MAY 2023 HIGHLIGHTS

Congressional Testimony

Inspector General Michael Missal Testified on VA's Use of COVID-19 Supplemental Funding before the House Veterans' Affairs Committee

Inspector General (IG) Michael J. Missal testified before the House Veterans' Affairs Committee on May 23, 2023. The hearing focused on whether COVID-19 supplemental funding protected and improved veteran care. IG Missal spoke about the findings and recommendations in numerous OIG reports that covered VA's expenditure of supplemental funds, as well as the adjustments VA made to deliver health care during the pandemic. He emphasized the need for VA to deploy a modernized financial management system and to promote greater staff adherence to policy. In response to questions, IG Missal discussed the importance of training and internal controls, VA's pivot to telehealth, and OIG criminal investigations that addressed pandemic-related fraud targeting VA. For the IG's opening statement (or other OIG hearing statements) visit the OIG website, with this full hearing available on the committee website.

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Former VA Pharmacist Pleaded Guilty in Connection with Fraud Scheme

Between May 2017 and June 2018—prior to a pharmacist's employment with the VA medical center in Aurora, Colorado—a former Office of Community Care benefits adviser referred more than 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives, including the pharmacist. These unlawful referrals led to payments totaling approximately $19 million from VA to these home health agencies. The pharmacist pleaded guilty in the District of Colorado to conspiracy to commit acts affecting a personal financial interest. As part of the plea agreement, the pharmacist resigned his VA position and agreed not to seek or hold federal employment for the term of the sentence imposed by the court. He also agreed to pay restitution of more than $600,000 and not to contest a prior asset forfeiture in the amount of almost $1.6 million. The VA OIG, Internal Revenue Service (IRS) Criminal Investigation, and FBI conducted the investigation.

Benefits Investigations

Two Business Owners Admitted to Defrauding VA of More than $2.1 Million

Two owners of a business that claimed to provide home health services to veterans conspired to submit, on behalf of unwitting VA beneficiaries, fraudulent applications to VA for pension with aid and attendance benefits. Aid and attendance is a higher monthly pension amount paid to a qualified veteran or surviving spouse for assistance with activities of daily living. The investigation, which was conducted by the VA OIG, revealed that the coconspirators falsely claimed to have provided home assistance to the beneficiaries before submitting the applications, disguised their role in the application process during their interactions with the victims, and received over $2.1 million in VA funds intended for more than 70 veterans or their surviving spouses. The defendants pleaded guilty in the Eastern District of Louisiana to wire fraud.

Investigations Involving Other Matters

Construction Company Owner Pleaded Guilty for Service-Disabled Veteran-Owned Small Business Fraud Scheme

The owner of a construction company falsely obtained service-disabled veteran-owned small business (SDVOSB) status from VA and the Small Business Administration by concealing the company's dependence on a non-SDVOSB. As a result, federal contracts valued at approximately $10 million "passed through" the defendant's company to the non-SDVOSB. Of this amount, VA awarded set-aside contracts valued at approximately $7.5 million. The defendant pleaded guilty in the District of Oregon to concealment of a material fact. The VA OIG, Small Business Administration OIG, Defense Criminal Investigative Service, and General Services Administration OIG conducted this investigation.

Former Procurement Supervisor and Business Executive Pleaded Guilty in Connection with Kickback Scheme

A former procurement supervisor at the Jesse Brown VA Medical Center in Chicago received kickbacks totaling approximately $36,250 from the president of a medical supply company in exchange for initiating and approving orders for medical products that were never delivered to VA. The total loss to VA is $1.7 million. Following an investigation by the VA OIG, both the former supervisor and medical supply company president pleaded guilty in the Northern District of Illinois to wire fraud.

Former Arkansas State Senator Sentenced for Role in Bribery Scheme

A former Arkansas state senator participated in a conspiracy to enrich himself and others through a nonprofit organization that contracted with VA to provide substance use counseling and housing services for veterans. As part of the conspiracy, the then state senator was hired by the nonprofit organization to also act as outside counsel. In exchange for payments and the commitment to pay for legal work, he performed official acts on behalf of the nonprofit organization, including holding up

agency budgets and drafting and voting on legislation. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, to include $1.7 million contributed by VA. The former state senator was sentenced in the Western District of Missouri to 50 months' incarceration, three years' supervised release, and a forfeiture of more than $468,000 after previously pleading guilty to conspiracy. The investigation was conducted by the VA OIG, Department of Labor (DOL) OIG, Department of Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, Department of Health and Human Services OIG, Medicaid Fraud Control Unit of the Missouri Attorney General's Office, IRS Criminal Investigation, and FBI.

Inventory Management Specialist Pleaded Guilty to Theft of Government Funds

An inventory management specialist at the Mountain Home VA Medical Center in Tennessee amended old purchase orders and then used his government-issued purchase card to submit payments to his wife's PayPal account in response to the "amendments." When the fraudulent purchase card payments were received, the inventory management specialist would transfer the funds to his own personal bank account. The loss to VA is over $147,000. Following an investigation by the VA OIG, the defendant pleaded guilty in the Eastern District of Tennessee to theft of government funds.

Former Agent Cashier Indicted in Connection with COVID-19 Fraud Scheme

According to a multiagency investigation, a former "agent cashier" (authorized to collect funds in various forms and disburse them) at the Pittsburgh VA Medical Center allegedly applied for and received $38,400 in Coronavirus Aid, Relief, and Economic Security (CARES) Act funds through the Pandemic Unemployment Assistance program to which he was not entitled while he was employed full time by VA. It is further alleged that the cashier stole a total of $19,145 from four veteran medical center inpatients. The former agent cashier was arrested after being indicted in the Western District of Pennsylvania for mail fraud and embezzlement. The VA OIG, VA Police Service, and DOL OIG conducted the investigation.

VA Physician Indicted for Sexually Assaulting Female Veteran Patients

A VA OIG investigation resulted in charges alleging that a primary care physician at the Atlanta VA Medical Center in Georgia sexually assaulted four female patients during routine examinations. The physician was arrested after being indicted in the Northern District of Georgia on charges of deprivation of rights under color of law (civil rights) and abusive sexual contact.

Registered Nurse Charged with Assault and Elderly Abuse

According to a VA OIG and VA Police Service investigation, a registered nurse at the VA medical center in Columbia, Missouri, allegedly shoved an elderly veteran patient into a hospital bed, resulting in a fractured left hip that required surgery. The nurse surrendered himself to authorities after being charged in Boone County (Missouri) Circuit Court with fourth-degree assault and elderly abuse.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to advance the integrity of its programs and operations. Its work helps VA improve program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The office released the following reports.

Management Advisory Memorandum

VA Needs to Improve Testing Procedures to Assess Compliance with Mandatory Improper Payment Requirements

The OIG concluded for fiscal year (FY) 2021 that VA complied with the Payment Integrity Information Act of 2019. VA published estimates of improper and unknown payments for programs susceptible to such payments in the materials accompanying its annual financial statement as required. Yet, the OIG determined in the course of assessing VA compliance that the department can improve its testing procedures for these payments. Specifically, the testing procedures for two programs—(1) Purchased Long-Term Services and Supports and (2) Medical Care Contracts and Agreements—do not include a review of documentation for proof of the receipt of goods and services. Therefore, payments for goods and services never rendered may not be identified. The OIG determined that the testing deficiencies led VA to understate improper and unknown payment estimates by as much as $50 million. This management advisory memorandum was issued to ensure VA leaders are aware of this weakness in payment testing methodology.

Information Technology

Federal Information Security Modernization Act Audit for Fiscal Year 2022

The OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to review VA's information security program for FY 2022 for compliance with Federal Information Security Modernization Act. After evaluating 47 major applications and general support systems hosted at 23 VA sites and on the VA Enterprise Cloud, CLA concluded that VA continues to face significant challenges meeting requirements. These deficiencies can be remedied by improving the deployment of security patches, system upgrades, and system configurations; enhancing performance monitoring; and addressing security-related issues that contributed to the IT material weakness reported in the FY 2022 audit of VA's consolidated financial statements. VA concurred with CLA's 26 recommendations and CLA will evaluate the corrective actions in the FY 2023 audit of VA's information security program.

Benefits

Goals Not Met for Implementation of the Beneficiary Travel Self-Service System

VA created the Beneficiary Travel Self-Service System (BTSSS) to automate the travel reimbursement claims process for veterans and caregivers incurring travel expenses for healthcare appointments, as well as to reduce costs, improve oversight, and minimize improper payments. In November 2020, VA started using BTSSS nationwide for travel claims. Complaints to the OIG, however, suggested the system was not meeting its goals, prompting a review to determine the effectiveness of implementation. Although the Veterans Health Administration (VHA) has made improvements, the OIG found BTSSS fell short of its four metrics for success: increased automated claims adjudication, reduced manual overrides, greater new system usage, and more claimant self-service use. VHA concurred with the OIG's recommendations to determine whether changes are needed to meet system goals and then implement them, increase outreach on self-service, and phase out the legacy beneficiary travel function. VHA should also assess whether duplicate reimbursement payments were made to veterans since going live.

Featured Report (Financial Efficiency)

VHA Can Improve Controls Over Its Use of Supplemental Funds

The CARES Act appropriated about $17.2 billion in supplemental funds to VHA to support COVID-19 pandemic responses. This audit assessed the effectiveness of VA's controls over these funds. Because VA's financial management system does not support the direct obligation of supplemental funds for all expenses, staff used expenditure transfers to shift funds between appropriation accounts. Expenditure transfers are documented using journal vouchers, which are documents explaining the purpose and details of the transaction. However, as VHA did not develop guidance for the type of documentation required, staff did not always sufficiently prepare the vouchers. As a result, staff could not always identify what was purchased or provide evidence the purchase was a proper use of funds.

Even when medical staff directly obligated CARES Act funds, they did not always (a) have documented purchase authority, (b) segregate duties, (c) properly track the receipt of goods to ensure the quantities ordered were received, or (d) properly certify and pay invoices. This was due to VHA not developing guidance with protocols for accounting processes or outlining clear roles and expectations for overseeing supplemental funds purchases. Therefore, the OIG questioned an estimated $187.2 million. Until VHA strengthens controls over payments, it cannot be sure they have been properly made. Congress also lacks assurance that funds allocated for veterans' COVID-19-related care are being spent as intended. The OIG recommended VA assess whether it can integrate its financial management system with other systems to reduce the need for expenditure transfers; the OIG also made eight recommendations to VHA to improve oversight of supplemental funds.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Healthcare Inspections

Issues Related to an Administrative Investigation Board at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota

The OIG conducted an inspection at the VA Black Hills Health Care System to evaluate facility leaders' response to an administrative investigation board's (AIB) findings and recommendations. In response to complaints alleging failures in leadership and management, misconduct, and inappropriate relationships between leaders and staff and between clinical staff and patients within the Mental Health Service, the then facility director convened an AIB, which made 11 recommendations. Following the retirement of the facility director, senior facility leaders (including the acting facility director) did not follow up on the recommendations. However, when the OIG became involved, facility leaders read the AIB report and developed an action plan for the recommendations. The OIG made two recommendations to monitor and track the action plans to completion and to independently determine if the state licensing board should be notified.

Failure of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota

A second inspection at the VA Black Hills Health Care System was conducted to evaluate the administrative and clinical responses by leaders and staff to a patient's allegations of being sexually harassed. The patient was participating in VA's Compensated Work Therapy program and the Transitional Residence program when reported being sexually harassed by a food service coworker, and subsequently died by suicide. The patient initially reported the harassment to a Transitional Residence staff member. Later that same year, the patient reported to the VA police that the sexual harassment began while participating in the Compensated Work Therapy program. The OIG determined that facility leaders did not take administrative actions aligned with policy when the patient reported being sexually harassed and made three recommendations related to reviewing the sexual harassment policy. This included ensuring that the policy addresses the safety and rights of patients who are both VA employees and participants in the Transitional Residence program.

Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California

The OIG did not substantiate that staff at the VA San Diego Healthcare System failed to adequately evaluate cognitive functioning, suicide risk, and the grave disability of a patient who died approximately six hours after leaving the facility. The mental health emergency response (code green) team resident physician documented that the patient denied thoughts of harm to self or others. The inspection found that the resident physician assessed the patient and determined that the patient did not meet criteria for a psychiatric hold. However, the OIG substantiated that staff failed to coordinate the patient's care and found that the code green team leader inaccurately documented having "passed care" to emergency department staff. There were also inconsistencies between facility policy and practice in the handling of the patient's code green event. The OIG made two recommendations to the facility director related to code green documentation and policy.

Deficient Care of a Patient Who Died by Suicide and Facility Leaders' Response at the Charlie Norwood VA Medical Center in Augusta, Georgia

The OIG reviewed leaders' responses to allegations that Charlie Norwood VA Medical Center providers delayed care and failed to provide services to a patient who died by suicide on VA grounds and that the facility director "covered it up." The review revealed that the patient received deficient clinical care that hindered referrals for mental health and pain management services. In addition, while facility leaders did not cover up the patient's death by suicide, they failed to initiate a timely investigation of the death as a "sentinel event." The OIG also identified an inaccurate behavioral health autopsy (BHA), failure to complete a Family Interview Tool Contact (FIT-C), delayed peer reviews, and a clinical review that did not identify multiple deficiencies in the patient's care. The OIG made nine recommendations related to mental health screenings, consults, community care, suicide risk assessments, crisis line referrals, suicides on VA campuses, BHAs and FIT-Cs, peer reviews, and clinical reviews.

Management Advisory Memorandum

Outdated Mental Health Policies Should be Published Expeditiously

This management advisory memorandum highlights concerns regarding outdated policies governing the VHA's mental health services and requests VA take follow-up action. Two policies cited in the memorandum—VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, and VHA Handbook 1160.06, *Inpatient Mental Health Services*—exceeded expected recertification dates by almost 10 and five years, respectively. In lieu of recertifying policies, VHA has issued operational memoranda. This practice was cited as a concern by the Government Accountability Office (GAO), resulting in VA's placement on GAO's high-risk list. Additionally, outdated policies may diminish the quality of care veterans receive and create challenges for oversight. The under secretary for health is responsible for ensuring VHA compliance with policy management requirements. VHA has

responded that it expects to issue updated handbooks by September 2023. The OIG will continue to monitor VHA's progress.

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 inspections. This month's CHIP reports focused on the following facilities:

- Central Texas Veterans Health Care System in Temple
- West Texas VA Health Care System in Big Spring
- Tennessee Valley Healthcare System in Nashville
- South Texas Veterans Health Care System in San Antonio
- Northern Arizona VA Health Care System in Prescott
- VA San Diego Healthcare System in California

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. As with CHIP reports, the OIG selects and evaluates specific areas of focus on a rotating basis for its vet center inspections. See the report overview section of each report for the areas of focus at the time of the inspection. Two VCIP reports were published in May that focused on selected vet centers in North Atlantic District 1's Zone 3 and Zone 4, including vet centers in Pennsylvania, West Virginia, Maryland, Virginia, and North Carolina.

Featured Hotline Case

The OIG's hotline staff accepts complaints from VA employees, the veteran community, and the public concerning potential criminal activity, waste, abuse, and gross mismanagement of VA programs and operations. The following is a case opened by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

Veteran Failed to Inform VA of Changes in Dependents Resulting in an Overpayment of Benefits

The OIG Hotline received an allegation that a veteran continued to receive additional dependency allowance for an ex-spouse and a stepchild following a divorce in 2018. The matter with supporting evidence was referred to the Nashville VA Regional Office for further review. The regional office mailed a notification letter to the veteran proposing to remove the ex-spouse and stepchild from the compensation award. The veteran was given 60 days to respond but failed to do so. VA removed the ex-spouse and stepchild from the veteran's compensation award, creating an overpayment of more than $21,000 to the veteran. In addition, a final decision notice was mailed to the veteran that summarized the evidence VA considered, laws and regulations applicable to the issue, and applicable review options the veteran may use to seek further review of the decision.

***

To listen to the podcast on the March highlights, go to www.va.gov/oig/podcasts.