# JUNE 2023 HIGHLIGHTS

## Congressional Testimonies

### Principal Deputy Assistant Inspector General (PDAIG) for Healthcare Inspections Testifies on Patient Care Coordination Oversight before the House Veterans' Affairs Subcommittee on Health

Dr. Julie Kroviak, PDAIG for Healthcare Inspections, testified on June 13 before the House Committee on Veterans' Affairs Subcommittee on Health. Her testimony focused on numerous OIG healthcare inspection reports that identified deficiencies in VA care coordination. Of particular concern, she noted that patients transitioning between levels of care and among service lines (specific areas of clinical care such as cardiology or oncology) are at the most risk. In response to questions, Dr. Kroviak discussed the challenges in coordinating care for veterans when community care providers do not promptly return medical records to the Veterans Health Administration (VHA). Her written congressional statement has been added to the archive of prior OIG congressional witnesses on the OIG website, where recordings of opening statements can also be viewed. To view the full hearing, please visit the committee website.

### PDAIG for Healthcare Inspections Also Testifies before the Senate Veterans Affairs' Committee on Rural Substance Use Disorder Treatment Programs

The next day, Dr. Kroviak provided testimony before the Senate Veterans' Affairs Committee that highlighted VHA's challenges in effectively meeting the needs of individuals with substance use disorders, especially within rural settings. She emphasized that VA should improve its collaboration with third-party administrators and community care providers for high-risk veterans with complex mental health conditions. Dr. Kroviak answered questions about VA's opioid-prescribing practices and the risks to patients when community care providers do not share appointment data and electronic health records with VA providers in a timely manner. The hearing can be viewed in its entirety on the committee website.

### Deputy Assistant Inspector General for Audits and Evaluations Testifies on Financial Management System Modernization Oversight before the House Veterans' Affairs Subcommittee on Technology Modernization

Nicholas Dahl, deputy assistant inspector general for Audits and Evaluations, testified on June 20 before the House Veterans' Affairs Subcommittee on Technology Modernization. His testimony spotlighted the findings and recommendations of several OIG oversight reports that examined VA's financial management systems. He discussed the vulnerabilities and deficiencies VA encounters due to a significantly outdated system, the benefits of a modern system, and how VA might improve its deployment of a new system. In response to questions, Mr. Dahl explained the findings in numerous OIG reviews of failed information technology system implementations at VA. To view the full hearing, visit 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

### Three Executives Indicted for Multibillion-Dollar Healthcare Fraud Scheme

A multiagency investigation resulted in charges alleging that three executives of a healthcare software and service company conspired to use telemarketers to reach out to targeted individuals—including Medicare, TRICARE, and CHAMPVA beneficiaries—and generate standardized orders for the individuals to receive medically unnecessary orthotic braces and pain creams and then getting doctors to sign the orders in exchange for kickbacks and bribes. Allegedly, the templates for the doctors' orders were based on the patients' interactions with the telemarketers, not the prescribing providers, who were limited in their ability to modify the orders. The prescribing providers received a fee in exchange for each order, and routinely did not contact the patients. The three executives' company received payment from VA, Medicaid, and other sources for the devices and creams that were improperly prescribed. The total loss to the government is $2.8 billion, including a more than $1 million loss to VA. The defendants were indicted in the Southern District of Florida. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), FBI, and Department of Health and Human Services (HHS) OIG.

### Pharmacy Owner and Marketing Manager Sentenced for Compounding Medication Fraud Scheme

The owner and marketing manager of a pharmacy were both sentenced in the Eastern District of Louisiana after admitting to their roles in a conspiracy to fraudulently bill compounded medications to the Department of Defense's TRICARE program and VA's Civilian Health and Medical Program (CHAMPVA). From 2014 to 2016, the defendants worked with coconspirators to mass produce compounded medications without proper regard for their effectiveness or patient need, but to maximize reimbursement from these federal programs. The defendants tricked beneficiaries into receiving the high-yield medications without having a medical necessity and pressured pharmacists to fill the prescriptions where no doctor-patient relationship existed. The total loss to the government is approximately $15 million. The loss to VA was about $619,000. The pharmacy's owner was sentenced to 18 months' imprisonment, two years' probation, and restitution of over $10.6 million. The marketing manager was sentenced to 26 months in prison, 36 months of probation, and restitution of $1.3 million.

The VA OIG, Department of Homeland Security, US Postal Service OIG, and DCIS conducted the investigation.

### Defendant Admitted to Fraudulent Receipt of VA Funds

A defendant pleaded guilty in the Southern District of Florida to wire fraud after fraudulently receiving VA funds intended to reimburse a not-for-profit integrated healthcare system for community care provided to veterans. The defendant also fraudulently received funds from a public school system, a counterfeit check, and loans from the Small Business Administration. The loss to VA is approximately $750,000. The VA OIG, Homeland Security Investigations, Federal Deposit Insurance Corporation OIG, US Secret Service, and Aventura (Florida) Police Department investigated this case.

### Defendant Pleaded Guilty to Role in Healthcare Fraud Scheme

A multiagency investigation resulted in charges alleging that multiple defendants participated in a healthcare fraud scheme through which telemarketers solicited durable medical equipment and cancer screening tests to prospective patients. Telemedicine doctors involved with the scheme and with whom the patients did not have an existing relationship wrote the resulting fraudulent prescription orders. Many of the companies providing the equipment and tests identified in the scheme billed CHAMPVA. The total loss to federal and private healthcare benefit programs is approximately $89 million. The total loss to VA is approximately $330,000. One defendant pleaded guilty in the District of New Jersey to conspiracy to commit wire fraud, conspiracy to commit healthcare fraud, and conspiracy to defraud the United States. The VA OIG, FBI, HHS OIG, and DCIS investigated the case.

### Non-VA Defendant Found Guilty for Role in Theft Scheme Involving Former VA Pharmacy Tech

An investigation by the VA OIG, Food and Drug Administration's Office of Criminal Investigations, and VA Police Service revealed that a former pharmacy technician at the Battle Creek VA Medical Center in Michigan used her position to steal more than $400,000 in diabetic test strips from the facility and then sold them to individuals not affiliated with VA. One of these unaffiliated individuals was found guilty at trial in the Western District of Michigan on various charges related to this scheme and agreed to forfeit nearly $428,000. Two other defendants previously pleaded guilty to theft of medical products, with each defendant agreeing to pay a civil settlement of $30,000.

## Benefits Investigations

### Chief Executive Officer of a Technical School Sentenced for Defrauding VA of Nearly $105 Million in Education Benefits

A VA OIG investigation revealed that the chief executive officer of a non-college-degree-granting technical school admitted to his role in the largest known incident of Post-9/11 GI Bill benefits fraud prosecuted by the Department of Justice. The defendant and multiple coconspirators defrauded the

benefits program by falsifying attendance records, student grades, and professional certifications to conceal they were not complying with VA's "85/15" rule. This rule is intended to ensure VA is paying fair market value tuition by requiring that at least 15 percent of enrolled students pay the same rate with non-VA funds. Non-college-degree-granting schools require students to attend in-person classes; online courses are not permitted. In addition to falsifying records and allowing students to complete coursework online at their own pace, the coconspirators posed as students when contacted by the state approving agency to confirm graduation and job placement data so they could maintain school eligibility. The chief executive officer was sentenced in the District of Columbia to 60 months in prison, 36 months of supervised release, and restitution to VA of over $104.6 million.

### Mortgage Lender Agreed to Pay $23.7 Million to Resolve False Claims Act Allegations

An investigation by the VA OIG and Department of Housing and Urban Development (HUD) OIG resolved allegations that a mortgage lender failed to comply with material program requirements when it originated and underwrote mortgages guaranteed by VA or insured by HUD's Federal Housing Administration. The requirements included maintaining quality control programs to prevent and correct underwriting deficiencies, self-reporting any materially deficient loans that they identify, and ensuring that the underwriting process is free from conflicts of interest. The lender entered into a civil settlement agreement under which it agreed to pay over $23.7 million to resolve False Claims Act allegations. Of this amount, VA will receive approximately $8.1 million.

### Business Owner Indicted for Defrauding VA of More than $6 Million

The owner of a business that claimed to provide home health services to veterans allegedly conspired with others 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, alleges 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 $6 million in VA funds intended for more than 300 veterans or their surviving spouses. The business owner was indicted in the Eastern District of Louisiana for wire fraud.

### Former VA Employee Pleaded Guilty to Theft of Government Funds

A former employee at the VA regional office in Bay Pines, Florida, opened a joint bank account that listed a friend, who is a veteran, as the other accountholder. The former employee then directed the veteran's VA compensation benefits—which were awarded without the veteran's knowledge—to be deposited into this joint account and used the funds for his own expenses. The loss to VA is approximately $566,000. The defendant pleaded guilty in the Middle District of Florida to theft of government funds. The VA OIG investigated the case.

## Investigations Involving Other Matters

### Former VA Nurse Sentenced in Connection with Workers' Compensation Fraud Scheme

From 2015 through 2021, a former nurse at the VA medical center in Chillicothe, Ohio, submitted fraudulent reimbursement claim forms to the Department of Labor's (DOL) Office of Workers' Compensation Program for medication she claimed to use due to an injury that resulted from her VA employment. In support of these false claims, the former nurse attached fraudulent homemade receipts pertaining to medication she did not pay for or receive. After reimbursing the defendant for the fraudulent medication claims, DOL then charged back those amounts to VA. After admitting to the fraud scheme, the defendant was sentenced in the Southern District of Ohio to six months in prison, 12 months of home confinement, three years of supervised release, and restitution of more $932,000 to VA. The VA OIG and DOL OIG completed the investigation.

### Veteran Sentenced for Making Threats

An investigation by the VA OIG and FBI Joint Terrorism Task Force revealed that a veteran made statements about being homicidal while on the phone with staff from the Enid VA clinic in Oklahoma and left the staff several agitated voicemail messages. The task force also received information that he made threatening statements to individuals unrelated to VA. The defendant was sentenced in the Western District of Oklahoma to 12 months in prison and three years of supervised release after previously pleading guilty to the interstate transmission of a threatening communication.

### Veteran Indicted for Starting a Fire at the Cleveland VA Medical Center

A multiagency investigation resulted in charges alleging that a veteran started a fire in the emergency department at the Cleveland VA Medical Center. The fire caused damages of approximately $100,000 and resulted in the evacuation of patients and staff. The veteran allegedly was also in possession of a stolen VA computer and another individual's debit card and, earlier the same day, threatened to physically harm a VA nurse. The defendant was indicted in Cuyahoga County Court (Ohio) on charges of aggravated arson, receiving stolen property, and aggravated menacing. This investigation was conducted by the VA OIG; VA Police Service; Cleveland Fire Department; and Bureau of Alcohol, Tobacco, Firearms and Explosives.

# 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.

## Financial Efficiency

### Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2022

The Payment Integrity Information Act of 2019 requires VA to annually review its programs and activities susceptible to significant improper payments based on Office of Management and Budget guidance. The OIG reviewed whether VA complied with the law in fiscal year (FY) 2022 and found that VA reported improper and unknown payment estimates totaling $3.5 billion for seven programs and activities. The FY 2022 estimate is a decrease from the previous two years. In addition, VA reported a decrease in its overall improper and unknown payment rates for six additional programs and activities. Overall, VA satisfied nine of the 10 requirements under the act and concurred with the OIG's recommendations to bring the remaining two noncompliant programs, the Pension Program and the Purchased Long-Term Services and Supports Program, into compliance with the remaining unmet requirement.

### Financial Efficiency Inspection of the VA New York Harbor Healthcare System

The OIG reviewed the stewardship and oversight of funds by the VA New York Harbor Healthcare System, specifically assessing the following four financial activities and processes: open obligations, purchase card use, inventory and supply, and pharmacy operations. The inspection team could not verify that inactive obligations were reviewed and found unreconciled open obligations more than three months old. Purchase card holders did not always obtain prior approval for purchases or perform required reconciliations, and the team estimated about $44.1 million in questioned costs due to noncompliance errors. Staff could improve inventory management by updating usage data so the prime vendor can maintain adequate stock and by consistently using contract waivers for nonprime vendor purchases. Pharmacy deficiencies included observed drug costs higher than expected, turnover rates below recommended levels, a noncompliant inventory process, and inadequate reconciliation reporting. The healthcare system director concurred with the OIG's 14 recommendations, which included ensuring staff review open obligations and pharmacy reconciliations, cardholders receive prior approval for and properly document purchases, and inventory staff update usage data and use the prime vendor.

### Financial Efficiency Inspection of the VA Philadelphia Healthcare System

The OIG's second financial efficiency inspection report released this month assessed the VA Philadelphia Healthcare System across the same four activities and processes listed above and found several opportunities to improve oversight and ensure the appropriate use of funds. In addition to identifying six open obligations with about $44,500 in residual funds that should have been deobligated, the inspection found approximately 18,500 purchase transactions with potential noncompliance errors, leading to about $16 million in questioned costs. The healthcare system could also enhance its inventory management by ensuring stock levels and inventory values are recorded correctly, as well as improve

the efficiency of its pharmacy by narrowing the gap between observed and expected drug costs, avoiding end-of-year purchases, and meeting requirements for monthly reconciliation reporting. VA concurred with the OIG's 12 recommendations made to the healthcare system director to improve these processes, encourage greater cost efficiencies, and promote the responsible use of VA's appropriated funds.

## Information Technology

### Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania

The first of two information security inspection reports published this month focused on the James E. Van Zandt VA Medical Center. These inspections assess whether VA facilities meet Federal Information Security Modernization Act security requirements across four control areas: configuration management, contingency planning, security management, and access controls. For this facility, the OIG found deficiencies in configuration management, including inaccurate component inventories and ineffective vulnerability management; a security management weakness involving the facility's special-purpose system; and weak access controls, such as inadequately restricting access to computer rooms and generators. Three of the OIG's four recommendations were addressed to the assistant secretary for information and technology and chief information officer, who did not concur with one: to verify and make necessary corrections to the systems' component inventory. The OIG stands by its recommendation, as the inspection identified about 2,500 devices on the facility's network as compared to only about 1,450 devices identified by the component inventory, and the assistant secretary's response did not include evidence that would prompt the OIG to reconsider its conclusion.

### Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota

The second information security inspection was conducted at the St. Cloud VA Medical Center. The OIG found deficiencies in three of the four control areas listed above: configuration management, contingency planning, and access controls. Deficiencies in configuration management included critical-risk vulnerabilities that VA's Office of Information and Technology did not identify, uninstalled patches, an inaccurate inventory, and unauthorized software, which deprive users of reliable information access and could risk unauthorized access to, or alteration or destruction of, critical systems. The team identified a contingency planning weakness concerning an untested emergency power shutoff in the data center. Weak access controls included missing logs and visitor access records, communication rooms with insufficient climate controls, and nonworking video surveillance in the data center. VA concurred with the OIG's eight recommendations to strengthen these controls, including six addressed to the assistant secretary for information and technology and chief information officer and two to the medical center director.

## Benefits

### Compensation and Pension Benefits Claims Backlog

The Veterans Benefits Administration (VBA) compensation program provides tax-free monthly payments to veterans for disabilities caused or exacerbated by diseases, events, or injuries from active military service. VBA also has a pension program designed to provide supplemental income to eligible veterans and their survivors. In response to a backlog of claims for the compensation and pension programs, Congress directed the OIG to evaluate the status of the backlog, review the causes, and analyze an initiative to digitally scan personnel files. The OIG found that VBA experienced an increased claims backlog starting in FY 2020 due to the COVID-19 pandemic. Additionally, because of the implementation of the PACT Act, VBA anticipates a further increase in the claims backlog during FY 2023. VBA developed a multilevel action plan to address the anticipated increase in backlog focused on hiring, technology, and proactive scanning. The initiative to digitally scan all personnel files also appeared to be working well.

### VA Developed Reporting Metrics for Appeals Modernization Act Decision Reviews but Could Be Clearer on Some Veterans' Wait Times

The Appeals Modernization Act (AMA) was designed to offer veterans faster resolution of disagreements with VA decisions, with three options: (1) a higher-level review by a VBA senior technical expert with no new evidence presented; (2) a supplemental claim that provides new evidence; or (3) direct appeal to the Board of Veterans' Appeals (excluded from this report's scope). Higher-level reviews and supplemental claims each have a completion goal of 125 days on average, and VA must report its performance to Congress and the public. The OIG found VA developed reporting metrics for AMA decision reviews but could be clearer on some veterans' wait times for higher-level reviews with errors that are then completed as supplemental claims. Separate process reports do not make clear the total expected wait times when a veteran's claim must go through both options consecutively. The OIG also determined reporting did not consider the total time allotted for final actions and made two recommendations to increase transparency.

# 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.

## Featured Report

### Review of Clinical Care Transition from the Department of Defense to the Veterans Health Administration for Service Members with Opioid Use Disorder

This national review evaluated the transition of clinical care from the Department of Defense (DoD) to VHA for service members with opioid use disorder (OUD), an established risk factor for opioid overdose death. Failure to document a patient's OUD history may decrease the likelihood of future providers using medically relevant information and may put patients at risk for adverse outcomes. The OIG conducted electronic health record reviews for two groups identified from a sample of discharged service members with an OUD diagnosis documented in the DoD treatment record: (1) patients without an OUD diagnosis in VHA data and (2) patients who experienced an opioid-related death.

Deficiencies were found in VHA primary care and mental health providers' documentation identifying OUD in encounters, progress notes, and problem lists for both groups—despite having a diagnosis of OUD in DoD treatment records. The OIG evaluated provider perceptions of barriers documenting OUD and use of risk-mitigation strategies. More than half of VHA providers who responded to a questionnaire reported no expectation of reviewing DoD treatment records when completing a patient's intake and identified barriers reviewing DoD treatment records. The OIG made five recommendations to the VA under secretary for health related to the identification of barriers for providers documenting OUD in electronic health records; training on the use, navigation, and retrieval of DoD treatment record information; evaluation of the barriers to access and use of DoD treatment records; and evaluating and updating processes for the identification of patients with OUD.

## Healthcare Inspections

### Inadequate Community Living Center Processes and Training at the West Texas VA Health Care System in Big Spring

This inspection assessed allegations that the community living center (CLC) nursing staff at the West Texas VA Health Care System failed to respond to a patient's medical emergency. The OIG determined that CLC nursing staff responded to the patient's medical emergency but failed to follow policy by not obtaining the automated external defibrillator (AED) and calling 911 immediately. Additional concerns were identified, including facility leaders failing to define CLC staff responsibilities when responding to medical emergencies, the lack of mock code and AED trainings for CLC staff, and the CLC registered nurse's incomplete patient care documentation. The OIG made three recommendations to the facility director to ensure that CLC nursing staff are trained on responsibilities when responding to medical emergencies, mock codes are completed on all CLC units, and all CLC clinical staff meet documentation requirements.

### Quality of Care Concerns and the Facility Response Following a Medical Emergency at the VA Southern Nevada Health Care System in Las Vegas

The OIG assessed an allegation that staff delayed intervention and care for a patient who died following a medical emergency at a VA outpatient clinic. While the inspection team substantiated that a nurse delayed initiating cardiopulmonary resuscitation (CPR) after establishing the patient did not have a pulse and was not breathing, the team was unable to determine if the delay led to the patient's death. Other failures identified included ineffective emergency notification speakers and incomplete incident documentation and review. The OIG made five recommendations to the facility director related to ensuring proper outpatient clinic emergency processes, including staff training, emergency notification, and documentation; ensuring compliance with CPR documentation; monitoring after-action plans for completion and compliance; consulting with the Office of General Counsel to determine if an institutional disclosure is warranted; and evaluating staff's understanding of advance care planning.

### Deficiencies in Emergency Department Care for a Patient Who Died by Suicide at the John Cochran Division of the VA St. Louis Health Care System in Missouri

This inspection found that deficiencies in the quality of emergency department care provided to a patient resulted in a delay of care and may have contributed to the patient's death. Over two hours and 20 minutes elapsed from the time the patient arrived in the emergency department to the time the patient was found unresponsive. An emergency department nurse, who did not properly administer a suicide risk screen and did not monitor the patient after triage, failed to communicate to a physician that the patient was awaiting evaluation, which led to the delay. The OIG also found deficiencies related to the root cause analysis process and determined that facility leaders did not complete a timely institutional disclosure or comply with VHA requirements in reporting to state licensing boards. The OIG also identified a concern related to the chief of the emergency department's conduct, specifically an attempt to direct staff responses to the OIG during the inspection. The OIG made six recommendations to the facility director related to the chief of the emergency department's conduct; standardized administration of the suicide risk screen; monitoring of emergency department patients; completion of root cause analyses and administrative investigations on the same event; completion of institutional disclosures within required time frames; and state licensing board reporting.

## 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:

- VA North Texas Health Care System in Dallas
- New Mexico VA Health Care System in Albuquerque
- Manila VA Clinic in Pasay City, Philippines
- Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network in Arlington
- VA Southern Nevada Healthcare System in North Las Vegas
- Phoenix VA Health Care System in Arizona

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To listen to the podcast on the June 2023 highlights, go to www.va.gov/oig/podcasts.