 million. A VA OIG, U.S. Postal Service (USPS) OIG, Department of Labor (DOL) OIG, Department of Homeland Security OIG, and Internal Revenue Service Criminal Investigation Division (IRS CID) investigation resulted in these defendants being charged with conspiring since January 2011 to bill multiple federal agencies for false and fraudulent claims and for services not rendered. The investigation also revealed that shortly after the execution of a federal search warrant on the business, two of the defendants laundered $700,000 in an attempt to conceal the money’s location from law enforcement.

Subject Pled Guilty for Office of Workers’ Compensation Programs Fraud
The defendant pled guilty to illegal involvement with a pharmacy that provided prescription medication to patients participating in DOL’s OWCP. Two additional subjects are awaiting trial relating to their participation with this scheme, and a fourth subject remains an international fugitive. A VA OIG, Department of Homeland Security OIG, USPS OIG, DOL OIG, and IRS CID investigation resulted in charges that allege the defendant was receiving kickbacks from the pharmacy. The defendant entered into an agreement with the pharmacy to receive $5,000, along with a percentage of the payments the pharmacy received from DOL OWCP. The defendant engaged a physician in Corpus Christi, Texas, to funnel prescriptions to the pharmacy. The pharmacy allegedly paid kickbacks of more than $320,600 to
the defendant in exchange for the $2 million that it received from DOL OWCP for the funneled prescriptions. The overall loss to VA is approximately $650,000.

**Three Individuals Indicted for Scheme to Defraud Incompetent Veterans**

A VA Community Residential Care (CRC) home sponsor and her adult son, along with a former CRC home sponsor, were each indicted and arrested for engaging in organized criminal activity. A VA OIG, Texas Department of Public Safety’s Criminal Investigations Division, and Texas Office of the Attorney General investigation resulted in charges that allege the defendants convinced incompetent veterans that were placed in their CRC homes to create new wills that made them the beneficiaries of the veterans’ estates. These charges further allege that the defendants defrauded the veterans’ estates of approximately $1.7 million.

**Education Institution Makes Reimbursements for Overpayments**

A school made a payment to VA of $645,185 as reimbursement for overpayments that were made from 2014 through 2016. An OIG investigation yielded evidence that this school, which was receiving GI Bill funds, engaged in discriminatory pricing by charging veterans who were 100 percent eligible for GI Bill benefits significantly more than what the school charged civilians and partially eligible veterans. One of several policy violations uncovered during the investigation also showed the school falsely certified to VA that it charged partially eligible veterans the full tuition instead of the actual reduced charges.

**Former Contract Physician Arrested on Sexual Assault Charges**

A former contract physician was arrested on charges of sexual penetration of an unconscious victim and sexual exploitation by a physician involving acts with two or more victims. A VA OIG and Medical Board of California investigation resulted in charges that allege the defendant engaged in inappropriate acts while conducting Compensation and Pension (C&P) examinations. During the investigation, several victims were identified after the case investigators contacted hundreds of female veterans about whether any inappropriate acts were performed by the defendant. In support of this investigation, a VA C&P Physician determined through an independent review that the defendant conducted examinations that exceeded standard practices, to include unnecessary pelvic examinations.

**Administrative Investigations**

**Alleged Misuse of VA Position and Resources**

The OIG investigated allegations that a senior manager at a VA medical facility abused that position and VA resources. The senior manager allegedly instructed a subordinate to provide the senior manager’s family member with additional daily Home-Based Primary Care home nursing visits as well as additional fee-basis homemaker services. More specifically, the complainant alleged that the senior manager requested these services be provided to a family member while the senior manager was on vacation. The senior manager also allegedly misused the position when instructing subordinates to waive any additional copayments for services rendered to the family member. Finally, the complainant alleged that the senior manager’s spouse acted as the senior manager’s surrogate by requesting expedited
scheduling with VA Choice Program physicians while self-identifying as the spouse of the senior manager. The OIG did not substantiate any of these allegations, so no recommendations were issued.

Audits and Reviews

VA Southern Nevada Healthcare System’s Alleged Unnecessary Use of Outside Vendors to Purchase Prosthetics

The OIG conducted a review concerning allegations that the VA Southern Nevada Healthcare System’s Prosthetics Laboratory was unnecessarily sending veterans to vendors to obtain prescribed compression garments and orthotic shoes, which resulted in the system paying higher prices for these items. The OIG substantiated this allegation and found that sending veterans to outside vendors was not justified because the system had sufficient personnel and inventory to provide the prescribed items. The OIG found that poor decision-making by laboratory employees, underutilized laboratory personnel, and unused inventory occurred because the former chief of prosthetics did not effectively monitor the laboratory’s operations. The OIG recommended that the system continue to improve its oversight and use of laboratory resources. Because the system’s previous chief of prosthetics is currently serving as the chief of prosthetics for the VA San Diego Healthcare System, the OIG made similar recommendations for that system as well.

FY 2017 Risk Assessment of VA’s Charge Card Programs

As annually required, the OIG conducted a risk assessment of the three types of charge cards used by VA—purchase cards, travel cards, and fleet cards. Based on its risk assessment of VA’s fiscal year (FY) 2017 charge card transactions, the OIG determined that VA’s purchase card program remains at medium risk of illegal, improper, or erroneous purchases. The data mining of purchase card transactions identified potential misuse of purchase cards. OIG investigations, audits, and reviews continue to identify patterns of purchase card transactions that do not comply with the Federal Acquisition Regulation or VA policies and procedures. The OIG determined that VA’s travel and fleet card programs have a low risk of illegal, improper, or erroneous purchases because these transactions represented only 3.1 percent and 0.4 percent, respectively, of the approximately $4.4 billion VA spent on charge card transactions during FY 2017.

National Healthcare Reviews

OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages FY 2018

The OIG conducted a review in response to newly established requirements in the VA Choice and Quality Employment Act of 2017 that requires the OIG to report a minimum of five clinical and five nonclinical occupations that experience the greatest staffing shortages within VA medical facilities. This year, the OIG conducted for the first time a facility-specific survey to identify particular staffing shortages. The most frequently cited shortages were in the medical officer and nurse occupations. The
OIG also found that several nonclinical occupational shortages were frequently reported (e.g., police and custodians). The most commonly cited challenges to staffing were lack of qualified applicants, noncompetitive salary, and high staff turnover. The OIG issued two recommendations concerning refining and formalizing VHA’s position categorization of clinical and nonclinical staff and ensuring it is applied across all facilities as part of a national staffing model that can be applied at the local level.

Healthcare Inspections

Alleged Mismanagement of Inpatient Care at the Colmery-O’Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas

The OIG inspected the Colmery-O’Neil VAMC in Topeka, Kansas, regarding allegations that the physicians were practicing beyond their clinical privileges and expertise, that they failed to seek assistance from specialists, and that a nurse practitioner did not have physicians’ help or supervision for the inpatient medical service. The OIG did not substantiate these allegations. The inspection did reveal that the VA Eastern Kansas Health Care System’s bylaws were not updated to reflect VA’s amended medical regulations permitting full practice authority for Advanced Practice Registered Nurses. The OIG also found the facility did not meet VHA surgical complexity requirements for surgeons or the anesthesia service. In addition, staff could not provide lists of after-hours on-call social workers, mental health staff, specialists, or radiologists. The OIG made six recommendations related to providers’ clinical privileges; bylaws updates; requirements for after-hours surgeon staffing and anesthesia service coverage; specialty care consults timeliness; on-call specialists’ availability; and emergency department specialty service coverage.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews 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) Long-Term Care;
(8) Women’s Health; and
(9) High-Risk Processes.
In the month of June, CHIP reviews were published for the following sites:

**Phoenix VA Health Care System, Phoenix, Arizona**
**VA Hudson Valley Health Care System, Montrose, New York**
**Memphis VA Medical Center, Tennessee**

To listen to the podcast on the OIG’s June 2018 activity highlights, go to [www.va.gov/oig/podcasts](http://www.va.gov/oig/podcasts).