APRIL 2022 HIGHLIGHTS

Congressional Testimony

Deputy Inspector General Testifies on the Electronic Health Records Modernization Program before the House Veterans Affairs' Subcommittee on Technology Modernization

Deputy Inspector General David Case testified before the House Veterans Affairs' Subcommittee on Technology Modernization on April 26, 2022. His testimony focused on VA's progress deploying the new patient electronic health record. He highlighted the OIG's recent reports on issues regarding the user and veteran experience at the Mann-Grandstaff VA Medical Center (the initial operating site) in Spokane, Washington. He also spotlighted the overall program's lack of a reliable implementation schedule that makes VA vulnerable to annual cost overruns of nearly $2 billion. Deputy Inspector General Case answered questions about the medication management challenges that VA staff have faced; significant training deficiencies, which led system users feeling unprepared at deployment; how the OIG defines patient harm for oversight purposes; and the need for VA to develop an integrated master schedule that identifies all work to be done, accounts for infrastructure upgrades and improved training, and includes a risk assessment. The written statement is available on the OIG website.

Healthcare Investigations

Medical Group Agreed to Pay $24.5 Million to Resolve False Claims Act Allegations

A multiagency investigation resolved allegations that a medical group billed federal healthcare programs for unnecessary medical services and testing, including urinary drug tests, telemedicine visits, and genetic and psychological tests. The medical group also allegedly made unlawful remunerations to its physician employees in violation of the Stark Law and made a false statement in connection with a loan obtained through the Small Business Administration's Paycheck Protection Program. The group entered into a civil agreement in the Middle District of Florida under which they will pay $24.5 million to resolve allegations that the group violated the False Claims Act. Of this amount, VA will receive close to $780,000. The VA OIG, Department of Labor (DOL) OIG, Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), and Office of Personnel Management OIG conducted the investigation.

Pharmacist-in-Charge and Pharmacy Technology Director Sentenced in Connection with Healthcare Fraud Scheme

According to a multiagency investigation, multiple individuals participated in a scheme to fraudulently bill compounded medications to TRICARE and VA's Civilian Health and Medical Program (CHAMPVA). As a result of paid claims for compounding prescriptions, the loss to CHAMPVA is approximately $619,000. Two defendants pleaded guilty to conspiracy to commit healthcare fraud,

including the technology director of a pharmacy, who was sentenced to 36 months of probation and $777,000 in restitution, and a pharmacist-in-charge, who was sentenced to 28 months in prison, one year of supervised release, and restitution of over $3 million. The investigation was conducted by the VA OIG, Department of Homeland Security, US Postal Service (USPS) OIG, and DCIS.

A Second Pharmacist-in-Charge Pleaded Guilty for Role in Healthcare Fraud

The pharmacist-in-charge at an independent pharmacy in Texas billed healthcare insurance programs for high-dollar pharmaceutical medications without dispensing them to beneficiaries. When the pharmacy was being audited by pharmacy benefit managers, the defendant conspired with a wholesale pharmaceutical company to procure the medications—as well as backdated invoices—in an attempt to fraudulently prove to the auditors that the pharmacy actually dispensed the medications to the patients when they did not, saving them at least $330,000 in "clawbacks" (money reclaimed by the insurance companies). The owner of the wholesale pharmaceutical company was previously charged with false statements related to healthcare matters, wire fraud, conspiracy to defraud the United States, and hoarding materials designated as "scarce." The pharmacist-in-charge pleaded guilty in the Southern District of Mississippi to conspiracy to commit healthcare fraud.

Texas Doctor Agreed to Pay Over $582,000 to Resolve False Claims Act Allegations

A multiagency investigation resulted in charges alleging that several doctors received thousands of dollars in illegal payments from management service organizations (entities that provide nonclinical, administrative services to medical practices) in exchange for ordering laboratory tests. The laboratories allegedly funded the scheme by paying volume-based commissions to recruiters who used the management service organizations to pay the doctors for their laboratory referrals. In connection with this investigation, a Texas medical doctor entered into a settlement agreement with the US Attorney's Office for the Eastern District of Texas to resolve allegations that he received illegal payments in violation of the Anti-Kickback Statute and Stark Law. Pursuant to this civil settlement, the doctor will pay more than $582,000. The VA OIG, FBI, HHS OIG, and DCIS conducted this investigation.

Two Defendants Pleaded Guilty in Connection with Kickback Scheme

Two other laboratories also allegedly engaged in a kickback scheme involving marketers and physicians that resulted in approximately $300 million in losses to the government. The laboratories, through marketers, allegedly paid hundreds of thousands of dollars to doctors for "advisory services" that were never performed in return for laboratory test referrals. Two defendants pleaded guilty in the Northern District of Texas to conspiracy to pay and receive healthcare kickbacks and offering or payment of illegal kickbacks. The VA OIG, FBI, HHS OIG, and DCIS conducted the investigation.

Defendant Sentenced for Role in Compounding Pharmacy Scheme

Another multiagency investigation revealed that multiple individuals engaged in a fraud scheme that involved charging inflated prices for medically unnecessary compounded medications to TRICARE, CHAMPVA, and private insurance companies. The defendants looked for compounded medication

ingredients that could be billed at the highest rate and then provided doctors with blank prescription pads that listed those specific compounded medications. The compounded prescriptions were fraudulently dispensed by doctors located in different states than the patients, and for whom no doctor–patient relationship existed. The compounded prescriptions were often fraudulently dispensed to patients by unlicensed pharmacies; dispensed without a physician's authorization; dispensed to TRICARE, CHAMPVA, and privately insured recipients without approval; or were billed for but never provided. The estimated loss to the government and private insurance is approximately $29.3 million. Of this amount, the loss to VA is more than $450,000. One defendant was sentenced in the Southern District of Florida to 366 days in prison, three years of supervised release, and restitution of more than $937,000. Another defendant surrendered after being charged with conspiracy to receive kickbacks. This investigation was conducted by the VA OIG, FDA Office of Criminal Investigations, Army Criminal Investigation Division, DOL Employee Benefits Security Administration, and DCIS.

Former Marion VA Medical Center Employee Sentenced in Connection with Workers' Compensation Fraud Scheme

A former employee at the Marion VA Medical Center in Indiana submitted 670 false reimbursement claims for treatment, mileage, and expenses pertaining to her workers' compensation disability claim. The former employee was receiving workers' compensation benefits in connection with a fall that she suffered while working at the medical center. Following an investigation by the VA OIG and DOL OIG, she was sentenced in the Northern District of Indiana to 27 months in prison, one year of supervised release, and restitution to VA of approximately $338,000.

Two Individuals Sentenced for Roles in Compound Pharmacy Conspiracy

A multiagency investigation resulted in charges alleging that numerous individuals participated in a conspiracy to fraudulently bill compounded medications to federal healthcare programs, including Medicare, DOL's Office of Workers' Compensation Programs, TRICARE, and CHAMPVA. The loss to VA is approximately $153,000. Two defendants were each sentenced in the Northern District of Oklahoma to 12 months of probation and ordered to pay combined restitution of close to $945,000 after pleading guilty to conspiracy to pay healthcare kickbacks. This investigation was conducted by the VA OIG, USPS OIG, FBI, HHS OIG, DOL OIG, and DCIS.

Benefits Investigations

Veteran Pleaded Guilty to Fraud Charges

In 2011, a veteran registered for VA healthcare benefits by presenting altered military service records that falsely reflected that he served in Vietnam and later used the same fraudulent documentation to obtain VA compensation benefits. The veteran also used altered documentation that claimed a different date of birth to obtain Social Security and Medicare benefits to which he was not entitled and to obtain a passport. The defendant pleaded guilty in the District Court of Alaska to healthcare benefits fraud, false statements relating to healthcare benefits, Social Security benefits fraud, false statements, and passport

fraud. The total loss to the government is over $530,000. Of this amount, the total loss to VA is over $330,000. The VA OIG, Social Security Administration (SSA) OIG, Department of State Diplomatic Security Service, and HHS OIG conducted the investigation.

Veteran Indicted in Connection with Disability Fraud Scheme

A VA OIG proactive investigation resulted in charges alleging that a veteran stole more than $800,000 from VA by falsely claiming he was unable to use both feet and his left arm. The veteran was reported to not only walk but was also able to drive unassisted and run a jukebox repair business from his home. He received nearly $9,000 per month from VA for his false claims of disabilities. The veteran was indicted in the District of South Carolina for theft of government funds.

Veteran and Wife Found Guilty of Conspiracy to Defraud the Government

According to an investigation by the VA OIG, a veteran and his wife falsely reported to VA that the veteran was unable to walk or use his arms. Furthermore, when applying for a VA Caregiver Support Program grant, the wife allegedly stated that she cared for the veteran full time when she often left the home while the veteran worked on the family ranch without assistance. The loss to VA is approximately $240,000. The couple was previously indicted on charges of conspiracy to defraud the government, false statements, theft, and false claims. They were found guilty in the Western District of Michigan on all counts.

Defendant Convicted of Theft of Government Funds and False Statements of Disability

According to a VA OIG and SSA OIG investigation, a veteran stole more than $420,000 from VA and SSA by falsely claiming he was unable to work due to a disability while simultaneously owning and operating an insurance company. The loss to VA is approximately $100,000. The veteran was convicted in the District of Massachusetts of theft of government funds and false statements.

Veteran Pleaded Guilty for Making False Statements about His Income

A VA OIG investigation revealed that a US Postal Service employee who previously served in the Army failed to disclose his employment to VA when he applied for monthly pension benefits in 2011. Despite earning more than $65,000 per year, the veteran signed and certified an application for VA pension benefits in which he falsely reported that he had no income. He also reported that his home was his only asset and that he had a medical condition that prevented him from working. After approving this application, VA paid over $230,000 in pension benefits to the veteran from 2011 to 2020. He pleaded guilty in the Southern District of Georgia to false statements.

Defendant Indicted on Theft Charges of Benefits Intended for Veteran

A VA OIG investigation resulted in charges alleging that from 2010 to 2020, a nonveteran unlawfully cashed Dependency and Indemnity Compensation benefits checks intended for a VA beneficiary who had passed away in 2009. The potential loss to VA is approximately $140,000. The defendant was arrested after being indicted in the Eastern District of New York on charges of theft of government funds and aggravated identity theft.

Audits and Reviews

Federal Information Security Modernization Act Audit for Fiscal Year 2021

The OIG contracted with CliftonLarsonAllen LLP (CLA) to evaluate VA's information security program for FY 2021 for compliance with the Federal Information Security Modernization Act. CLA evaluated 50 major applications and general support systems hosted at 24 VA sites and on the VA Enterprise Cloud. CLA concluded that VA continues to face challenges meeting requirements and made 26 recommendations, some for repeat deficiencies. CLA recommended that VA address security-related issues that contributed to the information technology material weakness reported in the FY 2021 audit of VA's consolidated financial statements; improve deployment of security patches, system upgrades, and system configurations; and enhance performance monitoring. CLA will follow up on the outstanding recommendations in the FY 2022 audit of VA's information security program.

Additional Actions Can Help Prevent Benefit Payments Being Sent to Deceased Veterans

The Veterans Benefits Administration (VBA) provides monthly disability compensation or pension benefits to eligible veterans. To ensure that payments properly stop when there is a record of a veteran's death, VBA primarily relies on an automated process called the "death match." In conducting a limited evaluation, the OIG team reviewed three samples of data and determined that VBA was unaware its systems failed to complete one automated weekly death match, which resulted in payments continuing for 43 veterans after their deaths. VBA's electronic systems also contained incorrect social security numbers for 87 of 140 sampled veterans, which may also result in compensation or benefit payments continuing after those veterans' deaths. VBA also could have minimized improper payments to 121 deceased veterans by obtaining death notification data from the Veterans Health Administration (VHA). The OIG made three recommendations to improve VBA's death match process and help prevent improper payments.

The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High Quality, Reliable Schedule

VA has projected its Electronic Health Record Modernization (EHRM) program will be completed in fiscal year 2028 and interoperable with the Department of Defense system to provide a continuous health record for veterans. VA needs a high-quality, reliable integrated master schedule to successfully complete the program within that time and avoid potential cost overruns of about $1.95 billion for each year of delay. The OIG audited the EHRM program's master schedule for compliance with scheduling standards and identified reliability weaknesses that included missing tasks, no baseline schedule, and no risk analyses. VA also did not comply with the Federal Acquisition Regulation (FAR) when it paid its contractor for deliverables before accepting them (reviewing them for compliance with contract requirements). VA concurred with the OIG's six recommendations to ensure the development of a more reliable integrated master schedule and to comply with the FAR.

Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims

In September 2021, the media reported on large quantities of unopened mail stored in the warehouse basement of the Atlanta VA Medical Center. An OIG review found the Atlanta VA Health Care System (HCS) and VHA's Payment Operations and Management (POM) mismanaged incoming mail starting in November 2020, resulting in a 10-month backlog of more than 17,000 mailed items. The mail included veterans' medical records, claims for payment from veterans and community care providers, and checks totaling nearly $207,000. The mail backlog followed a verbal agreement that transferred POM's responsibility for mail to HCS personnel, despite affected staff's exclusion from the preceding discussions. HCS leaders lacked a clear understanding of the additional workload they assumed and did not ensure enough staff were adequately prepared for managing the influx of mail. POM officials were later reluctant to help, citing the verbal agreement. VA concurred with the OIG's five recommendations, including addressing all negative consequences and facilities' ongoing transfers of mail responsibility.

National Healthcare Reviews

Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6

This Comprehensive Healthcare Inspection Program report provides a focused evaluation of facilities' COVID-19 pandemic readiness and response within Veterans Integrated Service Networks (VISNs) 2, 5, and 6. This evaluation focused on emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; community living center (nursing home) patient care and operations; facility staff feedback; and VA and the VISNs' vaccination efforts. The OIG has aggregated the findings from its routine inspections and grouped them by VISN. This report, the fourth in a series, describes findings from inspections between April 1 and September 30, 2021. It provides a snapshot of the pandemic's demands on these facilities' operations during the inspection period, including a review of VA's vaccination statistics. Interviews and survey results provide additional context on lessons learned and perceptions of readiness and response.

Healthcare Inspections

Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities

The OIG conducted an inspection to assess VA medical facilities' compliance and processes regarding VHA policies for reporting healthcare professionals to state licensing boards (SLBs) and the National Practitioner Data Bank (NPDB). The OIG found widespread noncompliance with SLB and NPDB reporting processes applied by facilities to healthcare professionals whose conduct or competence led to separation from employment. Failures were related to staff misunderstanding policies, poor facility practices, and a lack of VHA programmatic oversight. Additionally, conflicting language between VHA

policies and federal regulation contributed to NPDB reporting noncompliance. The OIG made four recommendations to the under secretary for health regarding ensuring SLB and NPDB reporting compliance and programmatic oversight, as well as aligning NPDB policy with federal regulation.

Quality of Care Concerns and Leaders' Responses at the Amarillo VA Health Care System in Texas

A healthcare inspection was conducted at the Amarillo VA Health Care System in Texas to evaluate allegations related to hypertension treatment and post-stroke care, nursing staff communications, and telephone communication processes. While the OIG was unable to determine whether delays in treatment for hypertension and headaches caused the patient's stroke, the OIG found the provider and clinic nurse failed to ensure the patient received urgent medical attention after presenting to clinic with stroke-like symptoms in early 2021. The OIG did not substantiate allegations regarding cardiology and neurology consults, a licensed vocational nurse, or telephone communication processes. The OIG was unable to determine whether nurses' communications were dismissive and condescending. The OIG identified multiple leaders failed to assess and follow through on the provider's ongoing quality of care deficits, which resulted in patients experiencing adverse outcomes. The provider has been functioning in an administrative capacity since late spring 2021. The OIG made six recommendations.

Management Advisory Memorandum

Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data

In June 2021, a complainant alleged that the then acting principal deputy under secretary for health had been informed in the fall of 2019 that VHA's reporting on patient wait times for appointments may be misleading, but no responsive action was taken. The OIG found no evidence of an intent or effort to mislead related to wait time reporting. This management advisory memo details, however, that VHA has employed different methodologies for calculating wait times reported online since 2014, and for determining whether wait time criteria are met for community care program eligibility. The methodologies deviated in some cases from VHA's scheduling directive and its stated wait time measures announced in 2014. As a result, VHA has used inconsistent start dates that affect the overall calculations without clearly and accurately presenting that information publicly. This memo serves to alert VA of the problems identified regarding wait time calculations and reporting.

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:

VA Western New York Healthcare System in Buffalo

Syracuse VA Medical Center in New York

Featured Hotline Cases

The OIG's Hotline Complaint Center accepts complaints from VA employees and the general public concerning criminal activity, waste, abuse, and mismanagement of VA programs and operations. The following are cases opened by the Hotline Division that were not included in inspections, audits, investigations, or reviews.

Communication Lapses between Staff of Dayton VA Medical Center and a Patient's Caregiver Led to Inadequate Social Services and Poor Care Management

A complainant contacted the OIG to allege that a caregiver was providing inadequate care to a veteran patient of the Dayton VA Medical Center in Ohio. The OIG referred this matter to the facility for investigation, which determined that the patient was last seen by a primary care provider in 2019. As a result of the case, the facility's Social Work Service contacted the patient and caregiver to reestablish care. In addition, the local police department conducted a wellness check, which revealed the veteran did not have a bed and was sleeping on a couch. There was also an odor present from an unknown source; however, the police officer confirmed there was food in the house and the veteran had eaten. A report was made with Adult Protection Services due to concerns of neglect. The Social Work Service began working to secure a hospital bed for the veteran, and the caregiver was instructed to call a VA social worker if there were issues with utilities or other care concerns.

Failure to Comply with Policy Related to the Prevention of Amputation in Veterans Everywhere (PAVE) Program at the Beckley VA Medical Center in West Virginia

A confidential complainant contacted the OIG to allege there is no active Prevention of Amputation in Veterans Everywhere (PAVE) program oversight at the Beckley VA Medical Center in West Virginia. The OIG referred this matter to the facility for investigation, which determined that the increased workload in the podiatry clinic made it difficult for the full-time podiatry provider and nurse to comply with VHA policy, including establishing monitoring guidelines for foot checks and foot screenings, and determining the level of risk for limb loss per established performance measure standards. As a result of this case, the facility approved a podiatry mid-level/PAVE coordinator position who not only performs these functions but provides additional clinic availability in the podiatry clinic and collaborates with the prosthetics department when deemed clinically necessary to order appropriate prosthetic or orthotic appliances. The position was filled in March 2022.