PODCAST TRANSCRIPT
NOVEMBER 2020 HIGHLIGHTS

Hello, this is Adam Roy with the Office of Inspector General in Washington, DC. You're listening to the OIG's highlights for November 2020. Let's start with the Office of Investigation and several cases impacting the VA, our veterans, and your taxpayer dollars.

We to Ohio where a former surgical service supervisor at the Louis Stokes Cleveland VA Medical Center was indicted on charges of theft of government property, honest services wire fraud, wire fraud, and false statements relating to healthcare matters. An investigation by the OIG and the FBI resulted in charges alleging the defendant received kickbacks and other items of value in exchange for steering VA business and other monetary awards to a medical supplies vendor. It is alleged that to justify the purchase of implants from the vendor, the defendant falsified some patient records to make it appear as if patients had implants that did not correlate to any actual surgical or medical procedure. The defendant is accused of defrauding VA of nearly $2.2 million. It is alleged that in a separate scheme, the defendant fraudulently used his VA-issued purchase card and facilitated the use of other VA employees' purchase cards to make purchases from a company that he controlled for an additional loss of over $1 million.

In Florida, a retired employee of the West Palm Beach VA Medical Center and a suspended employee of the Bruce W. Carter VA Medical Center in Miami pleaded guilty in connection with a bribery and kickback scheme. A vendor was also charged with conspiracy to commit healthcare fraud. The OIG investigation, which was initiated based upon a hotline complaint, resulted in charges alleging that 18 defendants engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach; Miami; and Philadelphia, Pennsylvania. To date, 15 individuals have pleaded guilty in connection with this investigation. The charges allege that VA employees placed supply orders 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.

Now in Texas, the owner of a heating, ventilation, and air conditioning (HVAC) school was indicted on charges of wire fraud, money laundering, and aggravated identity theft. The OIG, U.S. Postal Inspection Service, and FBI investigation resulted in charges alleging that the defendant fraudulently obtained state and VA approval for his for-profit HVAC school. The defendant then allegedly used the fraudulently obtained approval status to entice students to attend the school, which resulted in the unlawful collection of VA education benefits. The loss to VA is approximately $71 million.

In another case in California, the owner of a technical training school and his wife were sentenced in connection with an education benefits fraud scheme. The owner was sentenced to 45 months' incarceration, three years' supervised release, and was ordered to pay restitution to VA in the amount of

$29,350,999 and to forfeit approximately $3 million. The owner's wife was sentenced to two years' probation. The OIG and FBI investigation revealed the school's owner submitted fraudulent documents to VA for several years. The owner and his wife admitted to falsifying student enrollment documents and employer verification information dating back to 2015, which caused VA to pay over $29 million in tuition, books, fees, and monthly student housing allowances.

And wrapping up investigations, two nonveterans were charged in the District of Utah in connection with a service-disabled veteran-owned small business fraud scheme. The investigation by OIG and several other Federal organizations resulted in charges alleging the two defendants falsely claimed that a joint venture was eligible to receive service-disabled veteran-owned small business set-aside contracts from the government. The total value of these set-aside contracts is approximately $16.1 million. Of this amount, the total value of the VA set-aside contracts is approximately $4.3 million.

Now to publications.

The OIG published a review titled: *Enhanced Strategy Needed to Reduce Disability Exam Inventory Due to the Pandemic and Errors Related to Canceled Exams* that assessed how the Veterans Benefits Administration scheduled and conducted exams during the COVID-19 pandemic to limit veterans' exposure, minimize processing delays, and ensure claims were not prematurely denied due to missed or canceled in-person exams. The OIG also evaluated VBA's strategy for addressing the inventory of delayed disability exams. To protect veterans, VBA discontinued in-person exams and notified them of options such as telehealth exams, reviews of acceptable clinical evidence, or a future in-person exam. VBA and the OIG identified claims prematurely or improperly denied based on canceled exams. In response, VBA clarified guidance and established additional controls for exam management. While the exam inventory has increased (about 1.5 million exams needed as of July 31), the percentage of errors appears to have decreased. The OIG made two recommendations to help reduce the exam inventory and increase telehealth exams, including ensuring contractors follow telehealth guidance.

The OIG also published an audit titled: *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*. The Veterans Health Administration's homemaker and home health aide program offers personal care and related services to help frail or disabled veterans with daily activities. The OIG examined whether veterans received intended program services and VHA accurately processed program claims. VHA lacked assurance that veterans received services from licensed or certified agencies and, as a result, may have made up to $145.4 million in improper payments. Medical facilities also inconsistently applied program policies, prioritized veterans on program waiting lists, and addressed veterans who were difficult to place. VHA paid many claims on time and nearly always accurately, but improperly paid an estimated $8.5 million with at least $5.5 million potentially recoverable. Opportunities exist for reducing the risk of paying for inadequately supported or unauthorized claims. The OIG made eight recommendations to VHA to address these issues.

The OIG published an healthcare inspection titled: *Management of the Ophthalmology Clinic and Patient Safety Reporting Concerns at the VA Central Iowa Health Care System in Des Moines*. The OIG conducted an inspection in response to multiple allegations related to clinic management, quality of care, oversight, medication management, and facility leaders' failures. The OIG found many of the allegations unfounded; however, the team identified deficits in clinic staff members' knowledge and use of the required patient safety event reporting system. The OIG also identified issues with the management and impact of ongoing personnel conflicts within the clinic. The OIG made four recommendations related to staff training and use of the Joint Patient Safety Reporting system, addressing the clinic culture, and the oversight and management of the clinic.

In another inspection, titled: *Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died*, the OIG assessed an allegation regarding Veterans Crisis Line staff's management of a veteran caller who died the same day as contacting the crisis line. Staff did not initiate an emergency dispatch for the caller who reported use of alcohol and over-the-counter medications that cause drowsiness. Crisis line policies did not address management or safety planning with intoxicated callers or accidental overdose risk assessments. Crisis line leaders had implemented aggregated data view criteria and supervisor follow-up to oversee the quality of responders' telephone calls, but supervisory intervention only applied to consecutive calls, which may have contributed to inadequate quality assurance initiatives. The caller's lethality risk should have been considered high, and staff should have initiated other actions including urgent or emergent suicide prevention coordinator consult submission. The OIG made eight recommendations regarding suicide prevention strategies, review of the caller's contacts, lethal means training, supervisory documentation, substance use, overdose risk, safety planning, and internal reviews.

Also published, was an inspection titled: *Deficiencies in Ambulatory Care Center and Emergency Department Processes at the VA Loma Linda Healthcare System in California*. The OIG reviewed an allegation that a patient died in the emergency department waiting room at the facility. The OIG did not substantiate the allegation. The patient was unarousable in the waiting room and died after being transported to an emergency department room where a physician noted no heart sounds or pulse. The family declined intervention. The OIG was not able to determine if the failure to complete and document an assessment and lack of hand-off communication with the emergency department by ambulatory care center staff affected the patient's outcome. The facility conducted a fact-finding review and planned to complete addressing the issues identified in fall 2020. Although the facility revised the first look nurse policy, staff did not fully comply with the revised policy. The OIG made recommendations that the facility provide documentation training, review the hand-off communication policy, and ensure compliance with the revised policy.

The OIG published Comprehensive Healthcare Inspection Program—or CHIP—reports on three facilities in November and the CHIP Summary Report for fiscal year 2019. Inspections are performed approximately every three years at each facility. Facilities inspected were the Ralph H. Johnson VA

Medical Center in Charleston, South Carolina; the Carl Vinson VA Medical Center in Dublin, Georgia; and the Atlanta VA Health Care System in Decatur, Georgia.

And finally, the OIG published the Semiannual Report to Congress covering OIG activities from April 1 to September 30, 2020.

Thank you for listening to the VA OIG's monthly highlights for November 2020.

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