MARCH 2019 HIGHLIGHTS

Congressional Testimony

Inspector General Missal Testifies Before House Appropriations Subcommittee on VA Challenges

Inspector General Missal testified before the House Appropriations Subcommittee on Military Construction, Veterans Affairs (VA), and Related Agencies on March 13, 2019. The hearing focused on the OIG's extensive oversight of VA programs and operations, consistent with the OIG *Strategic Plan*. Mr. Missal also reported that the OIG is monitoring VA's implementation of several legislative mandates passed in the last Congress, as well as ongoing efforts related to the modernization of VA's electronic health records. New OIG oversight initiatives include a focus on Veterans Integrated Service Network leadership and the financial management and logistics processes in VA medical centers.

Cash Rewards Program Payments

Complainant Rewarded for Providing Key Information Leading to the Discovery of a Fraud and Bribery Scheme

A complainant was awarded $1,500 for notifying VA of suspected criminal activity by a Vocational Rehabilitation and Employment (VR&E) counselor. VA relayed the complaint to the OIG. The resulting OIG investigation revealed the VR&E counselor was involved in a fraud and bribery scheme. The counselor was receiving kickbacks from owners of three VR&E-approved education institutions for steering veterans to their schools, without regard for the veterans' educational needs or preferences. The OIG investigation also found that enrolled students rarely, if ever, received instruction from school employees and that the school's owners fraudulently obtained VR&E benefits by providing false information to VA.

Criminal Investigations Involving Health Care

Former Fayetteville, North Carolina, VA Medical Center Registered Nurse Pled Guilty to Drug Diversion Scheme

A former Fayetteville, North Carolina, VA Medical Center (VAMC) registered nurse pled guilty to acquiring possession of controlled substances by fraud, forgery, deception, and subterfuge. An OIG investigation revealed that the defendant diverted hydromorphone over four years. To advance the scheme, the defendant performed emergency overrides on the facility's Omnicell medication dispenser to withdraw the drug.

Veteran Sentenced for Drug Distribution

An OIG, Drug Enforcement Administration, and local police investigation revealed the defendant sold heroin to veterans at the West Haven, Connecticut, VAMC. The investigation was initiated in response to past illicit drug use at the VAMC, a recent drug overdose, and facility staff concerns. The defendant, who was a veteran, was given a five-year suspended sentence and three years' probation after pleading guilty to drug distribution.

Criminal Investigations Involving Benefits

Veteran and Husband Pled Guilty to Theft of Government Funds and Fraudulent Acceptance of Payments

An OIG investigation revealed that a veteran, with assistance from her husband, fraudulently led VA to believe that she was severely disabled. Based upon false statements and fraudulent documents, VA granted the highest possible disability rating to the veteran. This investigation determined that the veteran had little to no limitations and received no living assistance from her husband. The loss to VA is approximately $903,900.

Daughter of Deceased VA Beneficiary Pled Guilty to Theft of Government Funds

An OIG investigation revealed that VA continued to directly deposit monthly payments into a beneficiary's bank account after his death. The defendant acknowledged during an interview that she spent these deposited VA funds intended for her deceased father. The loss to VA is approximately $367,700.

Veteran and Wife Pled Guilty to Fraud Charges

A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendants submitted false claims to VA indicating the veteran was restricted to a wheelchair and had 100 percent loss of the use of both his arms and legs. To advance the scheme, the defendants made the same false representations to VA physicians. The wife also falsely stated she needed assistance from the veteran with feeding, bathing, driving, preparing meals, and taking her medications due to a debilitating physical condition, which resulted in SSA awarding her disability compensation. The total loss to the government is approximately $202,900, with VA's loss about $177,900.

Criminal Investigations Involving Other Matters

Five Individuals Indicted for Fraud Scheme

Five defendants were indicted for violations of wire fraud, major fraud against the United States, false claims, and conspiracy. Two additional defendants pled guilty to wire fraud and conspiracy. A joint investigation revealed the principal defendant used the financial stability of his company to "back-bond" smaller companies that were enrolled in different government contracting programs, including SBA's Service-Disabled Veteran-Owned Small Business (SDVOSB) program. The smaller companies were

awarded government contracts which were subsequently "passed" on to the principal defendant and his company. The investigation was conducted by the VA OIG, NASA OIG, Navy Criminal Investigative Service, Small Business Administration (SBA) OIG, and Defense Criminal Investigative Service. The total loss to the government is approximately $15.6 million, with the loss to VA at about $4.4 million.

Defendant Agreed to Pay $199,400 to VA to Resolve Fraud Allegations

A defendant entered into a settlement agreement with the United States for his role as the alleged owner of a SDVOSB. The defendant agreed to pay $275,000, of which VA will receive $199,400. A VA OIG, Department of Labor OIG, and SBA OIG investigation revealed that this defendant and several other defendants collaborated to create multiple fraudulent SDVOSBs in order to acquire government set-aside contracts.

Administrative Investigations

Alleged Improper Contracting within the Office of Information Security

The OIG Administrative Investigations Division followed up on an allegation that an employee in the Office of Information and Technology's Office of Information Security steered the award of two contracts (one for $43 million and a second for $47 million) to a company based on the employee's prior business relationship with a vendor's senior employee. The OIG did not substantiate those allegations and closed the matter with no recommendations for further action.

Alleged Improper Use of Personal Email and Misuse of Travel Funds

Another administrative investigation was conducted in response to an allegation that an employee within the Veterans Health Administration (VHA) National Center for Ethics in Health Care used personal email to conduct VA business for an extended period in disregard of federal law. In addition, the complainant alleged that the employee believed that the government should pay for the employee's travel home to the Northeast, even though the employee's duty station was Washington, DC. The OIG did not substantiate the allegations. The matter is considered resolved with no recommendations for further action.

Audits and Reviews

Federal Information Security Modernization Act Audit for Fiscal Year 2018

The OIG contracted with CliftonLarsonAllen LLP to assess VA's information security program in accordance with the *Federal Information Security Modernization Act of 2014* (FISMA). FISMA requires federal agencies to conduct annual reviews of their information security programs and report the results to the Department of Homeland Security. CliftonLarsonAllen LLP found that VA continues to face significant challenges complying with FISMA requirements. This report provides 28 recommendations for improving VA's information security program. Key areas for improvement include addressing an information technology material weakness previously reported and improving the deployment of

security patches, system upgrades, and system configurations. These improvements will mitigate security vulnerabilities and impose a consistent process across all field offices. CliftonLarsonAllen LLP is responsible for the findings and recommendations included in this report.

Independent Review of VA's Fiscal Year 2018 Detailed Accounting Submission to the Office of National Drug Control Policy

In accordance with the Accounting of Drug Control Funding and Performance Summary circular, federal agencies must submit to the Executive Office of the President's Office of National Drug Control Policy (ONDCP) an annual accounting of agency funds and activities related to the National Drug Control Program. Inspectors General must then evaluate the reliability of the agency's information. A previous OIG report, *Audit of VA's Financial Statements for Fiscal Years 2018 and 2017*, identified five repeat material weaknesses that persisted from previous years' reporting. CliftonLarsenAllen LLC identified two additional significant deficiencies. Beyond these identified issues, the OIG believes that the assertions in the submission of this report are fairly stated. This report is one of two OIG publications that examine VA's reporting requirements to ONDCP.

Independent Review of VA's Fiscal Year 2018 Performance Summary Report to the Office of National Drug Control Policy

ONDCP also requires federal agencies to submit annual performance-related information for National Drug Control Program activities, for which Inspectors General must evaluate the reliability. The OIG did not identify any information that caused its reviewers to believe VA lacked a system to accurately capture performance information or that the system was not properly applied to generate the performance data reported. This report is the second of two OIG publications that examine VA's reporting requirements to ONDCP.

National Healthcare Review

Review of Hepatitis C Virus Care within the Veterans Health Administration

The OIG's study of the care provided to patients with chronic hepatitis C by VHA facilities revealed that, of the patients with the disease who did not receive a curing treatment (direct-acting antivirals), VHA providers documented acceptable reasons for nontreatment for 85.5 percent of patients. The OIG found, however, that 9.6 percent of those hepatitis C-positive patients who completed the direct-acting antiviral treatment did not receive posttreatment testing to confirm they were cured. Of *all patients* who tested positive for hepatitis C antibodies, an estimated 99.1 percent received further confirmatory testing for chronic hepatitis C infection as required by policy. The OIG made two recommendations related to provider documentation for treatment considerations and posttreatment follow-up testing.

Healthcare Inspections

Review of Opioid Monitoring and Allegations Related to Opioid Prescribing Practices and Other Concerns at the Tomah VA Medical Center in Wisconsin

The OIG found that while the facility had an opioid monitoring program in place, there were opportunities to improve compliance with risk mitigation strategies. The OIG did not substantiate allegations related to leaders' failures to monitor temporary or covering providers' opioid prescribing practices and provide support, the number of opioid prescriptions, pain management consults, or provider change request restrictions. Allegations that physician assistants were being harassed and forced to write opioid prescriptions was also unsubstantiated. Interviewees reported leaders were supportive of tapering opioids, and that non-opioid pain management resources were available and encouraged. The OIG was unable to determine whether providers were combining benzodiazepine and opioid prescriptions after another provider discontinued them. The facility was recruiting for needed primary care providers and environment of care deficiencies at the Wausau Community Based Outpatient Clinic had largely been addressed. The OIG made a recommendation related to provider education and risk mitigation strategies.

Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas (VA Eastern Kansas Health Care System)

This healthcare inspection reviewed delays in a patient's diagnosis and care and the extent and causes of delays in communicating abnormal test results. It is one of three healthcare inspections in 2019 examining allegations concerning this system. Although there were delays in providers reporting radiology test results and diagnoses to patients, the OIG could not determine if the delays were due to missed "view alerts" (notifications regarding test results). There was evidence of ongoing patient evaluation and care; reviewed patients did not suffer adverse outcomes related to delays. However, the OIG found that providers failed to communicate abnormal test results within the required timeframe and that radiologists did not receive training for new national diagnostic codes or software generating view alerts. A peer review, administrative investigation, and an institutional disclosure were not performed as required. The OIG made five recommendations related to communicating test results, training radiologists, initiating a peer review, conducting an administrative investigation, and initiating an institutional disclosure.

Other Publication

Forever GI Bill: Early Implementation Challenges Issue Statement

This Issue Statement discloses information the OIG provided to members of Congress with some additional context, following a November 30, 2018, request from 12 senators and one congressman to investigate allegations that VA planned to withhold retroactive payments for missed or underpaid monthly housing stipends for students under the Forever GI Bill. The OIG found that the Veterans

Benefits Administration (VBA) failed to modify their electronic systems to make accurate housing allowance payments by the required implementation date under sections 107 and 501 of the Forever GI Bill. These sections fundamentally redesign how VBA pays monthly housing allowances to veterans using the Post-9/11 Educational Assistance Program. VA lacked an accountable official to oversee the project during most of the effort. This resulted in unclear communications and inadequately defined expectations. In November 2018, the Under Secretary for Benefits became the official responsible for implementing the Forever GI Bill.

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