PODCAST TRANSCRIPT
AUGUST 2020 HIGHLIGHTS

This is Hanna Lin, a health systems specialist with the VA Office of Inspector General (OIG) in Washington, DC. Here are the August highlights.

We kick things off with a reward the VA OIG presented to a confidential complainant who submitted two separate allegations, which involved fraud against VA's Service-Disabled Veteran-Owned Small Business (SDVOSB) program. VA OIG subsequently conducted investigations revealing that, in both instances, the two unrelated construction companies falsely represented that they were owned and controlled by service-disabled veterans. As a result of these false representations, the two construction companies obtained over $65 million in set-aside contracts from VA. The two construction companies and their principal owners entered into separate civil agreements under which they agreed to pay a total of almost $2.6 million to the federal government.

The VA OIG Office of Investigations was busy in the month of August. In the Northern District of Texas, a defendant was indicted on charges of soliciting and receiving healthcare kickbacks and conspiracy to pay and receive healthcare kickbacks. A multiagency investigation resulted in charges alleging the defendant received over $60 million in kickbacks from a compounding pharmacy for fraudulent prescriptions written by doctors that he recruited. The compounding pharmacy, and their subsidiaries, billed private and government healthcare insurance programs an estimated $700 million. In total, VA's Civilian Health and Medical Program and its Office of Workers' Compensation Program were billed more than $16.8 million. Of this amount, VA paid over $1.9 million. This investigation was conducted by the VA OIG, Federal Bureau of Investigation (FBI), Defense Criminal Investigative Service (DCIS), U.S. Postal Service Inspection Service, Department of Health and Human Services OIG, Office of Personnel Management OIG, Food and Drug Administration Office of Criminal Investigations, Internal Revenue Service Criminal Investigation, and Drug Enforcement Administration.

In a separate case, A former employee of the Bruce W. Carter VA Medical Center in Miami, Florida, was sentenced in the Southern District of Florida to 36 months' incarceration, three years' supervised release, and restitution of $592,717. Additionally, a former employee of the West Palm Beach VA Medical Center pleaded guilty to conspiracy to commit healthcare fraud. A VA OIG investigation that was based on a hotline complaint resulted in charges alleging that 16 defendants engaged in a bribery and kickback scheme involving multiple vendors and employees of the two VA medical centers. The charges allege that VA employees placed orders for supplies in exchange for cash bribes and kickbacks from the vendors. In many instances, the prices of supplies were grossly inflated, or the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts.

Wrapping up another case, a veteran was sentenced in South Carolina to 15 months' incarceration, three years' supervised release, and restitution totaling over one million dollars after previously pleading guilty to conspiracy to commit theft of government funds. A VA OIG proactive investigation revealed that for more than 20 years, the defendant fraudulently received approximately $9,000 per month from VA for the loss of use of his limbs and hearing problems with associated vertigo. This investigation determined that the defendant was able to ambulate without difficulty and did not require the assistance that he claimed to VA was necessary.

Finally, a certified public accountant was sentenced in the Eastern District of Wisconsin to three months' imprisonment; three years' supervised release; 100 hours of community service to a Service-Disabled Veteran-Owned Small Business or SDVOSB, minority-owned business, or a disadvantaged business enterprise; and a fine of $7,500. A multiagency investigation resulted in charges alleging the defendant provided accounting services to the leader of a 12-year fraud scheme, which involved over $260 million in government-funded contracts intended to benefit small businesses including SDVOSBs. The alleged scheme involved the purported operation of three construction companies by "straw" owners who qualified either as a disadvantaged individual or a service-disabled veteran, but who did not actually control the companies. The defendant allegedly advised the scheme's participants to hide their common ownership and affiliations, wrote letters attesting to their independence that were later submitted to the controlling government agencies, and lied to federal investigators when interviewed. This case was investigated by the VA OIG, General Services Administration OIG, Small Business Administration OIG, DCIS, and FBI.

In the month of August, the Office of Audits and Evaluations published two reports. In the first report, the OIG examined whether Veterans Benefits Administration decision makers accurately completed disability evaluations for veterans' service-connected heart disease. The OIG estimated that decision makers incorrectly evaluated about 12 percent of claims for heart disease between November 1, 2018, and April 30, 2019. Of those, about 870 resulted in improper payments totaling at least $5.6 million. The OIG determined that the disability benefits questionnaire format prompted inappropriate evaluations of veterans' heart conditions. VBA decision makers did not consistently ask for the clarification they needed to accurately determine disability. The OIG made three recommendations for improving the handling of disability benefits questionnaires for heart diseases to ensure they are properly filled out and the information is unambiguous and consistent.

In the second report, VBA program operations staff conduct site visits to regional offices to ensure that veterans service centers follow requirements for disability compensation benefits. The OIG determined whether program operations staff conducted site visits and identified deficiencies at regional offices, and if managers took sufficient follow-up action on frequently identified errors to improve disability claims processing. The OIG found that program operations staff generally identified deficiencies during site visits and communicated results to the relevant offices, which addressed those deficiencies. However, VBA did not fully use the information to achieve nationwide improvements because it did not have a

written policy for addressing frequently identified errors. The OIG recommended an annual report on all recurring deficiencies and action items, a plan to address them, and a follow-up process to monitor compliance and hold regional office managers accountable for corrections and action items.

The Office of Healthcare Inspections published four reports this month. In one healthcare inspection, *Surrogate Decision-Maker, Clinical, and Patient Rights Deficiencies at the Robley Rex VA Medical Center in Louisville, Kentucky*, the OIG substantiated an allegation that providers permitted a patient's neighbor, who had no legal authority, to make medical decisions for the patient. The patient had a three-week hospitalization that was marked by repeated episodes of confusion and agitation, was transferred to hospice care, and died five days later. Facility staff did not take the required steps to identify and confirm the eligibility of the patient's surrogate, such as reviewing other VA records, due to staff's varied understanding of the procedures and requirements. The OIG noted additional clinical and patient rights deficiencies and reviewed the facility leaders' evaluation of the deficiencies in the patient's care. The OIG made 15 recommendations to the facility director focusing on the patient's decision-making capacity, surrogate identification, medical assessments, medication management, a review of the patient's hospice admission, patients' rights, and quality management processes.

A separate inspection was titled, *Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds*. The inspection was conducted, in response to a referral from Senator Elizabeth Warren and a complaint, to assess mental health staffing, lengths of stay, medical assessments, prescribing practices, nurse staffing methodology, health programming, and facility levels of care. Inpatient psychiatry staffing was below expected levels but did not contribute to increased levels of stay. The OIG was unable to determine if medical provider staffing was inadequate. All required utilization management reviews were not completed. The OIG did not substantiate that patients remained on the acute inpatient mental health unit to treat medical issues or inappropriate prescribing practices. Nurse staffing methodology was not completed and required health programming was not occurring. Facility leaders failed to convert sustained treatment and rehabilitation and posttraumatic stress disorder beds to acute or residential beds. Recommendations were made related to staffing, utilization management reviews, medical assessments, nurse staffing methodology, programming, and levels of care.

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