VETERAN OVERSIGHT NOW PODCAST TRANSCRIPT

SAR 86 and October 2021 Highlights

Fred Baker:

Welcome back to another podcast episode for the VA Office of Inspector General.

Welcome to the first podcast under our new brand "Veteran Oversight Now." This is a monthly highlights podcast by the Veterans Affairs, Office of Inspector General. I am your host Fred Baker. Today it is only fitting that in our first podcast under the new name, that I'll be talking with VA's Inspector General Michael Missal. The VA OIG just submitted its Semiannual Report to Congress and IG Missal is here to discuss his observations of the past six months. Later in the podcast, I'll turn it over to co-host Adam Roy to provide an update on recent congressional testimony, investigations, and the reports published in October 2021. As always, you can stay connected with the VA OIG by signing up for email alerts on our website, www.va.gov/oig, and get our reports, podcasts, and other information delivered right to your inbox.

Mr. Missal, for the 86th time, the VA OIG has prepared a Semiannual Report to Congress, or SAR. This report covers our oversight of VA programs and operations from April 1 through September 30, 2021. What story does the semiannual report tell about the OIG's recent oversight activities?

IG Missal:

Fred, this SAR tells a great story of our commitment to the mission and our tremendous resilience. The pandemic transformed how we conduct our work, and despite great personal, professional, and external challenges, our staff have forged ahead. We modified processes and used technology to further our work. We conducted virtual site visits, had a greater reliance on data analytics, and performed other innovative measures to conduct oversight of VA during this stressful and ever-changing landscape. I thank the OIG staff for their outstanding dedication and commitment as they continue to provide effective, fair, and timely oversight during these challenging times.

Fred Baker:

Everyone has definitely had to work hard and be creative during this pandemic indeed. And yet, the results are remarkable. Allow me to share a few results with our listeners. In this past six-month period, the OIG identified over $2.9 billion worth in monetary impact for a return on investment of $29 for every dollar spent on oversight. The OIG hotline received and triaged more than 15,000 contacts in the past six months. Our investigators opened 169 investigations and closed 207, with efforts leading to 113 arrests. Mr. Missal, what comes to mind when you hear these numbers and results like these?

IG Missal:

Fred, what comes to mind when I hear these numbers and results is that show the great impact that we had. They demonstrate remarkable, productive, and meaningful work across the past reporting period and really throughout the entire fiscal year. Our work was all the more valued and impressive because we conducted it as the pandemic continued to dominate much of our personal and professional worlds. Despite these challenges, the quantity, quality, and impact of our oversight reports continued to increase. In the past six months, we published 214 reports and other work products, which generated 1,238 recommendations. While numbers are important and results matter, I believe the real value is the impact of our reports and other oversight efforts on improving the VA. Take for example those 1,200 plus recommendations. If fully implemented, it will directly improve VA programs and operations, save taxpayer dollars, and most importantly help the lives of our veterans and their families.

Fred Baker:

So now, the OIG's Office of Investigations doesn't publish reports, but they are involved in investigating a wide range of criminal activity and civil violations of law, including fraud related to VA benefits, procurement, and health care. In this past reporting period, what kind of work did our investigators do?

IG Missal:

Fred, during this reporting period, our investigators remained focused on high-impact investigations and continued to coordinate closely with the Department of Justice and other law enforcement partners to successfully address criminal and civil violations affecting VA. Related to the pandemic, the Office of Investigations worked to meet COVID-19 challenges in the ever changing VA landscape by creating a stand-alone healthcare fraud division, hiring an investigative counsel to manage the False Claims Act/Program Fraud Civil Remedies Act programs, and, as a member of the VA Health Care Fraud Task Force, helped DOJ select a special prosecutor to focus on VA-specific cases. Investigative staff actively participated in DOJ's COVID-19 Fraud Enforcement Task Force and its Procurement Collusion Strike Force, as well as the FBI's COVID-19 Fraud Response Working Group. All of these groups work to share information and pool resources to better support and advance our ongoing pandemic-related investigations.

Fred Baker:

Do any specific cases come to mind that are good examples of these efforts?

IG Missal:

Absolutely. For example, the recent sentencing of a defendant in a multimillion dollar COVID-19 scam in which a business owner made fraudulent misrepresentations in an attempt to secure orders from VA for personal protective equipment, or more commonly referred to as PPE, that would have totaled over $806 million. This individual promised he could obtain millions of genuine 3M masks from domestic

factories when he knew that fulfilling the orders would not be possible. He attempted to obtain an upfront payment from VA of over $3 million, but our timely efforts stopped that before it was paid. We were fortunate that our investigation would lead to a guilty plea of wire fraud in the Western District of New York and the defendant is awaiting sentencing.

In another high-impact investigation, a for-profit trade school owner was sentenced in connection with an education benefits fraud scheme. The school fraudulently obtained state and VA approval for its for-profit heating, ventilation, and air conditioning trade school. The owner then used the approval status to entice veterans to attend the school, which resulted in the fraudulent collection of VA education benefits. The owner was found guilty by a federal jury of seven counts of wire fraud and four counts of money laundering. He was sentenced to more than 19 years in jail and will pay restitution of approximately $65.2 million.

Investigations such as these highlight the importance of our work. They ensure justice is served, protect taxpayer dollars, and act as a deterrent to fraud and abuse.

Fred Baker:

Great. Now, let's get back to the reports published in this reporting period. The Office of Audits and Evaluations published over 40 reports resulting in 184 recommendations. Many of these reports acknowledged weaknesses in VA's governance and internal oversight as a contributing factor affecting program performance. Can you share some specific examples?

IG Missal:

I'm happy to do so Fred. Many of our reports identified numerous erroneous payments to veterans and organizations that could have been avoided. For example, one report concluded that lack of oversight contributed to benefits processing delays that led to about $350 million in VA overpayments. In another report, leaders missed opportunities to receive credits under its prescription drug return program, costing VA and taxpayers over $14.9 million. Improved program oversight would help VA ensure uses taxpayer dollars to better support veterans and their beneficiaries.

Speaking of cost savings, our contract review teams also conducted 58 preaward and postaward contract reviews and six claim reviews to help VA obtain fair and reasonable pricing on products and services. Teams identified potential cost savings of nearly $330 million and recovered over $18 million in contract overcharges.

Fred Baker:

The SAR also highlights the work of our Office of Healthcare Inspections. I'd like to read a statement in this SAR—(quote) "it is evident from OHI's published reports that despite the unwavering dedication of so many frontline VA healthcare providers and support staff, their leaders are struggling to create and

promote a culture that prioritizes the safety of every veteran they serve" (end quote). Mr. Missal, can you elaborate on this statement?

IG Missal:

Fred, patient safety, while a shared responsibility among all who serve in a healthcare setting, is ultimately dependent on proactive and engaged leadership. In our Comprehensive Healthcare Inspection Program, or CHIP, reports, our teams inspect individual facilities and focus on leadership stability as well as engagement with staff and patients. Moreover, several OIG hotline reports published this reporting period, highlighted the effect of VA leaders' failure to create an environment where staff at multiple levels felt empowered and safe to report on perceived compromises to patient safety.

Let me continue.

The lack of a patient-safety centric environment is widely apparent in the case of Reta Mays, a former nursing assistant who killed seven elderly veterans with fatal administration of insulin at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. She is now serving seven consecutive life sentences because of the hard work and dedication of our investigators and their strong partnership with the US Attorney's Office and FBI throughout this complex investigation. While responsibility for these heinous criminal acts ultimately lies with Ms. Mays, our published healthcare inspection found the facility had serious and pervasive clinical and administrative failures. These failures created the conditions that allowed Mays to commit these criminal acts and for them to go undetected for so long. Our inspection identified six key findings, from missteps in the hiring process, like completing the background check, to unsecured medications and deficient oversight by facility leaders. VA concurred with the report's 15 recommendations and is now taking steps to prioritize patient safety at the Clarksburg medical center. It is hoped that these recommendations will be considered by all other VA medical centers so that our veterans receive the highest quality of care delivered in a safe and accountable healthcare setting.

This was also sadly illustrated in Fayetteville, Arkansas, another similar crime. In that case, a pathologist impaired by substance abuse misinterpreted specimens for years, resulting in misdiagnoses, inappropriate treatment plans, or no treatment for life-threatening conditions in thousands of cases.

Both of these reports highlight the tragic outcomes of missed opportunities for staff and leaders to intervene and ultimately prevent veteran harm and deaths.

Fred Baker:

The Office of Healthcare Inspections also focused on mental healthcare services during this reporting period. For example, our teams reviewed the completion of suicide safety plans for patients and annual suicide prevention training for VHA employees. What else did our healthcare teams do to ensure mental healthcare, especially for high-risk veterans, remains an oversight priority?

IG Missal:

Our healthcare inspectors uncovered issues with the management of patients in acute alcohol withdrawal and those who reported intimate partner violence. The pandemic has isolated many veterans and disrupted how they receive healthcare services. Our office recognizes that this isolation and fragmented mental healthcare delivery can exacerbate substance abuse and domestic violence. To that end, our Office of Healthcare Inspections expanded its reviews of these topics systemwide to help ensure care and services are provided with the appropriate clinical, social, and legal supports.

Fred Baker:

This office also expanded its oversight to include vet centers, which are community-based clinics that provide a wide range of services to veterans and even active-duty and National Guard military members to support a successful transition from military to civilian life. What is the OIG specifically reviewing and why?

IG Missal:

Fred, similar to our CHIP reports that review VA facilities regularly, we have other inspection teams who visit vet centers at regular intervals and focus on key topics. The first three vet center inspection program reports were published in September and highlighted issues related to suicide prevention, care coordination for high-risk populations, staff training, and internal quality reviews.

Fred Baker:

Great. Mr. Missal, thank you for your time today. Is there anything else you would like to add before you sign off?

IG Missal:

Fred, I would really like to thank our staff for their dedication and commitment to our mission. We made a real difference for veterans and their families every day. I encourage listeners to visit our website and read the Semiannual Report to Congress as it summarizes the scope of our oversight work and the value we bring to our veterans and their families. I look forward to speaking with you again.

Fred Baker:

Thank you, IG Missal. And now, let's go to Adam for a recap of October's monthly highlights.

Adam Roy:

Thanks Fred

Dr. Julie Kroviak, the deputy assistant inspector general for Healthcare Inspections, testified before the House Veterans Affairs' Subcommittee on Health on October 27 about patient safety and the quality of

care at Veterans Health Administration medical facilities. Her testimony focused on several VA OIG healthcare inspections and criminal investigations. Committee members asked how VA was addressing issues identified in VA OIG publications and how VA was working to establish a culture of patient safety across the department. Dr. Kroviak discussed the need to standardize governance structures at the Veterans Integrated Services Network-, or VISN-, level and the value of collaboration between VA medical facilities and Vet Centers. Her full statement is available on our website.

We had some updates to ongoing investigations in October. A registered nurse at the John D. Dingell VA Medical Center in Detroit was indicted in the Eastern District of Michigan on charges of theft of government property and theft or embezzlement related to a healthcare program. The nurse allegedly stole COVID-19 vaccination record cards as well as vaccine lot numbers necessary to make the cards appear legitimate. The nurse then allegedly resold the cards for $150 to $200 each to individuals in the metro Detroit area. The investigation was conducted by the VA OIG, Department of Health and Human Services OIG, and VA Police Service.

In another case, the director of a trucking school was sentenced in the Central District of California to 15 months' imprisonment, three years' supervised release, and restitution of over $4 million for a scheme involving the fraudulent enrollment of veterans at the school from 2011 to 2015. According to the investigation conducted by the VA OIG, FBI, and Department of Justice OIG, the school's owner, employees, and veteran students either conspired or had knowledge of the scheme.

Another investigation revealed that two individuals fraudulently obtained several service-disabled veteran-owned small business set-aside construction contracts valued at more than $16 million. Of this amount, the total value of the VA contracts is approximately $4.3 million. One defendant was sentenced in the District of Utah to 12 months' probation and a fine of approximately $105,000 after previously pleading guilty to major program fraud. The second defendant was previously sentenced to 24 months' probation and a fine of approximately $52,000 after pleading guilty to the same offense. The investigation was conducted by the VA OIG; OIGs from General Services Administration, Department of Transportation, Department of Agriculture, and Small Business Administration; as well as the Air Force Office of Special Investigations; Army Criminal Investigation Command; and FBI.

And finally, a construction company agreed to pay approximately $4.75 million for violating the False Claims Act as part of a consent judgement with the US Attorney's Office for the Western District of New York. The company created a service-disabled veteran-owned small business as a "pass-through" to obtain set-aside contracts for which it was otherwise ineligible. The total value of the VA contracts awarded was approximately $20 million. The VA OIG, Small Business Administration OIG, Defense Criminal Investigative Service, and Army Criminal Investigation Command conducted the investigation.

In October, the VA OIG published five reports.

One report examined whether VISN 21 effectively managed its nonrecurring maintenance needs by executing medical facilities' long-range action plans. Within this network, deferred maintenance cost

estimates increased from $599.3 million to $1.4 billion between fiscal year 2012 and March 2021. VISN 21 medical facilities executed only 18 percent of approved nonrecurring maintenance projects, risking health service interruptions, environmental problems, accidents, and increased operating costs. Several factors contributed to these issues, including execution of nonurgent, out-of-cycle projects; insufficient engineering staffing; misalignment of long-range action plans with the nonrecurring maintenance program's budget; and a lack of program performance metrics. The OIG made seven recommendations to help VA more effectively manage its nonrecurring maintenance needs.

The VA OIG also reviewed the processing of automated pension reductions based on social security cost of living adjustments. Social Security payments may increase annually based on changes to the cost of living. When this happens, VA reduces pensions for veterans and other beneficiaries because they are receiving more income from another source. The OIG received two allegations in 2020 that the automated letters sent to beneficiaries failed to provide proper notification before pensions were reduced or discontinued. The review team found that pensions were not reduced in accordance with VA policies, which require the inclusion of specific information in the notification letters, such as the current and proposed pension amounts, and the consideration of evidence that the pension should not be reduced. The team determined that the monetary impact on each beneficiary was limited. However, inadequate processing of pension reductions could result in improper benefit payments, unnecessary debts, and undue stress for beneficiaries. The OIG made three recommendations to the under secretary for benefits to address these issues.

The VA OIG published three Comprehensive Healthcare Inspection Program reports, known as CHIP reports. The inspections discussed in these reports covered key clinical and administrative processes that are associated with promoting quality care. 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. In October, the VA OIG published CHIP reports on inspections at the James A. Haley Veterans' Hospital in Tampa, Florida; the Bay Pines VA Healthcare System in Florida; and the VA Caribbean Healthcare System in San Juan, Puerto Rico.

That's it for October highlights. Thank you for listening. Back to you Fred.

Fred Baker:

Thanks Adam. And thanks to our listeners for tuning in to this very special podcast.

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