Congressional Testimony

Inspector General Missal Testifies on Forever GI Bill Implementation Challenges Before House Veterans’ Affairs’ Subcommittees

Inspector General Missal testified at a hearing before the House Committee on Veterans’ Affairs’ Subcommittee on Economic Opportunity and Subcommittee on Technology Modernization. The hearing focused on the Department of Veterans Affairs’ (VA’s) delayed implementation of Sections 107 and 501 of the Harry W. Colmery Veterans Educational Assistance Act of 2017 (Public Law 115-48), also known as the Forever GI Bill. Mr. Missal reported that the Office of Inspector General (OIG) has continually identified systemic problems that the Veterans Benefits Administration (VBA) needs to address when implementing new initiatives and policies, including a lack of information technology system functionality, poor planning, and inadequate program leadership. These same systemic problems were a significant factor in the delays and disruptions VA experienced while implementing the housing allowances requirements in the Forever GI Bill. Mr. Missal noted that the OIG will continue to monitor VA’s implementation actions for the Forever GI Bill.

Inspector General Missal Testifies Before House Veterans’ Affairs’ Subcommittee Regarding VA’s Response to OIG Recommendations

Inspector General Missal testified before the House Committee on Veterans’ Affairs, Subcommittee on Oversight and Investigations. The hearing focused on the oversight conducted by the OIG and the Government Accountability Office. Mr. Missal discussed how OIG staff develop impactful recommendations and follow up to ensure VA satisfactorily implements them. His written statement also discussed recent reports that focus on high-risk areas like patient harm, programmatic weaknesses, and poor controls on expenditures. In response to questions, Mr. Missal discussed the common themes that underlie many OIG reports: poor governance structures, poor human resources procedures, and leadership vacancies.

The Office of Inspector General Provides Statement for the Record Concerning the Caregiver Support Program to House Veterans’ Affairs’ Subcommittee

The OIG provided a statement for the record to the House Committee on Veterans’ Affairs, Subcommittee on Technology Modernization, regarding the Caregiver Support Program. The program provides caregivers of eligible veterans with a monthly stipend payment and health insurance. The statement focused on the results of the OIG’s recent audit of the program, which found the Veterans Health Administration (VHA) did not always provide eligible veterans and their caregivers with consistent and appropriate access to the program, enrolled ineligible veterans and took too long to identify and resolve errors, did not consistently monitor enrolled veterans, and lacked effective governance for program operations. The statement also discussed forthcoming OIG follow-on work...
concerning the Caregiver Support Program, which will examine the extent to which VHA took timely and consistent action to discharge veterans and their caregivers.

Criminal Investigations Involving Health Care

**Former Sacramento, California, VA Medical Center Chief of Podiatry and Prosthetics Vendor Convicted of Healthcare Fraud and Conspiracy**

The former chief of podiatry at the Sacramento, California, VA Medical Center and a prosthetics vendor were found guilty of healthcare fraud and conspiracy following a two-week trial in the Eastern District of California. A VA OIG, Homeland Security Investigations, and VA Police Service investigation revealed that between March 2008 and February 2015, the former chief and vendor engaged in a scheme that involved billing VA for custom prescription footwear containing carbon graphite plates but instead provided veterans with inferior footwear containing preinstalled components. In addition, the former chief, the vendor, and a former employee of the vendor who separately pleaded guilty in December 2016, made materially false statements to VA regarding the manufacturing location of the shoes while applying for a national contract worth over $11 million per year. The loss to VA is approximately $2.16 million.

**Former Watertown, New York, VA Outpatient Clinic Physician Indicted on Sexual Abuse Charges**

A former VA Outpatient Clinic physician based in Watertown, New York, was indicted by a Jefferson County Grand Jury for aggravated sexual abuse, sexual abuse, and forcible touching. A VA OIG and New York State Police investigation resulted in charges alleging that the defendant sexually abused numerous active duty service members while conducting disability evaluation physical examinations as part of their service separation process.

**Former Altoona, Pennsylvania, VA Medical Center Registered Nurse Indicted for Drug Diversion**

A former Altoona, Pennsylvania, VA Medical Center registered nurse was arrested after being indicted in the Western District of Pennsylvania for acquisition of a controlled substance by means of fraud, misrepresentation, or deception. A VA OIG and VA Police Service investigation resulted in charges alleging that the defendant diverted 31 fentanyl patches (a synthetic opioid) on 29 occasions. To evade detection, the nurse allegedly diverted the patches on both work and nonwork days, a common tactic used by those who divert controlled substances.

**Defendant Sentenced for Drug Distribution at the Bedford, Massachusetts, VA Medical Center**

A defendant was sentenced in the District of Maine to 60 months’ incarceration and 48 months’ probation for his role in the distribution of crack cocaine at the Bedford, Massachusetts, VA Medical Center. This judicial action was a result of a year-long VA OIG and Drug Enforcement Administration (DEA) investigation that identified five individuals who were working together to distribute drugs to
veterans receiving addiction treatment at the medical center. The remaining four defendants were criminally charged, entered guilty pleas, and are awaiting sentencing.

**Defendant Sentenced for Drug Distribution at the Northampton, Massachusetts, VA Medical Center**

A defendant was sentenced in the District of Massachusetts to six months’ imprisonment and six years’ supervised release after previously pleading guilty to drug distribution. A VA OIG-led task force, which is supported by federal and state prosecutors and consists of law enforcement officers from the DEA and state and local departments, was formed to address a persistent drug problem and several overdose deaths that occurred at the Northampton, Massachusetts, VA Medical Center. This investigation, led by the task force, revealed that the defendant sold heroin on numerous occasions at the medical center.

**Two Defendants Indicted for Drug Distribution at the Cleveland, Ohio, VA Medical Center**

Two defendants were arrested after being indicted in the Northern District of Ohio for drug distribution resulting in serious bodily injury, conspiracy to distribute heroin and fentanyl, and use of a communications facility to facilitate a felony drug offense. An investigation by the VA OIG and the Federal Bureau of Investigation (FBI) resulted in charges alleging that the defendants sold a substance containing heroin, fentanyl, carfentanil (one of the most potent synthetic opioids), and acetyl fentanyl (another synthetic opioid) to an inpatient veteran while on the property of the Cleveland, Ohio, VA Medical Center. The veteran allegedly injected the substance directly into her peripherally inserted central catheter (or PICC line, a form of intravenous access), which resulted in a nonfatal overdose.

**Criminal Investigations Involving Benefits**

**Construction Contractor Pled Guilty for Role in Bribery Scheme**

A construction contractor pled guilty in the Eastern District of North Carolina to conspiracy to commit bribery. A VA OIG investigation revealed that the defendant’s company, which specialized in making homes more accessible for individuals with disabilities, provided over $20,000 in gratuities to a former VA employee. In exchange, the former VA employee steered construction work orders, which were funded by VA’s Specially Adapted Housing grant program and valued at more than $1 million, to the defendant’s company.

**Veteran Pled Guilty to Compensation Benefits Fraud Scheme**

A veteran pled guilty in the Northern District of Florida to theft of government funds and making false statements. An OIG investigation revealed the defendant maintained a full-time position as an auto service manager while receiving Individual Unemployability, a VA benefit reserved for veterans who demonstrate they cannot work due to their service-connected disability. The loss to VA is approximately $242,700.
Criminal Investigations Involving Other Matters

**Former Pharmaceutical Executives Convicted of Racketeer Influenced and Corrupt Organizations Act Conspiracy**

The founder and majority-owner of a pharmaceutical company and four former managers were found guilty of Racketeer Influenced and Corrupt Organizations (or RICO) Act conspiracy following a nine-week trial in the District of Massachusetts. Three other defendants previously pled guilty, including the former chief executive officer and the vice president of sales. An investigation revealed the pharmaceutical company’s upper management led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe their drug, a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. Through the creation of a reimbursement center, the defendants also conspired to mislead and defraud health insurance providers by using a variety of fraudulent reimbursement schemes to obtain payment authorizations from insurers. VA’s Civilian Health and Medical Program (CHAMPVA) paid the company approximately $3.3 million for this drug. This case was the product of a joint investigation by the VA OIG, U.S. Postal Inspection Service (USPIS), Defense Criminal Investigative Service (DCIS), Food and Drug Administration Office of Criminal Investigations (FDA OCI), Department of Labor (DOL) OIG, Health and Human Services (HHS) OIG, U.S. Postal Service OIG, Office of Personnel Management OIG, FBI, and DEA.

**Two Former Nonprofit Executives and a Former Arkansas State Senator Indicted on Conspiracy Charges**

Two former executives for a nonprofit organization and a former Arkansas state senator self-surrendered after being indicted in the Western District of Missouri for conspiracy, theft, bribery, wire and honest services fraud, and aiding and assisting false returns. A VA OIG, Internal Revenue Service Criminal Investigation, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, Medicaid Fraud Control Unit of the Missouri Attorney General’s Office, HHS OIG, DOL OIG, and FBI investigation resulted in charges alleging that the defendants conspired to unjustly enrich themselves and others through a nonprofit organization that contracted with VA to provide substance abuse counseling and housing services for veterans. As part of the conspiracy, the defendants allegedly unlawfully used the nonprofit’s funds for political contributions, excessive lobbying, and political advocacy, and paid themselves through a system of kickbacks that disguised the nature and source of the payments. To increase the supply of funds from which they could embezzle, the defendants allegedly led the nonprofit to seek out and obtain additional sources of revenue, including federal program funds, through “political outreach” that violated both law and public policy. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, to include $1.7 million contributed by VA.
Two Former Compounding Pharmacy Employees Convicted of Violating the Food, Drug, and Cosmetic Act

Two former employees of a compounding pharmacy were found guilty of violating the Food, Drug, and Cosmetic Act after a week-long trial in the District of Massachusetts. A VA OIG, USPIS, FDA OCI, FBI, and DCIS investigation revealed that the defendants routinely dispensed drugs in bulk without valid prescriptions. Specifically, the two defendants signed off on drug orders with obviously fictitious patient names such as “Flash Gordon,” “Long John,” “Filet of Fish,” and “L.L. Bean.” The compounding pharmacy was at the center of a 2012 nationwide fungal meningitis outbreak that killed 64 people and caused infections in 793 patients. Although no known VA patients died or became ill from the compounding pharmacy’s product, VA purchased approximately $516,000 of products that were produced in an unsafe manner and under unsanitary conditions. With these convictions, a total of 13 defendants, including the pharmacy’s part owner, have been convicted of 178 charges to date.

Two Defendants Indicted for Roles in Compounding Pharmacy Scheme

Two defendants were indicted and arrested in the Southern District of Florida for conspiracy to commit wire fraud, mail fraud, aggravated identity theft, conspiracy to pay kickbacks, and payment of healthcare kickbacks. A VA OIG, Army Criminal Investigative Command, DCIS, FDA OCI, and DOL Employee Benefits Security Administration investigation resulted in charges alleging that the defendants submitted false claims for compounded prescriptions to TRICARE (the Department of Defense’s healthcare program), CHAMPVA, and private insurance companies. According to the allegations, the compounded prescriptions were either fraudulently dispensed without a physician’s authorization; never dispensed; returned; or dispensed to TRICARE, CHAMPVA, and privately insured recipients without FDA approval. The overall loss to the government is approximately $18.9 million. Of this amount, the loss to VA is approximately $450,800.

Defendant Indicted for Theft by Deception and Forgery

A former employee of a nonprofit organization was arrested after being charged in Gloucester County, New Jersey, Superior Court with theft by deception and forgery. The nonprofit received grant funds under VA’s Supportive Services for Veteran Families program, which awards money to organizations that provide stable housing to veterans experiencing homelessness. Instead of using the funds for their intended purpose, a VA OIG and Gloucester County, New Jersey, Prosecutor’s Office investigation resulted in charges alleging that the defendant devised a scheme to divert the grant funds by creating false documents and dispersing funds to associates, family members, or other entities for her own benefit. The loss to VA is over $200,000.

Administrative Investigation

Alleged Improper Release of Procurement Information

The OIG received allegations that a current VA employee and the employee’s spouse, a former (retired) VA employee, improperly released VA procurement information. After interviewing the complainant’s
source, the OIG determined that the complainant’s information was hearsay and there was no direct evidence to support the allegations.

Audits and Reviews

Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package
The OIG conducted this audit to assess VHA’s oversight of VA medical centers’ migration from the Catamaran inventory management system to the Generic Inventory Package and to determine if the medical centers accurately managed expendable supply inventories. The audit found that VA medical centers encountered challenges as part of the migration and significant discrepancies existed in inventory data for expendable medical supplies. Also, inventory monitoring and management were lacking. Some of the deficiencies stemmed from the failure to provide oversight of the migration. The OIG also identified other factors including inaccurate or nonexistent inventory management practices. Recommendations included implementing controls to annotate supply item distribution, strengthening inventory documentation procedures, implementing controls to ensure storage access procedures are posted and supply item logs are complete, making certain barcode labels are affixed at item storage locations, strengthening procedures for the quality control review process, and updating quality control review documentation.

Improper Coding and Unnecessary Overtime at the Central Texas Veterans Health Care System
The OIG received allegations that a psychologist in the Central Texas Veterans Health Care System entered duplicate billing codes for group therapy sessions and received improper overtime pay. The audit substantiated that the psychologist improperly coded appointments and received about $7,700 for clinic time not spent providing direct patient care as well as more than 243 hours in unnecessary overtime pay. The OIG expanded the review to cover other psychologists in the system and found that they also entered improper codes. Coding errors occurred because the chief of psychology and the chief of health information management failed to provide proper oversight. The OIG recommended the health care system director ensure all psychologists receive medical coding training and stronger oversight, improve review of overtime hours, ensure facility hours are used to provide direct patient care, and confirm psychologists follow VHA’s scheduling policies and use approved systems.

Deferrals in the Veterans Benefits Management System
The OIG conducted this review to determine whether VBA staff properly created deferrals for disability compensation claims in its web-based electronic program and resolved the deferrals in a timely manner. A deferral allows VBA employees to return a claim to an earlier phase in the claims process for correction or additional action. Unwarranted deferrals can result in needless examination costs, delayed processing, unnecessary rework, and improper guidance to claims processors. Within the three-month OIG review period, an estimated 23,200 unwarranted deferrals occurred. The unwarranted deferrals
occurred because local and national oversight did not assess deferral accuracy, claims processors lacked feedback and accountability, guidance was unclear, and there were limitations to the Veterans Benefits Management System. VBA claims processors did generally resolve sample deferrals timely. The OIG recommended improving local and national oversight, creating internal documentation controls, update deferral guidance, and updating the deferral system with more space for documentation.

**Decision Ready Claims Program Hindered by Ineffective Planning**

The OIG conducted this review to determine whether VBA effectively planned and implemented the Decision Ready Claims (DRC) program. The DRC program was intended to streamline the processing of veterans’ claims applications by allowing veterans to work with a representative who assists in gathering evidence. VBA developed the program with a goal to complete claims within 30 days. The OIG found that VBA did not effectively plan the DRC program. By September 2018, VBA had completed only 1,803 claims. Furthermore, VBA contravened the plain language of federal statutes and regulations by obligating and expending funds before receiving claims from veterans. VBA decided to end the DRC program in February 2019. The OIG recommended the Under Secretary for Benefits work with the VA Secretary and Chief Financial Officer to determine whether any Antideficiency Act violations occurred, and, if so, take necessary actions to address these violations.

**Healthcare Inspections**

**Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California**

A healthcare inspection was conducted to evaluate allegations related to nurse staffing and inadequate supplies. The OIG did not substantiate deaths that occurred in the Emergency Department (ED) were related to insufficient nurse staffing. The OIG was unable to determine if high patient-nurse ratios caused unsafe working conditions and could not correlate adverse events with nurse staffing. The system had taken actions to improve supplies and linen availability. Quality of care concerns were noted for five patients who stayed in the ED more than four hours after a decision was made to admit. Other concerns included the coordination of care with another VA medical center and a faulty ED surveillance camera. The OIG made 10 recommendations related to ED data collection, ED patient flow and levels of care, coordination of care, root cause analyses, and a review of two patients with injuries after falls.

**Orthopedic Surgery Department and Other Concerns at the Carl T. Hayden VA Medical Center, Phoenix, Arizona**

The OIG conducted this inspection to evaluate aspects of the Orthopedic Surgery Department, including the care of specific patients, use of physician assistants (PAs), clinical privileging, and leaders’ responsiveness. The OIG substantiated care concerns related to two patients and that orthopedic surgeons were not consistently responsive to requests from PAs for assistance. The team substantiated the use of fee surgeons but did not find this problematic. The OIG did not substantiate orthopedic surgeons ignored critical patients or that facility leaders were unresponsive to concerns related to the
Orthopedic Service. The OIG determined operating room and anesthesia operations were inefficient. Additionally, the facility was not consistently compliant with VHA requirements regarding core privileges, ongoing professional practice evaluations, and PA policy and scopes of practice. Twelve recommendations were made related to two patients’ care; PA practice; and orthopedic department communications, process efficiencies, and privileging.

Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona

A healthcare inspection was conducted to assess allegations related to the inpatient mental health unit. The OIG substantiated unit staff did not consistently follow the facility’s patient safety observer policy for one-to-one care or have required training. The OIG was unable to determine whether a patient was improperly restrained because a seclusion room was not available or whether nurse staffing was adequate to meet patient care needs. While one room was closed temporarily, both seclusion rooms were available in 2018. Staffing methodology data used to determine nursing hours needed after the unit was partitioned in 2018 was not complete. The OIG noted a lack of cleanliness, patients not wearing personal clothes, and a noncompliant patient advocacy program. Seven recommendations were made related to documentation issues, the patient safety observer policy, staffing methodology, training, environment of care, and the patient advocacy program.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspections 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) Medical staff privileging;
(4) Environment of Care;
(5) Medication Management;
(6) Mental Health Care;
(7) Geriatric Care;
(8) Women’s Health; and
(9) High-Risk Processes.

Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan
Additional Publication

**Semiannual Report to Congress (SAR) October 1, 2018–March 31, 2019**

To listen to the podcast on the OIG’s May 2019 activity highlights, go to [www.va.gov/oig/podcasts](http://www.va.gov/oig/podcasts).