AUGUST 2023 HIGHLIGHTS

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

Multiple Companies and Individuals Charged in Connection with Foreign Medical Program Fraud Scheme

An investigation by the VA Office of Inspector General (OIG) and the US Department of State's Diplomatic Security Service resulted in charges alleging that 12 individuals and 24 companies participated in a long-term scheme that targeted veterans overseas. Allegedly, the defendants created a network of medical and pharmaceutical service providers that submitted thousands of false claims to VA's Foreign Medical Program for services that were double billed, grossly overpriced, unnecessary, or not rendered. They then deposited and transferred proceeds received from VA and their private business entities among several banking institutions to disguise their illicit activities. The total loss to VA is approximately $67 million. The Panamanian judicial system is prosecuting this case as a result of a filing by the Department of Justice in coordination with the US Embassy in Panama.

Former VA Pharmacist Sentenced in Connection with Fraud Scheme

Between May 2017 and June 2018, a former benefits adviser with the Office of Community Care referred more than 40 spina bifida beneficiaries to unlicensed home health agencies owned by the adviser's friends and family. Among the referrals, the benefits adviser sent patients requiring home health care to a pharmacist who ran such an agency and later obtained employment with the Rocky Mountain Regional VA Medical Center in Aurora, Colorado. These referrals led to payments totaling approximately $19 million from VA to the unlicensed home health agencies engaged in the fraud. The pharmacist was sentenced in the District of Colorado to four years' supervised release and ordered to pay restitution to VA of $613,000 and a fine of $5,000. As part of the plea agreement, the pharmacist resigned from VA and agreed not to seek or hold federal employment for the term of the sentence imposed by the court. The investigation was conducted by the VA OIG, FBI, and Internal Revenue Service Criminal Investigation.

Civil Complaint Filed against Two Debt Collection Agencies and Three Individuals

A multiagency investigation led to the filing of a civil complaint in the Northern District of Oklahoma alleging two debt collection companies and three individuals engaged in a healthcare, wire, and mail

fraud scheme by collecting fictitious debts from CHAMPVA, TRICARE, Medicare, and other insurance beneficiaries. The defendants allegedly collected over $1.4 million as part of the scheme. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, Department of Health and Human Services OIG, US Postal Service OIG, Department of Labor OIG, and FBI.

Business Executive Sentenced in Connection with COVID-19 Fraud Scheme

The owner of a pharmaceutical secondary wholesaler conspired with others to buy and then hoard designated "scarce" materials—including personal protective equipment—at the height of the COVID-19 pandemic. The defendant used deceitful means to sell the equipment to VA, defrauding at least a dozen VA medical centers by selling the equipment at excessive prices. In total, the VA paid $330,000 for this equipment. The defendant was sentenced in the Southern District of Mississippi to 60 months' imprisonment and 36 months' supervised release and ordered to pay restitution of $281,086 and a fine of $50,000. This investigation was conducted by the VA OIG, Food and Drug Administration Office of Criminal Investigations, and FBI.

VA Psychiatrist Sentenced for Scheme to Sell Opioids to Patients

A psychiatrist at the Marion VA Medical Center in Illinois used her position to intentionally sell prescription opioids to her patients for financial gain. She was sentenced in the Southern District of Illinois to five years' probation, to include one year of home confinement, after previously pleading guilty to conspiracy to distribute controlled substances. The VA OIG and FBI investigated the case.

Benefits Investigations

Business Owners Pleaded Guilty to Defrauding VA of More than $4 Million

The owners of a business that claimed to provide home health services to veterans submitted fraudulent applications on behalf of unwitting VA beneficiaries for VA pension with aid and attendance benefits. Qualified veterans or surviving spouses who receive aid and attendance benefits receive a higher monthly pension amount to assist with daily living activities. The investigation, which was conducted by the VA OIG, revealed that the defendants falsely claimed to have provided home assistance to the beneficiaries before submitting the applications and disguised their role in the application process during their interactions with the victims. They received more than $4 million in VA funds intended for more than 300 veterans or their surviving spouses. The business owners pleaded guilty in the Eastern District of Louisiana to wire fraud.

Veteran Indicted in Connection with Fraud Scheme

A VA OIG and FBI investigation resulted in charges alleging a veteran sustained accidental self-inflicted gunshot wounds after making illegal modifications to his military-issued rifle, which caused the weapon to go off during a convoy mission in Iraq. The defendant then allegedly fraudulently obtained a Purple Heart for that gunshot wound and a 100 percent service-connected disability rating from VA for

several issues, primarily caused by the accidental shooting. The total loss to VA is approximately $650,000. The veteran was indicted in the Southern District of West Virginia on charges of healthcare fraud.

Investigations Involving Other Matters

Former VA Employee Sentenced for Leading $3.5 Million Unemployment Insurance Fraud Scheme

A former registered nurse at the Richmond VA Medical Center in Virginia and three defendants engaged in a conspiracy to defraud at least five states of more than $3.5 million in pandemic-related unemployment insurance benefits. The former employee, who was the leader of the conspiracy, used a VA-issued computer to research available benefits, file and access claims, and falsify documents in furtherance of the scheme. The former employee was sentenced in the Eastern District of Virginia to 18 years' imprisonment and ordered to pay restitution of $2 million and forfeiture of $1.4 million after previously pleading guilty to conspiracy to commit aggravated identity theft as well as mail and wire fraud. Three coconspirators were previously sentenced to a total of 138 months' imprisonment in connection with this fraud scheme. The VA OIG and Department of Labor OIG conducted this investigation.

VA Employee Pleaded Guilty in Connection with Paycheck Protection Program Loan Scheme

A VA OIG investigation revealed that an employee of the Louis Stokes Cleveland VA Medical Center in Ohio claimed to own a janitorial services business in 2019 and provided receipts of $100,000 to qualify for a Paycheck Protection Program loan in May 2021. The defendant did not own a business or have any business income in 2019, making the VA employee ineligible for the loan. The loss to the government is about $20,800. The defendant pleaded guilty in the Cuyahoga County Court of Common Pleas to grand theft.

Veteran Pleaded Guilty to Making Threats against a VA Employee and the Loma Linda VA Medical Center

A veteran used a cellphone number cloaking application to threaten to kill a VA employee and their family and then later made threats to destroy the VA medical center in Loma Linda, California, with an explosive device. The defendant pleaded guilty in the Central District of California to threatening a federal employee. The VA OIG and FBI conducted this investigation.

Veteran Pleaded Guilty to Firearm Possession at the Tulsa VA Outpatient Clinic

A multiagency investigation revealed that a veteran made threats against the Ernest Childers VA Outpatient Clinic in Tulsa and later arrived at the facility with a loaded handgun and plastic zip ties. The

defendant pleaded guilty in the Northern District of Oklahoma to possession of a firearm in a federal facility. The VA OIG, VA Police Service, and Tulsa Police Department conducted the investigation.

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

Results of Consulting Engagement on Potential Risks Related to the Integrated Financial and Acquisition Management System and Future VA Financial Statement Audits

The OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to provide consulting services related to the deployment of VA's new general ledger system known as the Integrated Financial and Acquisition Management System (iFAMS) and potential risks to the auditability of future VA financial statements. CLA's observations include that VA is not periodically reconciling various reports to the iFAMS general ledger, has not prepared a risk assessment of financial statement auditability focusing on iFAMS implementation, and continues to rely on lump sum adjustments by financial personnel to correct balances in iFAMS. CLA did not, however, perform an audit of iFAMS, and this engagement was not a financial statement audit. CLA expressed neither an opinion nor a conclusion on the effectiveness of VA's controls over any part of its financial statements or the internal controls of iFAMS.

Financial Efficiency Inspection of the VA Milwaukee Healthcare System

This inspection assessed the oversight and stewardship of funds by the VA Milwaukee Healthcare System and identified potential cost efficiencies. The financial activities and administrative processes examined to determine whether the healthcare system had appropriate monitoring and controls in place included the use of managerial cost accounting information, accrued expense oversight, purchase card use, and inventory and supply management. The inspection team identified several opportunities for the healthcare system to improve its oversight and ensure the appropriate use of funds. The report has eight recommendations to the healthcare system director and one to the Veterans Integrated Service Network (VISN 12) director to use as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with effective financial efficiency practices and the responsible management of VA resources.

Summary of Fiscal Year 2022 Preaward Reviews and Audits of Healthcare Resource Proposals from Affiliates

Veterans Health Administration (VHA) contracting officers must request an OIG review or audit for any sole source healthcare proposal with an anticipated annual value of at least $400,000. In FY 2022, the OIG completed nine preaward reviews and 15 audits of sole source healthcare contract proposals. The combined estimated contract value was $389.6 million, and the OIG identified about $166.9 million in potential cost savings. For 18 proposals with full-time-equivalent pricing, the OIG determined the prices offered to the government were higher than the supported amounts; the most common issue was unsupported care provider salaries. In addition, all seven proposals with per-procedure pricing offered prices higher than the properly calculated Medicare rates. The OIG recommended contracting officers obtain lower prices than those offered. Finally, for 12 proposals, the OIG found potential conflicts of interest for VA personnel and recommended the contracting officer request an opinion from VA's Office of General Counsel.

Benefits

The Fiduciary Program Needs to Verify the Prompt Return of Deceased Beneficiaries' Funds to VA

The OIG reviewed an anonymous allegation received in June 2022 that two fiduciaries under the jurisdiction of the VA's fiduciary hub in Indianapolis, Indiana, had not released four beneficiaries' funds who died in 2010, 2013, 2015, and 2020. A team identified two additional beneficiary cases warranting examination. Findings included that between August and November 2022 both fiduciaries returned six deceased beneficiaries' remaining funds to either VA or an heir, but with delays ranging from 19 months to 12 years from the beneficiary's death or the date VA received the fiduciary's final accounting of the funds distribution. The OIG made four recommendations to promote the prompt return of deceased beneficiaries' VA-derived funds to heirs or VA through improved monitoring and guidance. Although the review focused on the two fiduciaries related to the initial allegations, the process deficiencies and related recommendations could have significant effect across the nationwide Fiduciary Program.

VA Should Ensure Veterans' Records in the New Electronic Health System Are Reviewed before Deciding Benefits Claims

Veterans Benefits Administration (VBA) staff need access to the new electronic health records system for benefits claims processing. The OIG examined whether VBA staff followed procedure to identify and route benefits claims involving new health system records to processors with records access. The OIG found 27 percent of such claims decided between August 1, 2021, and July 31, 2022, did not consider new health system records. A claims sample indicated veterans' benefits were not affected in the 30 cases reviewed, but the risk of error increases if claims involving new health system records are not checked before a decision. If checks are not completed, veterans may not receive the benefits to

which they are entitled. VBA concurred with the OIG's recommendations to conduct refresher training and update guidance to improve staff's handling of claims involving new health system records and strengthen oversight by clarifying staff accountability for failure to consider all evidence.

Additional Measures Would Better Protect Borrowers from Risks Associated with Interest Rate Reduction Refinance Loans

This audit focused on whether oversight of interest rate reduction refinance loans (IRRRLs) by the VBA's Loan Guaranty Service ensures veterans are protected from unfavorable refinancing and unallowable or unreasonable refinance charges. The OIG concluded that new controls implemented by the Loan Guaranty Service by May 2020 improved oversight of IRRRLs but did not fully protect borrowers from unfavorable refinances due to closing cost overcharges. These estimated potential charges amounted to roughly $3 million and affected approximately 18,400 FY 2020 borrowers based on the audit sample. The Loan Guaranty Service lacked controls and sufficiently detailed guidance to fully perform loan oversight and quality assurance. By implementing the nine recommendations the OIG made, the Loan Guaranty Service can more effectively protect borrowers from unfavorable IRRRLs and help ensure that VA is guaranteeing loans that comply with program requirements.

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 Inspection

Concerns with Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina

The OIG reviewed concerns regarding the Charles George VA Medical Center, including delays in Behavioral Health Interdisciplinary Program (BHIP) assessment and psychotherapy consults, prescriber turnover and scopes of practice, community care consults, and the role of the suicide prevention team. Psychotherapy and BHIP consults were not completed within required timelines. Although facility leaders discouraged community care consults, its providers submitted them during the review period. The facility also lacked processes to ascertain why staff leave to inform retention strategies needed to maintain staffing levels. Prescribers were not providing care outside their scope of practice or privileges. The facility leaders did fail to clarify a misunderstanding of the suicide prevention team role. The seven recommendations related to consults, community care referrals, BHIP assessment consults, staff retention, leaders' communication, suicide prevention, and follow-up for patients at high risk for suicide.

Featured Report

OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023

The OIG annually determines a minimum of five clinical and five nonclinical VHA occupations with the largest staffing shortages within each VHA medical center (facility). The OIG also compared the number of severe shortages against the previous four years' reports to assess changes. Facilities reported an increase in severe shortages in FY 2023 over the prior year, following annual decreases during FY 2018–FY 2021. Eighty-eight percent of facilities reported severe shortages for medical officers and 92 percent reported severe shortages for nurses. Practical nurse positions were the most frequently reported clinical occupation with severe shortages; the most frequently reported nonclinical occupation with severe shortages was for medical support assistance. All 139 facilities surveyed reported at least one severe shortage. The total number of severe shortages increased by 19 percent relative to FY 2022.

Deficiencies in Communication for a Patient with a Spinal Cord Injury at the Charlie Norwood VA Medical Center in Augusta, Georgia

This inspection assessed allegations that a spinal cord injury (SCI) patient was inappropriately admitted to the SCI unit, which did not adequately address the patient's needs. Specifics included the patient was not monitored and experienced significant postoperative bleeding following surgical treatment of leg fractures. The OIG did not substantiate that the patient's admission to the SCI unit was inappropriate. The patient did experience postoperative bleeding, which resulted in the patient's transfer to a higher level of care and multiple blood transfusions; however, this was not a result of the postoperative care that was provided on the SCI unit. The OIG did identify a concern related to lack of communication between an orthopedic surgeon and the SCI interdisciplinary team during the patient's outpatient fracture care management. One recommendation was made to the facility director related to establishing a process to optimize communication.

Concern with Veterans Health Administration's Lung Cancer Screening Program Requirements

This report focuses on VHA guidelines for lung cancer screening (LCS) and the requirements for a facility LCS program. VHA has 10 mandatory elements that must be in place for a facility to establish this type of program. Lung cancer is the leading cause of cancer deaths in the United States, where screening rates remain low. Although it generally has a poor prognosis, diagnosis at an early stage improves patients' survival. The OIG found that VHA guidelines presented barriers to broader adoption of LCS and did not ensure consistent implementation. Just over half of surveyed VHA facilities reported having an established LCS program. Three recommendations were made to the under secretary for

health that addressed the operational memorandum for LCS implementation and the lack of a requirement to offer eligible patients the screening.

Leaders' Failure to Resolve Cardiology Department Challenges at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana

OIG healthcare inspectors evaluated leaders' responses to long-standing Cardiology Department staffing and workplace challenges at the Richard L. Roudebush VA Medical Center (facility). Cardiology Department challenges identified during prior reviews by the OIG, VA's Office of the Medical Inspector, and National Cardiology Program Office (NCPO) remained unresolved. Although NCPO gave clear guidance about the actions and resources needed for the Cardiology Department, facility leaders' responses were neither timely nor commensurate with the associated recommendations and failed to address the underlying issues. Facility leaders did not fix cardiologist staffing deficits, support the chief of cardiology, and restore the partnership with the university affiliate. Facility leaders' lack of commitment to and accountability for the Cardiology Department's challenges, compounded by a lack of stability within key leadership positions, undermined efforts to remediate the department's deficiencies. VA concurred with OIG's four recommendations.

Deficiencies in Echocardiogram Interpretation Timeliness, Facility Policies, Patient Safety Reporting, and Oversight at the Fayetteville VA Coastal Health Care System in North Carolina

The OIG assessed an allegation and reviewed admission and treatment processes at the Fayetteville VA Coastal Health Care System. The assertion that the chief of medicine forced a hospitalist to admit a patient who needed unavailable services was not substantiated. The facility had limited inpatient cardiology and surgical services, and patients with needs that exceeded the facility's capabilities were transferred. The hospitalists' duties were consistent with those outlined in facility policy. Peers completed peer reviews, and no evidence was found of related punitive actions. The OIG identified deficiencies in the timeliness of inpatient echocardiogram interpretations, intensive care unit (ICU) policy, hospitalists' reporting of patient safety events, ICU privileging, and provider evaluations. One recommendation was made to the VISN director regarding privileging processes and five were made to the facility director regarding echocardiogram interpretation, ICU policy, staff education, patient safety reporting, and professional practice evaluations.

Comprehensive Healthcare Inspection

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 NY Harbor Healthcare System in New York
- Southern Arizona VA Health Care System in Tucson
- San Francisco VA Health Care System in California
- VA Palo Alto Health Care System in California
- Butler VA Health Care System in Pennsylvania
- Lebanon VA Medical Center in Pennsylvania
- VA Greater Los Angeles Healthcare System in California

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.

Lack of a Formal Process to Identify Incomplete Cases Led to Unsigned Electrocardiogram Reports at the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington

The OIG hotline received a complaint alleging that electrocardiogram (EKG) reports were not being read at the VA medical center in Walla Walla due to insufficient staffing. The matter was referred to VISN 20 for review, which determined that 22 of 519 EKG reports dating back to September 2022 were in a completed/unsigned status. VISN 20 staff determined that the lack of a formal process to routinely identify incomplete cases led to the unsigned reports. The 22 unsigned EKG reports were completed by medical center staff in Walla Walla by May 15, 2023. They further disclosed similar findings from a review of additional EKG reports from medical centers within VISN 20 in Roseburg and White City, Oregon. Beginning in August 2023, the VISN's Quality Management and Oversight office and Chief Nursing office created a plan to establish formal monthly reporting to the VISN's electronic health record modernization steering committee.

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