MARCH 2022 HIGHLIGHTS

Congressional Testimony

Deputy Inspector General Testifies before the House Veterans' Affairs Subcommittee on Economic Opportunity

On March 16, 2022, Deputy Inspector General David Case testified before the House Veterans' Affairs Subcommittee on Economic Opportunity. He focused on the OIG's support for the provisions in draft legislation titled *Quality Education for Veterans Act of 2022*, emphasizing how the bill's provisions would help prevent fraud in VA's education and job training programs. In response to questions, Mr. Case elaborated on the potential impact of the bill and stressed how it would strengthen the OIG's efforts to detect fraud. He also referenced multiple audits examining the accuracy of payments made to veterans participating in the Post-9/11 GI Bill and Veteran Readiness and Employment programs, as well more than 200 criminal investigations since 2017 involving educational institutions accused of misconduct. Mr. Case's written statement is available on the OIG website.

Counselor to the Inspector General Testifies before the House Veterans' Affairs Subcommittee on Oversight and Investigations

Chris Wilber, Counselor to the Inspector General, testified before the House Veterans' Affairs Subcommittee on Oversight and Investigations on March 30, 2022 regarding pending legislation. He expressed the OIG's support of H.R. 6052, *Department of Veterans Affairs Office of Inspector General Training Act of 2021*, which would mandate VA employees receive one-time training on how to cooperate with and report suspected wrongdoing to the OIG. Illinois Rep. Lauren Underwood sponsored the bill. It would also enable the Inspector General to send at least two messages a year through VA's email system to all personnel on OIG matters. Mr. Wilber explained that the training needs to be codified so that the independent OIG does not need to rely on future VA secretaries to continue the requirement for new hires. He also took questions regarding the VA OIG's need for testimonial subpoena authority. Mr. Wilber's written statement is available on the OIG website.

Healthcare Investigations

Former Chief of Cardiology for the VA Palo Alto Health Care System Pleaded Guilty to Felony Abusive Sexual Contact

A VA OIG and VA Police Service investigation found that the former chief of cardiology for the VA Palo Alto Health Care System repeatedly subjected a subordinate doctor to unwanted sexual contact while on VA premises. The former chief continued to subject the subordinate doctor to this nonconsensual sexual conduct despite being told that she was not interested in a relationship with him. He pleaded guilty in the Northern District of California to abusive sexual contact.

Former Surgical Service Supervisor at the VA Medical Center in Cleveland and Medical Vendor Sentenced for Kickback Scheme

An investigation by the VA OIG and FBI revealed that a former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor. To justify the purchase of surgical implant devices from the vendor, the supervisor falsified patient records to make it appear as if patients needed the implants, but in fact they did not correlate to any actual surgical or medical procedures. In a separate scheme, he fraudulently used his VA-issued purchase card and facilitated the use of other VA employees' purchase cards to buy goods from a company that he controlled. The supervisor was sentenced in the Northern District of Ohio to 37 months in prison and ordered to pay more than $1.2 million in restitution to VA. The medical supplies vendor was sentenced to 18 months in prison and ordered to pay approximately $193,000 in restitution to VA.

Two Defendants Pleaded Guilty for Role in Healthcare Fraud Scheme

From 2014 through 2016, multiple defendants allegedly conspired to commit healthcare fraud against the government by unnecessarily prescribing and billing for compound medication through a VA vendor and a coconspirator pharmacy in New Jersey. The pharmacy received over $8 million in reimbursements through federal healthcare programs. Of this amount, CHAMPVA paid approximately $493,000. Two defendants pleaded guilty in the District of New Jersey in connection with this investigation. The VA OIG, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigation Service (DCIS), and FBI conducted the investigation.

Eight People Pleaded Guilty for Healthcare Kickbacks

A multiagency investigation revealed that two laboratories engaged in a kickback scheme involving marketers and physicians. The laboratories provided kickbacks to marketers based on a percentage of their referrals for clinical testing. These referrals resulted in billings for expensive testing services that were not medically necessary. Claims submitted to all federal programs totaled approximately $300 million. Of this amount, VA paid claims of about $165,000. Eight defendants pleaded guilty in the Northern District of Texas to conspiracy to pay and receive healthcare kickbacks. The investigation was conducted by the VA OIG, HHS OIG, DCIS, and FBI.

Business Owner Sentenced in Connection with Healthcare Fraud Conspiracy

According to a multiagency investigation, a business owner created hundreds of durable medical equipment (DME) companies and placed them in the names of straw owners, leading to the submission of over $400 million in illegal DME claims to Medicare and CHAMPVA. The defendant's coconspirators allegedly purchased physician orders for DME from "marketers" who bribed doctors to sign the orders often without ever contacting the beneficiaries. The defendant also admitted to using company funds to purchase numerous personal items that she falsely claimed as business expenditures to the Internal Revenue Service (IRS). The defendant was sentenced in the Middle District of Florida to 51 months in prison; three years of supervised release; and $10.4 million in restitution to Medicare,

$52,000 to CHAMPVA, and $48,000 to the IRS. The court also issued a final order of forfeiture against the defendant for $20.3 million. She previously pleaded guilty to conspiracy to commit healthcare fraud and filing a false tax return. The loss to VA is approximately $400,000. This investigation was conducted by the VA OIG, IRS Criminal Investigation (CI), FBI, and HHS OIG.

Psychiatrist and Office Assistant Agreed to Pay $3 Million to Resolve False Claims Act Allegations

From January 2013 to April 2021, a psychiatrist and his office assistant allegedly submitted false billings to the Department of Labor (DOL) Office of Workers' Compensation Programs, including billing for a level of service higher than what was actually provided, double-billing for initial consultations, billed for no-show appointments, and falsified treatment records to reflect the fraudulent billing during that period. The defendants entered into a civil settlement with the US Attorney's Office for the Eastern District of Pennsylvania and agreed to pay $3 million to resolve these allegations. The investigation was conducted by the VA OIG, DOL OIG, US Postal Service (USPS) OIG, and FBI.

Louisiana Doctor Pleaded Guilty in Connection with Workers' Compensation Fraud Conspiracy

A multiagency investigation found that a Louisiana doctor was paid more than $650,000 in kickbacks from a medical supply company for his purchase of topical medications, which he dispensed to his clinic's patients engaged with the Office of Workers' Compensation Program. The doctor pleaded guilty in the Western District of Arkansas to conspiracy to commit healthcare fraud, wire fraud, and illegal remunerations (taking kickbacks). The VA OIG, DOL OIG, DCIS, and USPS OIG conducted this investigation.

Former Social Worker at the Providence VA Medical Center Charged for Identity Theft Scheme

A multiagency investigation resulted in charges alleging that a former social worker at the Providence VA Medical Center in Rhode Island fraudulently claimed to be a wounded US Marine Corps veteran who was the recipient of a Purple Heart and a Bronze Star. The former social worker allegedly schemed to collect hundreds of thousands of dollars in benefits from veteran-focused charities using the personally identifiable information of an actual Marine to falsely claim she served in the Marine Corps from 2009 to 2016, achieved the rank of corporal, was wounded in action, and was honorably discharged. She also falsely claimed to have cancer due to her military service after using her position to access the VA medical records of a veteran cancer patient. This investigation was conducted by the VA OIG, Naval Criminal Investigative Service (NCIS), US Postal Inspection Service, VA Police Service, IRS CI, FBI, and DCIS.

Benefits Investigations

Veteran Pleaded Guilty for Role in Compensation Benefits Fraud Scheme

According to an investigation by the VA OIG and Social Security Administration OIG, a veteran

allegedly conspired with her father and her then husband, both of whom are also veterans, to submit fraudulent documents and misrepresent the severity of their respective disabilities to obtain VA compensation benefits. The defendant fraudulently received about $35,000 in Social Security Disability Insurance benefits for her claimed disabilities. The total loss to VA is approximately $820,000. The defendant pleaded guilty in the District of Maryland to charges of conspiracy to commit theft of government property and theft of government property.

Deceased Veteran's Son Sentenced for Theft of Government Funds

A VA OIG investigation revealed that from September 2006 until June 2018, the son of a deceased VA beneficiary repeatedly conducted withdrawals of VA survivors pension benefits from the beneficiary's bank account. The defendant was sentenced in the District of New Jersey to 14 months of home confinement, three years of probation to be served concurrent with the home confinement, and restitution of over $201,000 to VA after previously pleading guilty to theft of government funds.

Sister of Deceased Veteran Sentenced for Theft of Public Funds

From December 2006 to September 2017, the sister of a deceased VA beneficiary repeatedly conducted withdrawals of VA Dependency and Indemnity Compensation benefits from her sister's bank account. She was sentenced in the District of Massachusetts to one month of imprisonment, three years of supervised release, and restitution of over $102,000 to VA after previously pleading guilty to theft of public funds.

Veteran Arrested for False Statements

In September 2017, a veteran from Fayetteville, New York, allegedly made false statements to the Federal Aviation Administration (FAA) on a Form 8500-8, which is an application pilots submit to the FAA to renew their medical certifications. The indictment alleges that the veteran stated on the form that he had no history of criminal convictions and had never received medical disability benefits, despite having an extensive criminal record dating back several decades and having received VA service-connected disability benefits for many years. He was arrested in the Northern District of New York after previously being indicted for making false statements to the FAA on his pilot's medical certificates. This case is being investigated by the VA OIG and Department of Transportation OIG.

Investigation Involving Other Matters

Nonveteran Construction Company Owners Sentenced for Fraud Scheme

Between 2009 and 2018, a nonveteran owner of a construction company and his coconspirators allegedly controlled and operated a service-disabled veteran-owned small business (SDVOSB) that was awarded approximately $335 million in set-aside contracts, of which about $118 million was awarded by VA. When the company grew too large to compete for small business contracts, the owner and his coconspirators used the minority status of another coconspirator to set up a second company that was certified by the SBA's 8(a) Business Development Program. The second business was awarded an

additional $11 million in set-aside contracts. The nonveteran owner was sentenced in the Western District of Missouri to 28 months of incarceration, three years of supervised release, and a personal money judgment of more than $5 million after pleading guilty to defrauding the government. The owner of the second business was sentenced to 12 months of home confinement and five years of probation. The investigation was conducted by the VA OIG, DCIS, General Services Administration OIG, Small Business Administration OIG, US Army Criminal Investigation Division, Department of Agriculture OIG, IRS CI, US Secret Service, US Air Force Office of Special Investigations, NCIS, Defense Contract Audit Agency—Operations Investigative Support, DOL OIG, and DOL Employee Benefits Security Administration.

Administrative Investigations

Former Education Service Executive Violated Ethics Rules and Her Duty to Cooperate Fully with the OIG

At the request of Congress, the OIG conducted an administrative investigation to assess allegations that the former executive director of VBA's Education Service committed ethical violations arising from her spouse's consulting work for Veterans Education Success (VES). VES is a nonprofit advocacy group that regularly had business before the Education Service. As a result of the investigation, the OIG made four findings. First, the former executive director participated in Education Service matters involving VES without considering whether it raised an apparent conflict of interest and acted contrary to ethics guidance she received from her supervisors. Second, she sought résumé feedback from the president of VES to aid in her search for career advancement without considering whether this raised apparent conflict of interest concerns in subsequent VES matters. VES also endorsed her for presidential nominee positions. Third, although she provided insufficient detail about her spouse's business in 2019 and 2020 public financial disclosures, VA ethics attorneys had found them compliant. She remedied the subsequently identified deficiency in her 2021 disclosure. Finally, the OIG found that she refused to cooperate fully in the OIG's investigation by refusing to complete her follow-up interview. Her husband and VES president also refused to participate in OIG interviews, and the OIG lacks testimonial subpoena authority over individuals who are not VA employees. The former executive director resigned from VA in January 2022 and, as a result, the OIG made no recommendations. VA concurred with the OIG's findings.

Audits and Reviews

Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints

The Patient Advocacy Program helps VHA to improve customer service, support veterans' access to quality care, and resolve healthcare issues. Patient advocates document concerns, communicate resolutions, and provide follow-up and feedback. The OIG conducted this audit to determine whether

VHA patient advocates resolved about 162,000 serious complaints in its patient advocate tracking systems on time and as required in FY 2020. The audit also assessed whether program leaders used program data to identify and address pervasive healthcare issues. The audit found the program lacked adequate governance and monitoring at the local, regional, and national program levels. Moreover, patient advocates and supervisors did not always enter complaints into the tracking system. Although patient advocates generally closed serious complaints on time, they did not always adhere to documentation requirements. VA concurred with the three OIG recommendations to revise program policy, strengthen controls for record reviews, and improve program management.

Summary of Preaward Reviews of VA Federal Supply Schedule Nonpharmaceutical Proposals, Fiscal Years 2018–2020

The OIG reviewed 103 nonpharmaceutical Federal Supply Schedule (FSS) contract proposals valued annually at $10 million or more for high-tech medical equipment, $3 million or more for all other FSS contracts, $100,000 or more based on manufacturer sales under dealers or resellers, or as requested by the National Acquisition Center. These preaward reviews help contracting officers negotiate fair and reasonable prices for the government and taxpayers. This report summarizes reviews conducted in fiscal years (FYs) 2018–2020, which were not published because they contain proprietary commercial information protected from release under the Trade Secrets Act. The OIG determined commercial disclosures were accurate, complete, and current for 24 of the 103 proposals reviewed. The remaining 79 could not reliably be used for negotiations until corrected. The OIG recommended lower prices than offered for 76 proposals, resulting in the National Acquisition Center awarding contracts or modifications with cost savings of about $242.4 million.

Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened

This review examined VBA's compliance with legal requirements to reinstate disability benefits questionnaire forms from non-VA medical providers used to submit medical information for processing disability claims. The OIG also examined whether claims processors followed procedures for using the published questionnaires. VBA complied with the requirements of the law. However, disability benefits questionnaires that were incomplete, inaccurate, or of questionable authenticity from non-VA medical providers were not always processed correctly when determining benefits entitlement—causing underpayments of about $13,900 and overpayments of $74,800 over the nine months studied. Improper processing occurred because VBA lacked sufficient controls to ensure that questionnaires from non-VA medical providers were properly relied on when determining entitlement to benefits. VBA concurred with the OIG's recommendations to correct all identified processing errors, revise and update VBA's adjudication procedures manual, and ensure claims processors understand the need to document the evaluation of evidence when using publicly available disability benefits questionnaires.

Review of Allegations of Improper Maintenance at VA's Houston National Cemetery in Texas

Following a whistleblower disclosure referred from the US Office of Special Counsel, the OIG assessed allegations that the Houston National Cemetery's equipment, gravesites, and other features were not maintained as required. Although the OIG found that the cemetery was generally well maintained, some of the allegations were substantiated. Four pieces of motorized equipment were not maintained in accordance with NCA standards because cemetery staff stopped conducting routine preventive maintenance checks during the pandemic. Some gravesites were improperly maintained, and one water feature had an inoperable pump. None of the substantiated allegations at the Houston National Cemetery were pervasive issues. The OIG recommended that the cemetery director (1) revise the equipment policy to ensure that routine activities are resumed after emergencies and (2) provide an action plan to repair the gravesites. VA concurred with and has already taken action on both recommendations, with the first being closed as implemented at publication.

VA's Compliance with the VA Transparency & Trust Act of 2021

A new federal law requires VA to report to Congress how it plans to spend emergency COVID-19 relief funding, and charges the OIG with overseeing the use of that funding. The OIG's inaugural report found VA's plans generally outlined how it intended to spend the funds. However, NCA's plan included $3.6 million for a shrine project that may have violated the law because the work did not appear to be directly related to COVID-19. The OIG also identified planned use of funds that did not include a projected cost related to maintaining information technology projects. The OIG recommended the assistant secretary for management/chief financial officer consult appropriate officials to determine whether emergency funds used for the shrine project violates the law and take corrective action if necessary. He should also determine obligations for sustaining essential information technology investments, provide an updated spending plan to Congress, and include that information in future updates.

Independent Review of VA's Fiscal Year 2021 Detailed Accounting and Budget Formulation Compliance Reports to the Office of National Drug Control Policy

The OIG reviewed VHA assertions required by the Office of National Drug Control Policy in its FY 2021 detailed accounting report and budget formulation compliance report. The OIG's review was conducted in accordance with generally accepted government auditing standards, which incorporate the attestation standards established by the American Institute of Certified Public Accountants. The OIG believes this review provides a reasonable basis for its conclusion. In the detailed accounting report, VHA reported three material weaknesses, two significant deficiencies, and five matters concerning noncompliance with laws and regulations. These are identified in the OIG report, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, which is summarized above. Based on the OIG's review, except for any effects of the matters described in the preceding sentence, the OIG is not aware of any material modifications that should be made to VHA management's assertions for them to be fairly stated.

Information Technology Inspection

Inspection of Information Technology Security at the VA Financial Services Center

VA's Financial Services Center provides products and services to VA and other government agencies. The OIG inspected whether the Financial Services Center was meeting federal guidance related to configuration management, contingency planning, security management, and access controls. Within configuration management, the inspection team identified deficiencies with component inventory, vulnerability management, and flaw remediation. While the team did not identify deficiencies with contingency-planning controls, its review of security management controls identified a deficiency with system and information integrity procedures. Finally, the team identified access control deficiencies in system audit and video surveillance controls. Without these controls, VA may be placing critical systems at unnecessary risk of unauthorized access, alteration, or destruction. The OIG recommended maintaining an accurate inventory, implementing a more effective patch and vulnerability management program, developing local system and information integrity procedures, generating and forwarding audit reports for analysis, and continuing to upgrade the video surveillance system.

Healthcare Inspections

Three Reports on VA Electronic Health Record Implementation Deficiencies at the Initial Operating Site

Given the enormity of VA's 10-year, multibillion-dollar electronic health record modernization effort and its potential impact on patient safety and the quality of health care provided to veterans, the OIG released three reports in its ongoing oversight of VA's implementation of this new system. These reports focus on the system's rollout at the initial operating site. Since the October 2020 go-live event at the Mann-Grandstaff VA Medical Center in Spokane, Washington, the OIG has received wide-ranging complaints to its hotline as well as concerns from members of Congress. The following reports focus on a number of those complaints and the failings specifically found with medication management, care coordination, and the "ticketing" process for staff to request help and report problems:

- **Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington**
  Deficiencies in medication data migration and management resulted in patients having inaccurate, or incomplete medications in their records or made filling prescriptions accurately more difficult—all of which can affect patient care and safety. Areas of concern included (1) data migration, (2) medication formulary availability, (3) medication order processing, (4) provider notification and alerts, (5) controlled substance tracking, (6) prescription drug monitoring program documentation, (7) medication reconciliation, and (8) medication list accuracy.

- **Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington**
  The EHR rollout caused problems in coordinating veterans' care that ranged from the flags for patients at high risk for suicide not transferring, to both veterans and their care providers having trouble accessing video appointments and patient portal messaging. Although the OIG did not identify associated patient deaths, future deployment of the new EHR without resolving identified deficiencies could increase risks to patient safety.
- **Ticket Process Concerns and Underlying Factors after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington**
  The failures to process and respond to VHA staff ticketing requests for help, or to report concerns, resulted in issues with reporting, tracking, and resolving problems. These deficiencies made it difficult for clinicians and administrative staff to serve patients and impeded EHR fixes that can affect future sites. The inspection team also identified five causal factors contributing to the deficiencies identified in the two companion reports above: usability, training, interoperability, needed fixes, and problem resolution.

Financial Inspections

Financial Efficiency Review of the Durham VA Health Care System in North Carolina

The VA OIG assessed the Durham VA Health Care System's oversight of funds. The healthcare system had 200 obligations that were inactive for 181 days or more ($74 million). In a subsample of 20 obligations, VA staff had not reviewed 17. Without reviews, funds cannot be reobligated to support veterans. Healthcare system staff used purchase cards instead of contracts for 21 of 40 sampled transactions, which lacked required supporting documentation, resulting in $308,000 in questioned costs. The healthcare system did not conduct required quarterly audits and had 105 more administrative FTE staff than expected. Pharmacy efficiency could be improved at the healthcare system by narrowing the gap between observed and expected drug costs, decreasing turnover rates, and conducting noncontrolled drug line audits. The OIG made nine recommendations to the healthcare system director and one recommendation to the director of contracting for the VA Mid-Atlantic Health Care Network.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports 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 inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis. See the Purpose and Scope section of each report for the areas of focus at the time of the inspection.

Recently published CHIP reports include the following:

James J. Peters VA Medical Center in Bronx, New York

Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

Salem VA Medical Center in Virginia

W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina

Veterans Integrated Service Network 6: VA Mid-Atlantic Health Care Network in Durham, North Carolina

While the OIG selects and assesses specific areas of focus on a rotating basis each fiscal year, it also reviews broader issue areas, such as VHA facilities' leadership performance. The results of these evaluations are published in CHIP summary reports. One CHIP summary report was released in March:

Evaluation of Medical Staff Privileging in Veterans Health Administration Facilities, Fiscal Year 2020

This CHIP summary report provides a focused evaluation of VHA facilities' selected medical staff privileging program requirements. The report describes related findings from healthcare inspections performed at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes. The OIG reviewers evaluated meeting minutes and other relevant documents. The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with focused professional practice evaluation criteria, reprivileging decision processes, ongoing professional practice evaluations, processes for recommending continuing privileges, timely completion of and required signatures for provider exit review forms, and state licensing board reporting. The OIG issued six recommendations, including three repeat recommendations related to minimum specialty criteria for focused professional evaluations, inclusion of service-specific criteria in ongoing professional practice evaluations, and use of professional practice evaluation results in executive committee recommendations to continue licensed independent practitioners' privileges.

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