JUNE 2021 HIGHLIGHTS

Investigations Involving Health Care

Seven Defendants Indicted in Connection with Compound Pharmacy Scheme

Seven defendants were indicted in the Southern District of Texas for their roles in a healthcare fraud and kickback scheme which totaled approximately $110 million. An investigation by the VA Office of Inspector General (OIG), US Postal Service OIG, Department of Labor OIG, FBI, Department of Health and Human Services OIG, Defense Criminal Investigative Service, and Texas Health and Human Services resulted in charges alleging that the defendants conspired to fraudulently bill federal and private healthcare insurance programs for compounded medication. The loss to VA is over $2.8 million.

Virginia Businessman Sentenced in Connection with Multiple Fraud Schemes

The chief executive officer of a government service provider was sentenced in the Eastern District of Virginia to 21 months' imprisonment and three years' supervised release. Prior to sentencing, the defendant paid full restitution of approximately $349,000. An investigation by the VA OIG, Department of Homeland Security OIG, and FBI revealed that the defendant made false statements to both VA and the Federal Emergency Management Agency to obtain contracts, which were valued at approximately $38 million, to provide personal protective equipment. The defendant falsely claimed to VA and the Federal Emergency Management Agency that he possessed large quantities of personal protective equipment such as N95 masks. The defendant also electronically submitted applications containing false information for Paycheck Protection Program and Emergency Injury Disaster Loans, which resulted in his receipt of approximately $1 million in loans. The investigation also revealed that the defendant submitted a fraudulent DD Form 214 (certifying release or discharge from active duty) to VA, which falsely reflected that he served in the US Marine Corps. As a result, the defendant fraudulently received VA compensation benefits. The loss to the Small Business Administration is approximately $261,000 and the loss to VA is approximately $74,000.

Nonveteran Sentenced in Connection with Identity Theft Scheme

A nonveteran was sentenced in the Eastern District of Tennessee to 27 months' imprisonment and restitution of $25,502 after previously pleading guilty to aggravated identity theft and theft of medical services. An investigation by the VA OIG and VA Police Service revealed the defendant assumed the identity of a veteran, who was a family friend, to gain admittance to the Mountain Home VA Healthcare System in Tennessee. Further investigation revealed the defendant used the veteran's identity upon admittance to several Knoxville area hospitals that subsequently attempted to bill VA for services provided but were denied due to this investigation.

VA Employee Pleads Guilty to Video Voyeurism and Disorderly Conduct

An employee at the VA Joint Ambulatory Care Center in Pensacola, Florida, pleaded guilty in the Northern District of Florida to charges of video voyeurism and disorderly conduct. An investigation by

the VA OIG and VA Police Service revealed that on approximately 17 occasions, the defendant illegally placed a recording device that resembled a cellular phone charger in a unisex employee restroom. The defendant admitted that he placed the device in the restroom to record individuals and then later watch the footage.

Former West Haven VA Medical Center Employee Sentenced for Larceny

A former housekeeper at the West Haven VA Medical Center in Connecticut was sentenced to 90 days' imprisonment and one year of supervised release after pleading guilty to larceny. An investigation by the VA OIG, VA Police Service, and West Haven Police Department revealed that the defendant stole a box of personal protective equipment from the medical center. The defendant then resold the contents of the box, which were masks and face shields, to employees at a nearby gas station. The defendant, who retired from VA while under investigation, was sentenced in Connecticut Superior Court.

Investigations Involving Benefits

Veteran Indicted for Theft of Public Funds

A veteran was indicted in the Eastern District of Missouri for theft of public funds. A VA OIG proactive investigation resulted in charges alleging the defendant has been rated as 100 percent service-connected disabled for bilateral blindness since 2000 despite maintaining a valid driver's license. It is alleged that the veteran was observed driving nearly daily and mowing his lawn. The loss to VA is approximately $880,000.

Former VA Fiduciary and his Business Indicted for Theft of Government Funds and Misuse of Funds by a Fiduciary

A former VA-appointed fiduciary and his business were indicted in the District of South Carolina for theft of government funds and misuse of funds by a fiduciary. A VA OIG investigation resulted in charges alleging the defendants misappropriated over $315,000 in VA benefits that were intended for 13 of their veteran clients.

Former VA Fiduciary Pleads Guilty to Misappropriation

A former VA-appointed fiduciary pleaded guilty in the Western District of Pennsylvania to misappropriation by a fiduciary. A VA OIG investigation revealed that the defendant embezzled VA funds intended for his veteran brother, including over $130,000 in unauthorized money transfers, over $25,000 in ATM cash withdrawals, and numerous purchases for his own personal use. Some of the purchases included a diamond ring, a pickup truck, and two motorcycles.

Security Training School Owner Sentenced in Connection with Education Benefits Fraud Scheme

The owner of a security training school approved for VA benefits under the Vocational Rehabilitation and Employment program was sentenced in the District of Columbia to 30 months' imprisonment and restitution of $150,000. An investigation by the VA OIG and FBI revealed that the defendant obtained

funds by providing false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. The investigation revealed that enrolled veterans rarely, if ever, received instruction from school employees. The loss to VA is approximately $150,000.

Investigation Involving Other Matters

Defendant Sentenced in Connection with Workers' Compensation Fraud Scheme

A defendant was sentenced in the Northern District of Texas to over seven years' incarceration, 36 months' supervised release, and restitution of over $6 million after previously pleading guilty to conspiracy to commit healthcare fraud. An investigation by the VA OIG, Department of Labor OIG, Department of Homeland Security OIG, and US Postal Service OIG revealed that over a three-year period the defendant submitted fraudulent claims for durable medical equipment to Department of Labor's Office of Workers' Compensation Program. The total loss to the government is approximately $6 million. Of this amount, the loss to VA is approximately $2.5 million.

Audits and Reviews

Program of Comprehensive Assistance for Family Caregivers: IT System Development Challenges Affect Expansion

The Program of Comprehensive Assistance for Family Caregivers provides benefits for caregivers of eligible veterans. The VA MISSION Act of 2018 expanded program eligibility from veterans injured after 9/11 to include veterans injured in any conflict. A prerequisite to expansion is an information technology (IT) system that fully supports the program. The OIG assessed VA's efforts to implement that system. The OIG recognizes VA's efforts and challenges as millions of veterans may now be considered for the program. However, VA did not meet the act's deadlines for implementing and reporting on the system. It lacked effective governance and leadership when upgrading and replacing the legacy system. The new IT system, the Caregiver Record Management Application, was fully implemented on October 1, 2020. Although the system meets the MISSION Act requirements, VA did not establish its appropriate security risk category and fully assess privacy vulnerabilities. The OIG made four recommendations for corrective action.

Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic

The OIG assessed how effectively VA managed its emergency caches during the first wave of the COVID-19 pandemic in early 2020. These caches contain a standard supply of drugs and medical supplies, including personal protective equipment, for use during a pandemic. The review team found that only nine of 144 medical facilities activated their emergency caches from February through June 2020. Medical facility directors reported that they did not need the supplies or that the quantity was not sufficient for a pandemic. In addition, the Veterans Health Administration (VHA) changed the process

for mobilizing caches during the pandemic but did not communicate this clearly to medical facility directors. The review team also identified problems with cache maintenance and monitoring, such as expired or missing personal protective equipment and incomplete documentation on cache activations. The OIG made three recommendations to the undersecretary for health to improve the use and oversight of the emergency caches.

Review of VHA's Financial Oversight of COVID-19 Supplemental Funds

In response to the CARES Act, the OIG reviewed VHA's tracking and reporting of COVID-19 supplemental funding from pandemic relief legislation. VA met Congress and the Office of Management and Budget's monthly reporting requirements on obligations and expenditures and reported weekly to the Office of Management and Budget by program activity. The OIG noted concerns where VA's reporting was not complete and accurate, indicating internal controls weaknesses. Despite the risks identified, VA performed only a limited summary fund review of its COVID-19 obligations and expenditures before reporting. The OIG concluded the variances affected the quality of reporting. Given the inherent risks due to outdated financial information technology, the OIG recommended developing a procedure to ensure information accurately represents the underlying source transactions. This procedure would help ensure proper accounting for all COVID-19 obligations and expenditures.

Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency

The OIG reviewed how underlying human resources processes affect VA's reporting of staffing and vacancy data on its public website. In this third legally mandated report, the OIG found VA has acted to address longstanding data integrity concerns with the primary system for reported staffing and vacancy information. The OIG identified opportunities for VA to improve the transparency and governance of position data to improve the quality of reported information. The OIG also found VHA delegated much of its data reconciliation to its local facilities, which introduced variability in the process and did not allow for the consistent creation, maintenance, and verification of information. The OIG recommended validating inventory data; establishing standards to ensure positions are consistently approved, created, and maintained; and regularly monitoring position management. The OIG also recommended implementing policy and procedures for staffing level approvals and publishing detailed guidance establishing authoritative position management documents.

Medical/Surgical Prime Vendor Contract Emergency Supply Strategies Available Before the COVID-19 Pandemic

VA's demand for personal protective equipment increased dramatically during the COVID-19 pandemic. The OIG reviewed emergency contingency supply plans by the Medical/Surgical Prime Vendor-Next Generation program's prime vendors and whether medical facilities took advantage of those options. All four prime vendors developed contingency plans that included an advance-order list. Three also offered options to purchase and store medical supplies in advance. However, the OIG found none of 16 medical facilities assessed used those emergency strategies. Most facility leaders did not know those plans existed. Most facilities reported maintaining their own contingency stocks; however,

staff eventually had to buy supplies on the open market where they paid higher prices. The OIG recommended educating chief logistics officers on prime vendors' contingency plans, and ensure they understand how those plans can help mitigate supply shortages. The OIG also recommended clarifying the intent of the emergency and continuous supply provisions in the Medical/Surgical Prime Vendor-Next Generation contracts.

Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs

The OIG audited VA's annual clothing allowance benefit for veterans who use a prosthetic appliance or prescription skin medication that damages clothing and found VA generally ensured entitled veterans received their benefits. However, the OIG found that the VHA handbook needs detailed guidance on administering the benefit, including the roles, responsibilities, and functions of all staff involved. The OIG also found that some veterans may no longer meet entitlement requirements. Although most veterans are required to apply each year for benefits, those given "recurring status" are automatically renewed. If those cases were reevaluated, VA could save an estimated $129.7 million over the next five years. The OIG recommended the under secretary for health revise the VHA clothing allowance benefits.

Stronger Financial Management Practices Are Needed at VA's Maryland Health Care System

The OIG examined whether VA's Maryland Health Care System effectively managed purchases and payments for medical equipment and supplies that support patient care. The team also reviewed fiscal oversight of purchase cards and internal controls governing the use of overtime. The OIG found ineffective processes, internal control weaknesses, and inadequate oversight in five areas. VA concurred with eight OIG recommendations, including implementing controls to ensure proper equipment request submissions and documentation in the Enterprise Equipment Request portal before purchase and payment. The health care system's logistics service should also work with the prime vendor to ensure estimated supply data is timely, accurate, and meets supply requirements, and correct unit conversion errors to improve inventory accuracy. Purchase cardholders should also comply with record retention requirements and all staff should be made aware of overtime policies and procedures. Supervisors are called on to effectively monitor overtime worked and to maintain supporting documentation.

Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records

The OIG evaluated whether VA's community care staff accurately uploaded records for non-VA medical care to veterans' electronic health records. These records enable continuity of care by VHA providers and inform treatment decisions. The audit team found that the VHA medical facilities reviewed, which used community care staff to index (categorize) non-VA medical records, did not comply sufficiently with VHA requirements. Errors included using ambiguous or incorrect document titles, indexing records for non-VA care to the wrong referral or veteran, and entering duplicate records.

These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, and a lack of facility-level policies. Inaccurate indexing poses a risk to veteran care and increases the burden on the VHA staff who locate and correct the errors. The OIG made two recommendations to the under secretary for health to address the issues identified.

VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Care

VHA emergency departments measure timeliness using software that records how quickly patients move through a facility. The OIG audited this data because accurate recording is necessary to providing quality services for the 2.3 million patients receiving VA emergency care yearly. The OIG found the data were inconsistently entered and contained inaccuracies, including possible data manipulation at the Baltimore VA Medical Center in Maryland, which affected records of about 30 percent of total patient visits at that department. The OIG also found that data and evidence in health records indicated patients with the most critical needs did not always receive care on time. The OIG made five recommendations to improve oversight of VHA's emergency departments, including ensuring the Baltimore facility reevaluates its corrective action plan, ensuring staff receive training on recording triage times, strengthening reliability reviews to improve data accuracy, establishing routine oversight for data reliability, and monitoring the highest-risk patients.

Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards

The OIG audited the National Cemetery Administration's governance and oversight of the Veterans Cemetery Grants Program and whether critical noncompliance issues at two Hawaii state cemeteries were addressed. Program staff did not prioritize some grants as regulations required, but generally ensured cemeteries used grants for their intended purpose. However, the administration did not ensure cemeteries with grants met all national shrine standards for markers, maintenance, and safety. The audit team observed noncompliance issues at eight state cemeteries, including the Hilo and Makawao cemeteries in Hawaii. As a result, the National Cemetery Administration lacks assurance that veterans and family members buried in those cemeteries have been appropriately honored. The OIG made 11 recommendations to the under secretary for memorial affairs to ensure better management of state cemetery grants and veterans cemeteries. The OIG also recommended the administration continue to seek increased grant funding and work with Hawaii's government to correct longstanding problems at its eight state veteran's cemeteries.

Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk

The OIG conducted this review to determine whether VHA contracting officers complied with mandates to ensure contractors account for and return their personnel's personal identity verification (PIV) cards as required, such as at the end of a contract or employment. PIV cards are federally issued credentials used by authorized individuals to gain access to federal facilities and information systems. VHA lacked adequate internal controls to monitor whether contracting officers complied with federal PIV card

requirements for contractors' personnel. None of the reviewed contracts had sufficient evidence to demonstrate these requirements were met, mainly due to a lack of awareness of the distinct roles and responsibilities among VHA contracting staff and inadequate oversight of contracting officers. The OIG made 10 recommendations to the under secretary for health to address deficiencies related to compliance with requirements for PIV cards issued to contractors' personnel.

Information Technology Inspection

Inspection of Information Technology Security at the VA Outpatient Clinic in Austin, Texas

The OIG inspected whether the VA Outpatient Clinic in Austin, Texas, was meeting federal guidance in four areas related to configuration management, physical security, security management, and access controls. The inspection team identified security deficiencies in the clinic's configuration management controls related to component inventory and vulnerability and patch management. VA's Office of Information and Technology did not detect 150 of the 246 vulnerabilities the team identified. The team also discovered media protection deficiencies when three hard drives that potentially held personally identifiable information and personal health information were not labeled or processed for sanitization. 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, distributing the media protection standard operating procedure, and ensuring compliance with the procedure's labeling and sanitization provisions.

National Healthcare Review

Deficiencies in Emergency Preparedness for VHA Telemental Health Care at VA Clinic Locations Prior to the Pandemic

A review of 58 VHA outpatient clinics' emergency preparedness evaluated the delivery of telemental health care as of November 1, 2019. The review focused on clinic-specific emergency procedures, defined emergency procedure roles and responsibilities, staff emergency contact information, and patient safety reporting methods. This review excluded telemental health delivered in patients' homes, a preferred setting for pandemic telemental health care, and in non-VA clinic settings. The OIG identified issues related to (1) missing telehealth emergency plans and procedures; (2) emergency procedures not specific to telehealth care or the patient-clinic location; (3) lack of a process for annual updates to telehealth emergency procedures; (4) undefined emergency procedure roles and responsibilities for telehealth staff; (5) insufficient emergency contact information; (6) lack of a process to verify and communicate emergency contact information; and (7) lack of a consistent process to designate the telehealth setting in patient safety reporting methods. Five recommendations were made.

Healthcare Inspections

Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

A healthcare inspection assessed and substantiated allegations that former pathologist, Dr. Robert Levy, misdiagnosed specimens and altered quality data. Pursuant to a criminal investigation by the OIG, Dr. Levy was sentenced to 20 years in prison. After reviewing Dr. Levy's almost 34,000 cases, clinicians identified more than 3,000 errors including 34 that required disclosure to patients. Errors occurred because Dr. Levy, a self-admitted alcoholic, subverted quality processes that facility leaders did not detect, signs of impairment were unaddressed, and facility culture did not support reporting impaired behaviors. Ten recommendations were made to the under secretary for health related to competency and pathology quality processes, pathology reports, and consulting with external pathologists. Other recommendations addressed consulting with legal and human resources staff about administrative actions, alcohol testing, and management of impaired healthcare workers. Two recommendations to the facility director addressed peer references during reappraisal and evaluation of the facility's safety climate.

Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida

The OIG assessed allegations that a patient's care was delayed and mismanaged in the facility's emergency department resulting in the patient's death and complaints of inadequate emergency department nurse staffing levels. The OIG did not identify pandemic-related scheduling and quality deficiencies in the patient's surgical care. The OIG substantiated deficient and mismanaged emergency department care, which may have resulted in a delay in care. The OIG was unable to determine if more expeditious care would have affected the patient's mortality. The OIG found that the facility did not have a policy that prohibited Emergency Severity Index 2 patients from remaining in the waiting room, which conflicted with guidance from the Emergency Nurses Association. The OIG did not substantiate inadequate levels of nursing staff in the emergency department during the week of the patient's death or that facility leaders received complaints. The OIG made two recommendations.

Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens

The healthcare inspection assessed an allegation that improper feeding at the New York Harbor Health Care System's Community Living Center contributed to a patient's death. The OIG substantiated that improper feeding during lunch by a registered nurse contributed to the patient's death. Approximately five hours after being fed lunch, a piece of chicken was removed from the patient's airway during intubation. The OIG was unable to determine the exact size of the chicken but concluded that the piece of chicken was larger than appropriate to feed to the patient. The Cardiopulmonary Resuscitation Subcommittee completed an insufficient review of the code. No staff member submitted an incident report, and while a clinical disclosure was completed, an institutional disclosure was not. The OIG made seven recommendations to the facility director related to nursing competencies and training,

documentation, review of the patient's care, committee oversight, incident reports, and institutional disclosure.

Traumatic Brain Injury Services and Leaders' Oversight at the Southeast Louisiana Veterans Health Care System in New Orleans

The OIG conducted an inspection to assess allegations that clinicians failed to adequately evaluate and treat Traumatic Brain Injury (TBI) for patients who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn. The OIG did not substantiate the allegations. The OIG reviewed data from the VHA Support Service Center and found the facility screening rate generally met or exceeded VHA's national benchmark. The OIG independently reviewed 327 electronic health records to determine if patients who had a positive initial TBI screen received a timely comprehensive evaluation and if clinical services were initiated, if indicated. Clinical services were indicated for 96.69 percent of patients who received a TBI diagnosis and were initiated for 92.57 percent. The OIG found that care plans were thorough and found several areas in which facility staff exceeded VHA standards. The OIG did not identify any adverse clinical outcomes. The OIG made no recommendations.

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 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. Recently published CHIP reports include:

Battle Creek VA Medical Center in Michigan

VA Northern Indiana Health Care System in Marion

John D. Dingell VA Medical Center in Detroit, Michigan

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