JUNE 2019 HIGHLIGHTS

Congressional Testimony

Inspector General Missal Testifies on OIG's Oversight of VA's Police Program before the House Veterans' Affairs' Subcommittee

Inspector General Missal testified at a hearing before the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations on June 11, 2019. The hearing focused on the Office of Inspector General (OIG) report, *Inadequate Governance of the VA Police Program at Medical* Facilities. The OIG assessed whether VA's Police Program has an effective governance structure in place, meets requirements for size and qualifications, and conducts adequate inspections to ensure compliance with policies and procedures. Mr. Missal reported that the VA failed to develop adequate threat assessments and written policies, which contributed to security vulnerabilities. Moreover, the splintering of oversight responsibilities, between Veterans Health Administration (VHA) and the Office of Security and Law Enforcement, confusion about roles, and lack of clear guidance undermines VA's well-intentioned goals and objective, which is to provide for the safety of veterans and their families, VA personnel, and visitors to VA facilities. Mr. Missal discussed the five recommendations and reported that all remained open. The OIG will continue to monitor VA's progress in implementing the recommendations.

Assistant Inspector General for Audits and Evaluations Testifies before the House Veterans' Affairs' Subcommittee on Health

Mr. Larry Reinkemeyer, Assistant Inspector General for Audits and Evaluations, testified at a hearing before the House Committee on Veterans' Affairs' Subcommittee on Health on June 19, 2019, regarding the challenges facing VHA's Emergency Pharmacy Cache Program. Mr. Reinkemeyer's testimony was drawn from the OIG report, *Emergency Cache Program: Ineffective Management Impairs Mission Readiness*. He discussed the OIG's findings, focused on VHA's failure to properly stock the caches and conduct mandatory exercises and inspections, as well as the lack of appropriate governance. The Subcommittee was provided an update regarding VHA's progress in addressing the report's recommendations.

OIG Division Director Testifies on Ensuring Access to Disability Benefits for Veteran Survivors of Military Sexual Trauma (MST)

Mr. Steve Bracci, Director of the Denver Benefits Inspections Division for the OIG Office of Audits and Evaluations, testified before the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs on June 20, 2019. The hearing focused on VA's actions to implement the recommendations in the OIG report, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma (MST)*, which found that VA incorrectly processed veterans' MST-related claims. Mr. Bracci advised that two of the six recommendations were closed, and the OIG is awaiting information on the progress of action plan implementation for the remaining four recommendations.

Inspector General Missal Testifies before the House Oversight and Reform Subcommittee on the Progress and Challenges at the Washington DC VA Medical Center

Inspector General Missal testified before the House Oversight and Reform Subcommittee on Government Operations on June 20, 2019. The hearing focused on the concerns raised by the OIG reports on *Critical Deficiencies at the Washington DC VA Medical Center* and the *Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical* Center. The subcommittee was interested in the progress and challenges with implementing the related OIG recommendations. Mr. Missal discussed why the OIG took the unusual step of issuing an interim report and spoke about the vital need for a medical center to have stable, competent leadership and adequate staffing in order to deliver quality healthcare.

Criminal Investigations Involving Health Care

Former Memphis, Tennessee, VA Medical Center Police Service Sergeant Arrested for Conflict of Interest and Wire Fraud

An OIG investigation resulted in charges alleging that a former Memphis, Tennessee, VA Medical Center Police Service sergeant created a shell security company, which she then paid for its services for area VA facilities using her government purchase card. The funds from the purchase card were allegedly laundered through an account opened by the defendant with a third-party processor and subsequently deposited into the defendant's personal bank account. The loss to VA is approximately $137,000. The defendant was subsequently arrested for conflict of interest and wire fraud.

Former Hampton, Virginia, VA Medical Center Inpatient Pled Guilty to Receipt of Child Pornography

A veteran pled guilty in the Eastern District of Virginia to receipt of child pornography. An OIG investigation revealed that while residing as an inpatient at the domiciliary at the Hampton, Virginia, VA Medical Center, the defendant used a computer belonging to his roommate to access and download child pornography.

Veteran Sentenced for Making Threats against a VA Doctor

A veteran was sentenced in the District of Arizona to time served and three years' supervised release after previously pleading guilty to threats to assault, kidnap, or murder an employee of the United States. The defendant served over 19 months in prison after being arrested in October 2017. A VA OIG investigation revealed the defendant made threatening statements towards a VA doctor during 880 calls over one weekend to Senator John McCain's office, the Tucson, Arizona, VAMC, and the White House.

Criminal Investigations Involving Benefits

Fiduciary Arrested for Compensation Benefits Fraud

A former VA-appointed fiduciary was arrested after being indicted in the Western District of Tennessee for misappropriation by fiduciaries, theft of government funds, and public health and welfare Social Security Disability Insurance benefits fraud. A VA OIG and Social Security Administration OIG investigation resulted in charges alleging the defendant obtained loans in the veteran's name, used funds from the veteran's bank accounts for his own personal expenses, and moved into the veteran's home while the veteran was in a nursing home. The loss to VA is approximately $100,000.

Criminal Investigations Involving Other Matters

Two Defendants Pled Guilty for Their Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme

An investigation revealed a veteran defendant participated in a "pass through" scheme where he falsely claimed to control the service-disabled veteran-owned small business (SDVOSB) construction company when in fact it was owned and operated by his non-veteran co-conspirator. The non-veteran defendant submitted false invoices, past performance questionnaires, and references on behalf of the company to perpetuate the conspiracy. VA awarded $118 million in set-aside contracts to the company. When the company grew too large to compete for small business contracts, the non-veteran defendant used the minority status of the veteran defendant to set up a second 8(a) certified company. The second 8(a) company was awarded an additional $11 million in set-aside contracts. The veteran owner of the SDVOSB pled guilty in the Western District of Missouri to making a false statement related to the award of $350 million in set-aside government contracts. A non-veteran owner of the same SDVOSB pled guilty to conspiracy to commit wire fraud. The investigation was conducted by the VA OIG, Department of Labor (DOL) OIG, General Services Administration OIG (GSA OIG), Internal Revenue Service Criminal Investigation (IRS-CI), Department of Agriculture OIG, Small Business Administration OIG, DOL Employee Benefits Security Administration, Army Criminal Investigation Command, and U.S. Secret Service.

Pharmaceutical Company and Subsidiary Charged with Mail Fraud

An investigation revealed the pharmaceutical company's upper managers conspired to bribe medical practitioners to unnecessarily prescribe a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees that were used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. The defendants also conspired to mislead and defraud health insurance providers by using 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. A pharmaceutical company and its subsidiary were charged in the District Court of Massachusetts with

mail fraud. As part of a global settlement, the pharmaceutical company agreed to a deferred prosecution and the subsidiary pled guilty. The pharmaceutical company agreed to pay $225 million in criminal and civil penalties. The investigation was conducted by the VA OIG, U.S. Postal Inspection Service (USPIS), Federal Bureau of Investigation (FBI), Food and Drug Administration Office of Criminal Investigations (FDA OCI), U.S. Postal Service OIG (USPS OIG), Department of Health and Human Services OIG (HHS OIG), Defense Criminal Investigative Service (DCIS), Office of Personnel Management OIG, Drug Enforcement Administration, and DOL OIG.

Defendant Pled Guilty to Conspiracy to Commit Healthcare Fraud

A joint investigation revealed the defendant submitted false claims to DOL's Office of Workers' Compensation Program (OWCP) on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, assigned inaccurate billing codes in an effort to increase the practice's OWCP reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not even performed. The defendant conspired with others to perpetuate the fraud for about six years. The loss to VA is approximately $2.9 million. A medical office administrator pled guilty in the Northern District of Texas to conspiracy to commit healthcare fraud. This was a VA OIG, Department of Justice OIG, DOL OIG, USPS OIG, and IRS-CI investigation.

Five Individuals Charged in Kickback Scheme

Three physicians and five marketers were charged via criminal information (a formal charging document) in the Northern District of Oklahoma with conspiring to pay healthcare kickbacks and healthcare fraud for their participation in a scheme to defraud multiple federal government healthcare insurance programs. An investigation resulted in charges alleging that the defendants participated in a conspiracy to fraudulently bill CHAMPVA, OWCP, Medicare, and TRICARE for compounded medications. The total loss to the federal government is approximately $4.3 million. Of this amount, the loss to VA is approximately $590,000. The VA OIG, DCIS, HHS OIG, FBI, DOL OIG, USPS OIG, and IRS-CI conducted this investigation.

Two Former Compounding Pharmacy Employees Sentenced in Drug Scheme

A joint VA OIG investigation revealed the defendants committed fraud by introducing adulterated and misbranded drugs into interstate commerce. 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, VA purchased approximately $516,000 of products that were produced in an unsafe manner. To date, 13 defendants, including the pharmacy's part-owner, have been convicted of 178 charges. A former pharmacist of a compounding pharmacy was sentenced in the District of Massachusetts to 30 months' imprisonment and one year of probation. On May 30, 2019, another former pharmacist for the same compounding pharmacy was sentenced in the District of Massachusetts to a two-year probationary period, which included eight months of home confinement. The VA OIG worked with USPIS, FDA OCI, FBI, and DCIS on this investigation.

Workers' Compensation Clinic Owner Convicted in Fraud Scheme

A workers' compensation clinic owner was found guilty by a federal jury in the Western District of Texas of healthcare fraud, wire fraud, and aggravated identity theft. A VA OIG, USPS OIG, FBI, and DOL OIG investigation revealed that between October 2012 and December 2016, the defendant charged multiple federal agencies for false and fraudulent claims of services not rendered. The defendant also used the name and physical therapy license number of another person without their knowledge to further the scheme. The overall loss to the government is approximately $6.3 million. Of this amount, the loss to VA is approximately $400,000.

Audits and Reviews

VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2018

The OIG conducted this review to determine whether VA complied with the Improper Payments Elimination and Recovery Act of 2010 (IPERA) for fiscal year (FY) 2018. IPERA requires federal agencies to review and identify programs and activities that may be susceptible to significant improper payments. IPERA requires federal inspectors general to review their agencies for compliance. In FY 2018, VA reported improper payment estimates totaling $14.73 billion. VA did not satisfy two of the six IPERA requirements. VA did not meet improper payment reduction targets for eight programs and activities. It also did not report a gross improper payment rate of less than 10 percent for seven programs and activities that had improper payment estimates in its FY 2018 Agency Financial Report. The OIG recommended taking steps to achieve reduction targets for three programs and kept five previous recommendations open.

Exempt Veterans Charged VA Home Loan Funding Fees

An OIG review determined the Veterans Benefits Administration (VBA) needed to make certain that exempt veterans did not pay VA home loan guaranty funding fees and to refund fees improperly charged to exempt veterans. Veterans receiving disability compensation do not have to pay funding fees for VA home loans. The review team estimated about 72,900 exempt veterans were charged $286.4 million in fees between 2012 and 2017. Also, VBA managers who oversee the loan guaranty program knew since October 2014 that exempt veterans may have paid funding fees. VA could owe an additional 34,400 exempt veterans refunds of $164 million over the next five years if adequate controls are not implemented. The OIG recommended VBA issues refunds to exempt veterans who paid funding fees, reviews future cases for refund eligibility, updates veteran exemption status in real time, and verifies lenders apply funding fee refunds to loan balances in a timely manner.

Inadequate Oversight of Contracted Disability Exam Cancellations

Responding to a hotline complaint, the OIG reviewed whether a VA-contracted disability medical exam provider—Medical Support Los Angeles—had the capacity to complete scheduled exams, and whether VBA staff were canceling exams initially scheduled with the provider and rescheduling them through other contractors. The OIG expanded the review to determine whether there was adequate nationwide

oversight of contracted disability exam cancellations. The OIG found that Medical Support Los Angeles failed to establish an adequate network of exam providers and, in December 2017, VBA began canceling exams scheduled with the contractor. More than 8,700 exams were canceled and rescheduled by March 2018. The OIG determined in its nationwide examination of contractors that additional VBA oversight was needed to address information systems' limitations, staffing shortages, and some VBA contracting officer's representatives lack of required qualifications.

VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract

Between March and August 2016, VA's Technology Acquisition Center (TAC) awarded the Transformation Twenty-One Total Technology Next Generation contract for information technology services. The contract has a total maximum value of $22.3 billion. The OIG conducted this audit to determine whether task orders issued under the contract were administered according to federal and VA acquisition regulations, as well as VA national and local policies and procedures. The OIG also examined whether the TAC performed task order award and modification procedures according to applicable regulations and policies and performed actions that reasonably ensured contractors could successfully complete contract requirements. While the OIG identified no violations of federal and VA acquisition regulations, the audit team found oversight weaknesses that could place information technology systems and hundreds of millions of taxpayer dollars at unnecessary risk. The OIG made seven recommendations to mitigate the control deficiencies, such as improving procedures that contracting officer's representatives and TAC contracting officers should perform.

Alleged Unapproved Acquisition of a Robotic Surgical System for the W.G. (Bill) Hefner Veterans Affairs Medical Center in Salisbury, North Carolina

The OIG conducted this review following a November 2017 anonymous complaint that the W.G. Hefner VA Medical Center located in Salisbury, North Carolina, purchased a robotic surgical system for about $2.3 million without adequate planning and approval. The complainant alleged that the purchase was made using "leftover" funds without approval, and that the purchase was unnecessary because the building was unsuitable and the medical center already had a similar, unused system purchased in 2012. The OIG substantiated that staff were permitted to order the new robotic surgical equipment using year-end spending without proper review and approval. This occurred due to an ineffective capital investment review process and weak internal controls over the ordering process within the Veterans Integrated Service Network 6. The OIG did not substantiate that the purchase was unnecessary. The OIG recommended clarifying approval requirements and ensuring the capital investment board meets annually to review requests in a timely manner.

Staffing and Vacancy Reporting under the MISSION Act of 2018

The OIG performed this review as required by the VA MISSION Act of 2018. VA has experienced chronic healthcare professional shortages since at least 2015, and the law requires annual reporting on steps taken to achieve full staffing and the additional funds needed to achieve that level. The law also

requires VA to publicly release quarterly staffing and vacancy data. The OIG found VA partially complied with the law's requirements, reporting personnel and time-to-hire data as prescribed. But VA's initial reporting of staff vacancies and employee gains and losses was not transparent enough to allow stakeholders to track VA's progress toward full staffing. VA also did not follow specifications for reporting gains and losses by quarter. The OIG recommended the Assistant Secretary for Human Resources and Administration ensure that staffing and vacancy data are reported as required, disclose limitations in the data, maintain historical data publicly, and update the methodology.

Healthcare Inspections

Alleged Complications Associated with Phototherapy at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi

A healthcare inspection was conducted to assess the care of a patient who was mistakenly treated at the facility with phototherapy for bed bugs. Two days later, the patient was hospitalized for first-degree (outer layer of skin) and second-degree (deeper layers of skin) burns. Although phototherapy is not indicated for the treatment of patients with bed bugs, a dermatology clinic registered nurse provided phototherapy to the patient for the treatment of bedbugs without a provider assessment and order. Staff improperly attributed the need for multiple actions taken throughout the patient's coordination of care to the facility's Integrated Pest Management policy that guides environmental actions. As a result of the patient's injuries, facility leaders initiated a fact-finding review but the review's charge letter was unclear regarding its confidential or non-confidential status. Confidential reviews may not be used for administrative action. Seven recommendations were made to improve the dermatology clinic nurse practice requirements, the facility's pest management policy, and ensure the completion of actions recommended by an internal review.

Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership at the VA Loma Linda Healthcare System in California

The OIG conducted an inspection at the request of Congressmen Pete Aguilar and Mark Takano related to a series of concerns regarding the environment of care (EOC), infection control (including Legionella), care provider availability, leadership responsiveness, and the dental clinic at the VA Loma Linda Healthcare System. The EOC had inconsistent levels of cleanliness and repair. Staff also lacked bloodborne pathogen and cleaning training. The OIG found inconsistent water temperatures to deter Legionella and in the notification of water testing results. The Sterile Processing Service's storage room was not consistently within temperature and humidity parameters. The facility's healthcare-associated infection rates underperformed Veterans Health Administration's national averages. Additionally, facility leaders' corrective actions to address EOC concerns were not effective. Inpatient provider availability was limited and there were mental health staff vacancy challenges. The OIG substantiated the dental clinic was not routinely cleaned, but no determination was made that there was biohazard

exposure. The OIG made 14 recommendations regarding EOC, infection control, Legionella inhibition, training, staffing, and documentation.

Alleged Deficiencies in Out of Operating Room Airway Management Processes at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System

The OIG conducted a healthcare inspection to address care and process issues for an Emergency Department patient and to examine out of operating room airway management processes (OOORAM) at the medical center in Topeka, Kansas. The OIG substantiated an Emergency Department patient suffered minor airway trauma; a provider did not document failed intubation attempts; and a provider documented a normal neurological examination for the patient. The OIG did not substantiate that the patient was inadequately sedated prior to intubation. The OIG found the facility was not in compliance with tracking competency assessments for OOORAM providers. The OIG team noted that leaders addressed OOORAM issues when they became aware of deficiencies and were working to implement new processes. The team also identified that providers' credentialing information was not consistently uploaded into a database and committee minutes lacked discussions related to resuscitative events, data analysis, and proposed improvements. The OIG made seven recommendations for improving areas such as OOORAM documentation, review of OOORAM policy, and training and competency.

Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility

A healthcare inspection was conducted to assess the alleged delay in the diagnosis of a patient's cancer at a Veterans Integrated Service Network 15 medical facility. In summer 2016, a patient had abnormal imaging results indicating possible cancer. The patient's primary care providers did not evaluate or confirm the cancer diagnosis until spring 2018. The patient completed suicide prior to treatment. The OIG identified deficiencies in the coordination of the patient's care between multiple providers, provider changes, surrogate provider assignments, and providers' and the patient's notification of imaging study abnormalities. These deficiencies contributed to the patient's delayed diagnosis. Additionally, VHA policy requires a retrospective review to conduct a root cause analysis when certain events occur. However, facility leaders conducted a proactive risk assessment of the patient's care, instead of the required root cause analysis. The OIG made eleven recommendations related to the new electronic health record, review of patient's clinical care, care provider assignments, surrogate designations, care provider and patient test results notifications, disclosures, and internal reviews.

Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities

The healthcare inspection assessed utilization of clinical pharmacists working under a scope of practice in the mental health outpatient setting. Mental health clinical pharmacists' (MHCPs') independence levels were not clearly identified by staff or facilities' bylaws. Guidance provided conflicting instructions regarding requirements for collaborating agreements and lacked provision for oversight by a specific physician. Scopes of practice also inconsistently described delegated mental health duties.

Additionally, there were insufficient processes for mental health chiefs to review and endorse MHCPs' scopes of practice. Referral processes were not clear or standardized regarding how diagnoses were conveyed to MHCPs or whether involvement of a licensed independent practitioner with prescriptive authority was considered to determine appropriateness for patients' referrals. Policies lacked guidance instructing MHCPs on when or how to refer patients to a higher level of care. The OIG made nine recommendations related to MHCP autonomy, collaboration, scopes of practice, and referral processes.

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) Geriatric Care;
(8) Women's Health; and
(9) High-Risk Processes.

Edward Hines, Jr. VA Hospital, Hines, Illinois

Jesse Brown VA Medical Center, Chicago, Illinois

To listen to the podcast on the OIG's June 2019 activity highlights, go to www.va.gov/oig/podcasts.