



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

## PODCAST TRANSCRIPT JUNE 2020 HIGHLIGHTS

This is Quintin Durden, a Deputy Director with the VA Office of Inspector General (OIG) in Washington, DC. Here are the June highlights.

In the Office of Investigations, significant actions in criminal cases included the guilty plea of a chief of pathology to involuntary manslaughter and mail fraud, the sentencing of a community care benefits advisor for a fraud and kickback scheme concerning spina bifida beneficiary referrals, the arrest of a medical technology company president related to improper billing for COVID-19 testing, and the sentencing of an employee of a former VA-appointed professional fiduciary for defrauding victims of their VA and Social Security Administration (SSA) beneficiary funds.

A Fayetteville, Arkansas, VA Medical Center Chief of Pathology pleaded guilty to involuntary manslaughter and mail fraud. The defendant misdiagnosed thousands of VA patients while under the influence of a potent substance that causes a lengthy intoxication period but no hangover and is undetectable using routine drug and alcohol testing methods. The defendant also circumvented contractually obligated drug and alcohol testing to conceal his chemical dependency.

In another case, a Veterans Health Administration (VHA) Office of Community Care benefits advisor was sentenced to 192 months' imprisonment and three years' supervised release and ordered to pay restitution of approximately \$19 million to VA. An investigation by VA OIG, the Federal Bureau of Investigation (FBI), and the Internal Revenue Service Criminal Investigation (IRS-CI) revealed a fraud scheme in which the defendant referred over 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives in exchange for kickbacks.

The president of a medical technology company was charged and arrested for securities fraud and conspiracy to commit healthcare fraud for allegedly conspiring to improperly bill healthcare insurers for approximately \$69 million in false and fraudulent claims for allergy and COVID-19 testing. The defendant and others allegedly schemed to manipulate the company's stock price by making false claims about its ability to provide COVID-19 tests in accordance with federal and state regulations. It is also alleged the defendant and others made numerous misrepresentations to potential investors concerning the COVID-19 tests and used a VA solicitation to further the stock manipulation scheme.

Finally, an employee of a former VA-appointed professional fiduciary was sentenced to 71 months' imprisonment, three years' supervised release, and restitution after an investigation by VA OIG, SSA OIG, the FBI, and IRS-CI revealed the defendant engaged in a sophisticated financial scheme with three other defendants to use their nonprofit organization to defraud victims of their VA and SSA beneficiary funds. The defendants unlawfully transferred money from their clients' accounts to their own business accounts and then used funds from these accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme that resulted in a loss to VA of approximately \$3.3 million.

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The release of reports was limited during March through June 22, 2020, in recognition of VA's need to focus on the initial pandemic response. Given VA's phased reopening efforts for its administrations and offices to return to more routine operations, the OIG resumed its standard publication release practices as well.

In the month of June, the Office of Audits and Evaluations published 13 reports. In one report, [VA Improved the Transparency of Mandatory Staffing and Vacancy Data](#), the OIG found VA partially complied with Section 505 of the VA MISSION Act of 2018 by reporting time to hire data using a 100-day target instead of the Office of Personnel Management's required 80-day target. The OIG also found that the reporting of staffing and vacancy data on the VA website showed improved transparency and usefulness of its data by posting all quarterly staffing and vacancy publications, as well as summaries and additional context. The OIG recommended the assistant secretary for human resources and administration / operations, security, and preparedness ensure time to hire data are reported as required and confer with the Office of General Counsel (OGC) to ensure that changes in reporting methodology adhere to the Act.

In the report, [Disability Compensation Benefit Adjustments for Hospitalization Need Improvement](#), the OIG examined whether veterans received accurate compensation when hospitalized by VA for more than 21 days for service-connected disabilities. These veterans are entitled to receive temporary increases in benefits. The audit revealed VA regional office employees did not adjust or incorrectly adjusted disability compensation benefits in about 2,500 of the 5,800 cases eligible for adjustments when veterans were hospitalized by VA for the 21-day period. It's estimated VA made \$8 million in improper payments in calendar year 2018. Errors occurred because employees did not generate required reports and maintain report logs, and managers provided ineffective oversight. Also, employees processing adjustments lacked proficiency because they handled such cases infrequently and lacked training to maintain their knowledge. The OIG made six recommendations for improvement to the under secretary for benefits.

OIG found in the audit report, [VA Police Information Management System Needs Improvement](#), that VA did not have an effective strategy to update its police information system needed to further advance governance of police operations in its medical facilities. Persistent weaknesses included inadequate planning that stalled new system implementation, limited officers' access to information, and created incompatible parallel systems. As a result, VA employees could not get law enforcement information needed to do their jobs. Information security controls were also lacking, putting individuals' sensitive personal information at risk. The OIG recommended VA consider the Law Enforcement Training Center's role in overseeing police records management, a working group to evaluate whether the updated system meets police needs, and a strategy to fully implement the system or its replacement.

VA and other government agencies spend billions of taxpayer dollars annually through VA's Federal Supply Schedule (FSS) contracting program. Due to the sensitive commercial proprietary information included in the FSS proposals, reports issued to VA are not published. However, in the report, [A Synopsis of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in FY 2019](#), OIG presented findings for 19 FSS proposals and identified the monetary benefit to VA without disclosing sensitive commercial information. The OIG's review showed that commercial pricing disclosures were not reliable for negotiations for 14 of the 19 FSS proposals from FY 2019. The OIG recommended VA obtain revised disclosures before awarding the contracts. The OIG's FSS lower

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pricing recommendations collectively reflected more than \$1 billion in estimated cost savings to VA. Nearly \$203 million has been sustained by VA as of May 8, 2020.

The Office of Healthcare Inspections published four reports. In one report, [Deficiencies in Virtual Pharmacy Services in the Care of a Patient](#), the OIG evaluated concerns related to a Virtual Pharmacy Services (VPS) pharmacist's discontinuation of one of two antidepressant medications for a Minneapolis VA Health Care System patient who died by suicide six weeks later. The OIG found that the pharmacist did not access the patient's electronic health record or notify the psychiatrist when discontinuing the medication. The OIG was unable to determine whether the discontinuation of the antidepressant medication contributed directly to the patient's death; however, possible worsening of the underlying depressive illness may have been a contributing factor. Other findings included that VPS pharmacists were unable to fully perform the duties as described in their functional statement and the 95 prescriptions-per-hour productivity target may be unreasonable. Also, pharmacy benefits management leaders failed to monitor VPS prescription processing accuracy and outline program management and quality assurance objectives and processes. The OIG made five recommendations to the under secretary for health for improvement.

Finally, the Office of Special Reviews published three investigative reports. In one report, [Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel](#), the OIG substantiated an allegation that a VA OGC attorney used VA time and resources to work on matters related to his outside law practice. The OIG determined the attorney represented private clients in U.S. bankruptcy court who owed money to the federal government, which implicated criminal conflict of interest laws prohibiting federal government employees from representing third parties when the United States is a party or has a direct and substantial interest. The investigation also revealed OGC officials received complaints about the attorney using VA time and resources for his law practice as early as 2012 but failed to adequately supervise him or meaningfully investigate his conduct. After the OIG informed OGC about this review's initial findings, OGC investigated the attorney and removed him from federal service in March 2020. VA's OGC concurred with the OIG's seven recommendations.

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