DECEMBER 2021 HIGHLIGHTS

Healthcare Investigations

Former VA Purchasing Agent Sentenced for Theft of Medical Products

From 2013 to 2021, a former purchasing agent for the VA community-based outpatient clinic in Fort McPherson, Georgia, used his government purchase card to make hundreds of unauthorized purchases of continuous positive airway pressure (CPAP) supplies, which he stole and then resold for profit. The VA OIG investigated the matter, and the former purchasing agent was sentenced in the Northern District of Georgia to 27 months' imprisonment, 36 months' supervised release, and restitution of $2 million.

Former VA Employee Sentenced for Theft of Government Funds

According to an investigation by the VA OIG, from October 2015 through April 2020, a veteran made numerous false statements to VA indicating that he was unemployed and in need of a full-time caregiver. During this same time frame, the defendant worked full-time as a veteran service representative at the VA regional office in San Diego, California. The defendant was sentenced in the Southern District of California to eight months' imprisonment, three years' supervised release, and restitution of approximately $183,000 after previously pleading guilty to theft of government funds.

Former Shuttle Driver at the Omaha VA Medical Center Sentenced for Threatening VA Employees

A VA OIG investigation revealed that a former shuttle driver at the VA medical center in Omaha, Nebraska, described to multiple VA medical officials a detailed plan to gather her weapons—including an Uzi, AR-15 rifle, sawed-off shotgun, and Glock 9 mm handgun—and then drive to the facility to shoot and kill two coworkers and her supervisor. The defendant, who was detained for 14 months prior to sentencing, previously pleaded guilty to influencing, impeding, or retaliating against a federal official by threats. The defendant was sentenced in the District of Nebraska to 12 months' imprisonment (time served) and three years' supervised release with conditions related to mental health treatment, substance abuse treatment, and restricted weapons possession.

Benefits Investigations

Veteran Found Guilty of Theft of Government Funds and False Statements

A VA OIG investigation resulted in charges alleging that a veteran fraudulently led VA to believe he was blind. The defendant, who had been receiving 100 percent service-connected disability benefits since June 2011, falsely stated to VA that he was unable to drive and had someone drive for him. Despite these claims, the defendant possessed a valid driver's license with a motorcycle endorsement and drove on a routine basis. He was found guilty by a federal jury in the Middle District of Florida on charges of theft of government property and false statements. The loss to VA is about $430,000.

Rooming House Operator Indicted in Connection with Theft Scheme

From March 2009 to February 2020, a District of Columbia rooming house operator used VA and Social Security Administration (SSA) benefit funds intended for the care of elderly, mentally ill, disabled, and veteran beneficiaries for her own personal use. The defendant was arrested on charges of mail fraud, wire fraud, theft of government property, aggravated identity theft, first-degree theft, representative payee fraud, making a false statement, and tampering with documents. The scheme resulted in the theft of more than $400,000 in government benefits from tenants of her rooming house, including at least $170,000 in VA funds. The investigation was conducted by the VA OIG, SSA OIG, and the Special Inspector General for the Troubled Asset Relief Program.

Attorney Found Guilty of Loan Fraud

According to a multiagency investigation, a licensed attorney fraudulently applied for over $8 million in loans from five financial institutions, laundered money, and made material misrepresentations during bankruptcy proceedings between 2015 and 2018. To obtain loans from the financial institutions, the attorney provided banks with misleading documents that suggested that he was operating a lucrative law firm. The law firm's purported income was based on bogus, unpaid invoices the firm submitted to entities that the attorney controlled, including bankrupt entities. The fraudulent loans included a VA-guaranteed loan for $2.9 million. The attorney was found guilty of bank fraud, wire fraud, money laundering, and making misrepresentations during bankruptcy proceedings after a two-week bench trial in the District of New Hampshire. The VA OIG, FBI, and Small Business Administration OIG conducted the investigation.

Veteran Found Guilty of Threatening a Federal Employee

An investigation by the VA OIG and VA Police Service revealed that on multiple occasions a veteran threatened to inflict serious physical harm on a Veterans Benefits Administration (VBA) fiduciary supervisor because VA was reviewing the veteran's ability to handle his own financial affairs. The veteran was found guilty by a federal jury in the Northern District of Ohio of threatening a federal employee and acquitted of assault of an officer.

Investigations Involving Other Matters

Four Defendants Sentenced for False Surety Bond Conspiracy

From March to December 2015, four individuals provided federal, state, and local government agencies and private construction companies with worthless surety bonds by using nonexistent assets (land, trusts, and gold) to back the bonds. The defendants collected nearly $6 million in fees for the fraudulent bonds from the government and private contractors. Over $1 billion of government and private construction projects were at risk of default due to this scheme, potentially leaving the government and private entities financially responsible for the total amount of the contracts. The contracts included construction projects at VA medical centers and national cemeteries, Department of Defense military bases, and vital public infrastructure, such as housing projects, major bridges, and dams. The defendants were

collectively sentenced to 196 months' incarceration in the Southern District of Florida. Each defendant was also sentenced to 36 months' supervised release and ordered to jointly pay restitution of $2.6 million and forfeiture of $1.2 million. The investigation was conducted by the VA OIG and the Environmental Protection Agency OIG.

Former Federal Contractor Guilty of Wire Fraud and Aggravated Identity Theft

A multiagency investigation found that a former federal contractor obtained federal contracts while he was debarred from practicing and posed as a federal contracting officer to negotiate fraudulent contracts with victim companies. The scheme resulted in losses of approximately $2.4 million in government funds, of which about $800,000 was awarded by VA. The defendant pleaded guilty in the Eastern District of Washington to wire fraud and aggravated identity theft. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, Army Criminal Investigation Command Major Procurement Fraud Unit, General Services Administration OIG, Department of Justice OIG, Department of State OIG, Air Force Office of Special Investigations, and Naval Criminal Investigative Service.

Audits and Reviews

VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements

The Federal Risk and Authorization Management Program (FedRAMP) standardizes security and risk assessment for cloud technologies for federal agencies, including VA. In April 2019, the OIG received allegations that the VA Office of Information and Technology's (OIT) Project Special Forces (PSF) was not following FedRAMP policies for software-as-a-service applications. The OIG found that OIT authorized some applications without FedRAMP authorization and that PSF did not follow security requirements in developing interfaces. This noncompliance occurred for two reasons: (1) OIT had not fully implemented a formal process for granting the authority to operate until April 2019, and (2) OIT staff misunderstood the FedRAMP authorization requirements for applications containing data classified as less sensitive. Failure to comply with FedRAMP standards increases the risk that VA and veterans' data could be compromised. The OIG made two recommendations to address the applications without federal authorization and two recommendations to ensure that PSF improves security controls and documentation. VA concurred with all recommendations.

Systems and Tools Implemented to Track COVID-19 Vaccine Data

The OIG examined whether the Veterans Health Administration (VHA) effectively implemented systems to report on COVID-19 vaccine supply to VA medical facilities and doses administered to VA employees and veterans enrolled in VA's healthcare system. The team determined that facility-level vaccine supply data, which are manually entered, were not verified and vaccination data in key systems contained inaccuracies due to inadequate validation and user error. The team also found that some VHA staff initially lacked system access to enter employee vaccination data and the VHA COVID-19 vaccine dashboard contained unvalidated data. Accurate data are needed to schedule COVID-19 vaccinations,

report the percentages of vaccinated veterans and employees to the Centers for Disease Control and Prevention, and help prevent COVID-19 vaccine theft. The OIG made three recommendations: verify medical facility vaccine supply data; monitor and minimize data entry errors; and ensure the dashboard data are reliable, accurate, and complete.

VHA Risks Overpaying Community Care Providers for Evaluation and Management Services

This review examined the risk of VHA improperly paying non-VA healthcare providers for evaluation and management services not supported by medical documentation. The review team found that some providers billed VA at a significantly higher rate than their peers for high-level evaluation and management services. In addition, some providers billed separately for evaluation and management services during periods when the global surgery package was in effect. This package is supposed to cover all surgery-related services for a set period. The OIG determined VHA risked overpaying for evaluation and management services by about $19.9 million in fiscal year (FY) 2020. The OIG made two recommendations to the undersecretary for health related to (1) reviewing medical documentation for evaluation and management services billed by non-VA providers and then developing processes to act on the review results, and (2) ensuring non-VA providers receive continuing education materials on proper medical documentation for these services.

VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services

The OIG evaluated whether VHA paid for non-VA acupuncture and chiropractic care that was not authorized or supported by medical documentation, and whether VHA followed guidance for reauthorizing care. The team found that VHA paid for care that was not authorized, including for more visits than allowed and for treatment codes that deviate from established standards for care. In addition, VHA paid for acupuncture and chiropractic services that were not appropriately supported by medical documentation. The audit team estimated that improper payments for acupuncture and chiropractic care amounted to about $136.7 million during FYs 2018 and 2019. The OIG made six recommendations to the under secretary for health related to adding automated payment system controls, auditing the payment process, retrospectively auditing non-VA medical documentation, making continuing education material related to medical documentation available to non-VA providers, following the Office of Community Care's field guidebook, and documenting clinical justification for non-VA care.

Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits

VBA provides monthly benefits to veterans with disabilities caused by diseases or injuries incurred or aggravated during active military service. Special monthly compensation (SMC) pays additional benefits, such as housebound entitlement, for certain disabilities or a combination of disabilities. In September 2016, the OIG found that VBA incorrectly processed about 27 percent of high-risk housebound SMC cases. The OIG conducted this review to determine whether VBA implemented the OIG's 2016 recommendations to address those processing errors. VBA continues to have the same

estimated error rate, resulting in about $165 million in improper payments. Without improving oversight, accountability, and monitoring, VBA risks wasting taxpayer dollars and potentially subjecting veterans to repay overpayments. The OIG recommended that VBA review active high-risk housebound cases and conduct ongoing reviews, update and monitor SMC housebound training, ensure system enhancements are created and cannot be bypassed, and correct all processing errors identified in this review.

Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains

The OIG examined whether VA has an effective governance structure for ensuring deceased veterans' unclaimed remains are interred with dignity. The review was initiated after reports of deceased veterans' unclaimed remains being stored in a funeral home for decades. The review revealed significant deficiencies. VA had insufficient outreach to likely custodians of unclaimed veterans' remains and failed to fully engage entities with databases that could help locate them. Also, no single office or executive was responsible for overseeing the more than two dozen offices providing related benefits and services. As a result, VA does not have an accurate count of veterans whose remains are unclaimed. Moreover, the financial structure did not support cross-administration accounting—increasing the potential for fraud and duplicate benefit payments. Remains that are unidentified could be placed in mass graves or stored for years unnoticed. The OIG made 11 recommendations to address the issues identified.

Inadequate Oversight of VHA's Home Oxygen Program

VHA uses contractors to provide oxygen services to veterans who need respiratory care in their homes. The OIG examined whether VHA's oversight of the home oxygen program ensured patients received reevaluations of their need for home oxygen, home visits were conducted as required, contractor performance was monitored, and invoicing and payments were checked for accuracy. The OIG found that prescribing providers did not always reevaluate home oxygen patients within prescribed timelines and medical facility staff did not always conduct home visits for the required number of patients. In addition, monitoring by contracting officers and their representatives was inadequate due to a lack of oversight and differing interpretations of guidance. Payments, however, were generally processed accurately. The team also found that VHA paid for services using expired contracts for two facilities. The OIG made six recommendations to the under secretary for health for corrective action.

MISSION Act Market Assessments Contain Inaccurate Specialty Care Workload Data

The OIG audited the accuracy of data measuring VA's specialty healthcare capacity. As required by the MISSION Act, VHA will use the data to identify gaps in furnishing care and implement recommendations for modernizing or realigning VA facilities. The audit examined the accuracy of three data components: workload, wait times, and providers' clinical time allocations. The OIG concluded that only the workload data inaccuracies were significant enough to affect potential management decisions. VHA's reported FY 2019 workload for 12 specialties across all VA care providers was found to be overstated by 10.7 percent, or about 563 full-time equivalent physician positions. This overstatement could result in the waste of taxpayer dollars and diminish access to care for some veterans. The OIG

recommended that the acting under secretary for health perform additional analyses to ensure materially accurate data are used for implementing recommendations regarding facility modernization.

Healthcare Inspections

Deficiencies in Disclosures and Quality Processes for Perforations Resulting from Urological Surgeries at West Palm Beach VA Medical Center in Florida

The OIG conducted a healthcare inspection in response to an allegation that a urologist perforated two patients' organs during procedures. The OIG substantiated the allegation and found that facility leaders took reasonable actions based on the results of management reviews. The inspection also identified deficiencies in disclosures, quality reviews, timeliness of management reviews, and the process for delineating urologists' privileges. The urologist did not complete clinical disclosures as required, and institutional disclosures were not considered. Adverse events were not reported to the patient safety manager. The surgical workgroup did not provide oversight of surgical service morbidity and mortality conferences. A planned peer review was not completed, and management reviews were delayed. The OIG found that the form used to delineate privileges for urologists was not subjected to a required annual review for appropriateness of available privileges. The OIG made seven recommendations.

Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma Health Care System in Muskogee

This healthcare inspection was the result of an allegation from a patient who sought help with gastrointestinal symptoms at the facility three times in 2020 and was allegedly sent away. The patient was diagnosed with colorectal cancer in early 2021 at a non-VA hospital. The OIG did not substantiate that the patient was sent away three times. However, there was no documented evidence that the fecal immunochemical test (FIT) was mailed to or discussed with the patient. An emergency department physician failed to perform a digital rectal examination when the patient's presentation included having blood in the stool. Facility staff did not adequately review and respond to the patient's complaints. In addition, leaders did not fully respond to complaints about the emergency department physician. The OIG made four recommendations to the facility director related to FITs, emergency department providers' physical examinations, patient complaints, and emergency department physician-related complaints.

Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas

The OIG assessed an allegation that the facility failed to diagnose and treat a patient's cancer. The OIG substantiated this allegation and found that pulmonary staff did not follow up and primary care providers did not ensure completion of annual lung cancer screening. Primary care providers did not follow up after a renal nodule had increased in size, and the patient did not have prostate cancer recurrence surveillance. One primary care provider delayed ordering an oncology consult, improperly copied and

pasted documentation, and did not document an assessment of the patient's lung nodules. Facility staff documented resolution of a family member's complaint despite not contacting the family. The OIG made five recommendations to the facility director related to lung cancer screening and follow-up care, abnormal radiology finding follow-up, patient surveillance after prostatectomy, documentation, and complaint responses.

Financial Inspections

Financial Efficiency Review of the Eastern Oklahoma VA Health Care System

The OIG assessed the oversight and stewardship of funds and identified opportunities for cost efficiency at the Eastern Oklahoma VA Health Care System. The team focused on four areas: (1) the system's review of open obligations for goods and services to determine whether they were still valid and necessary; (2) use of purchase cards, such as requirements for documenting transactions; (3) the number of administrative staff compared to similar facilities and the accurate recording of labor costs; and (4) efficiency in pharmacy operations, such as inventory management and the healthcare system's efforts to reduce costs. The OIG made nine recommendations for improving cost efficiency. The number of recommendations should not be used, however, to gauge the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations in the areas reviewed.

Financial Efficiency Review of the Marion VA Medical Center in Illinois

This financial inspection assessed the oversight and stewardship of funds and identified opportunities for cost efficiency at the Marion VA Medical Center in Illinois. The review also focused on four areas: (1) use of the Medical/Surgical Prime Vendor–Next Generation program, a collection of contracts that streamlines purchasing for certain medical supplies; (2) use of purchase cards, including documentation; (3) open obligations for goods and services to determine whether they were still valid and necessary; and (4) efficiency in pharmacy operations. The OIG made eight recommendations for improvement.

Management Advisory Memorandum

Review of SES Reassignments in the Veterans Benefits Administration

The OIG reviewed the reassignments of two executive directors in VBA to determine whether VA's policies and procedures were followed for determining the directors' eligibility for relocation allowances. The OIG found nothing improper with the allowances paid to the two executive directors. There were, however, inconsistencies in VA's guidance found during the course of the review regarding the approval of relocation allowances. The OIG issued a VA management advisory memorandum to share observations from its review. No additional steps were taken, including any further reporting on the examination of the two executive directors' circumstances, as no wrongdoing or violation of law or policy was identified. The Office of Human Resources and Administration was asked to inform the OIG of what action, if any, it takes to address the issues identified.

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 the OIG's current areas of focus:

- COVID-19 pandemic readiness and response
- Quality, safety, and value
- Registered nurse credentialing
- Medication management (targeting remdesivir use)
- Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
- Care coordination (spotlighting interfacility transfers)
- High-risk processes (examining the management of disruptive and violent behavior)

There were two published CHIP reports in December:

Fayetteville VA Coastal Health Care System in North Carolina

Hampton VA Medical Center in Virginia

While the OIG selects and assesses specific areas of focus on a rotating basis each fiscal year, it also reviews broader issue areas. These include VHA facilities' leadership performance and organizational risks as well as women's health care. These focus areas are consistent with the OIG's charge under the Caregivers and Veterans Omnibus Health Services Act of 2010 to provide oversight of patient care quality and safety to leaders at the national, network, and facility levels. These leaders are directly accountable for program integration and communication within their level of responsibility. The results of these evaluations are published in CHIP summary reports. Two CHIP summary reports were also released in December:

Evaluation of Leadership and Organizational Risks in Veterans Health Administration Facilities, Fiscal Year 2020

Evaluation of Women's Health Care in Veterans Health Administration Facilities, Fiscal Year 2020

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based clinics that provide a wide range of psychosocial services to clients, including eligible veterans, active-duty service members, National Guard members, reservists, and their families. These centers help support a successful transition from military to civilian life. The following are the OIG's current inspection areas of focus:

- Leadership and organizational risks
- Quality reviews
- COVID-19 response
- Suicide prevention
- Consultation, supervision, and training
- Environment of care

Two VCIP reports were recently published:

Continental District 4 Zone 1 and Selected Vet Centers

This VCIP report focused on four randomly selected vet centers within: Casper, Wyoming; Denver, Colorado; and El Paso and Midland in Texas.

Vet Center Inspection of Pacific District 5 Zone 2 and Selected Vet Centers

This VCIP report focused on four randomly selected vet centers: Fresno, High Desert, and Santa Cruz County in California, and Honolulu, Hawaii.

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