FEBRUARY 2024 HIGHLIGHTS

Congressional Testimony

Deputy Inspector General Testifies on VA's New Electronic Health Records Pharmacy Software

Deputy Inspector General David Case testified before the House Committee on Veterans' Affairs Subcommittee on Technology Modernization on February 15. He focused on VA's progress on resolving issues with the new electronic health record (EHR) system's pharmacy functions. His testimony previewed the findings in three upcoming OIG reports about the system, including identified shortcomings in pharmacy-related patient safety issues and the EHR's appointment scheduling package. Mr. Case warned in his written statement, "As of September 2023, about 250,000 veterans—who either received medication orders or had medication allergies documented in the new EHR from October 2020—may be unaware of the potential risk for a medication- or allergy-related patient safety event if they receive care at a legacy EHR site." He also discussed the OIG's concern that the Veterans Health Administration is requiring mental health staff at new EHR sites to make fewer attempts to contact no-show patients than required at EHR sites using the legacy system. The written statement can be found on the OIG website and the hearing can be viewed on the committee website.

Deputy Assistant Inspector General for Audits and Evaluations Testifies on VA's Compensation and Pension Programs

Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, testified on February 14, before the House Veterans Affairs' Subcommittee on Disability Assistance and Memorial Affairs. He was accompanied by Dana Sullivan, director of the Claims and Appeals Division within the OIG's Office of Audits and Evaluations. Mr. Arronte's testimony focused on the OIG's findings and recommendations regarding overpayments, underpayments, or other improper payments in VA's compensation and pension programs. In his remarks, he stressed that incorrect payments often result from VA's ineffective internal controls, inadequate technology, or human error due to unclear policies and guidance. His oral and written statements can be found on the OIG website. The hearing can be viewed 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

Featured Investigation

Manufacturer Agreed to Nearly $2 Billion Global Resolution of Criminal and Civil Investigations into Sales and Marketing of Branded Opioid Drug

The Department of Justice announced that an opioid manufacturer entered into a global resolution under which the company agreed to pay a criminal fine of $1.086 billion, civil settlement of $475.6 million, and criminal forfeiture of $450 million. The manufacturer also agreed to plead guilty to a misdemeanor charge of violating the Federal Food, Drug, and Cosmetic Act by introducing misbranded drugs into interstate commerce. A multiagency investigation resolved allegations that the manufacturer's sales representatives marketed their opioid drug to prescribers by touting the medication's purported abuse deterrence, tamper resistance, and crush resistance despite a lack of clinical data supporting those claims. In an attempt to increase revenue, the manufacturer allegedly partnered with a consulting company to devise a marketing scheme that targeted healthcare providers that the company knew were prescribing their opioid for nonmedically accepted indications. The loss to federal healthcare programs is approximately $208.5 million. Of this amount, the loss to VA is approximately $8.5 million. This investigation was conducted by the VA OIG, FBI, Department of Health and Human Services (HHS) OIG, Food and Drug Administration (FDA) Office of Criminal Investigations (OCI), Defense Criminal Investigative Service (DCIS), and Amtrak OIG.

Defendant Sentenced for Scheme Involving Stolen Diabetic Test Strips

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. She was aided by several codefendants. Following an investigation by the VA OIG, VA Police Service, and FDA OCI, one of her codefendants was sentenced in the Western District of Michigan to 78 months of incarceration and restitution of over $427,000. The codefendant also agreed to pay more than $1.2 million to resolve the government's civil claims arising from his misconduct. The former pharmacy technician and another codefendant were previously sentenced in connection with this scheme.

Surgical Sales Representatives Pleaded Guilty for Roles in Multimillion-Dollar Bribery Scheme

Two surgical sales representatives admitted to defrauding VA with the help of two now former VA employees at the James H. Quillen VA Medical Center in Mountain Home, Tennessee. The sales representatives created and used two shell companies to submit invoices to VA for

orthopedic surgeries, which the VA employees paid for using a purchase card. The billings for these surgeries, including a vast array of components, instruments, and implants, were approximately seven to 10 times higher than historical billings for similar surgeries. The sales representatives routinely provided the VA employees with envelopes of cash, which totaled more than $80,000. The loss to VA is approximately $3.7 million. Both sales representatives pleaded guilty in the Eastern District of Tennessee to conspiracy to commit bribery and "honest services" wire fraud.[1] The two former employees were previously indicted in the Eastern District of Tennessee on charges of bribery, money laundering, honest services fraud, and wire fraud. The VA OIG, General Services Administration OIG, and IRS CI conducted the investigation.

Former VA Pharmacy Technician Sentenced for Drug Diversion Scheme

A pharmacy technician who worked at the VA medical center in Kerrville, Texas, stole more than 40 packages containing controlled substances intended for veterans from mailboxes in and around Kerrville and sold the substances to accomplices for further distribution. The former pharmacy technician was sentenced in the Western District of Texas to 42 months of incarceration, 36 months of supervised release, and restitution of more than $2,000. The VA OIG, Drug Enforcement Administration, Kerr County Sheriff's Office, and US Postal Inspection Service conducted the investigation.

Health Services Company Owner Admitted to Role in Fraud Conspiracy Involving Several Compounding Pharmacies

A multiagency investigation resulted in charges alleging numerous individuals engaged in a scheme to solicit and receive kickbacks from multiple North Texas compounding pharmacies in return for directing prescriptions for patients in federal programs to those pharmacies at a higher cost. The owner of a health services company pleaded guilty in the Northern District of Texas to conspiracy to solicit and receive related kickbacks. The total loss to the government is over $6 million. Of this amount, the loss to VA is over $848,000. This investigation was conducted by the VA OIG, US Postal Service OIG, Department of Labor OIG, DCIS, FBI, and HHS OIG.

Company Owner Pleaded Guilty to Healthcare Fraud Scheme Resulting in $89 Million Loss to Multiple Benefits Programs

According to another multiagency investigation, a marketing call center and telemedicine company owner allegedly participated in a healthcare fraud scheme that involved telemarketers soliciting durable medical equipment (typically medical equipment and supplies) and cancer screening tests to prospective patients. Telemedicine doctors with whom the patients did not have an existing relationship allegedly wrote the resulting prescription orders. Many of the

[1] This is defined as a scheme or artifice to deprive another of the intangible right of honest services.

companies identified as allegedly perpetrating the scheme billed VA's Civilian Health and Medical Program (CHAMPVA). The total loss to federal and private healthcare benefit programs is approximately $89 million. The total loss to VA is approximately $330,000. The call center and company owner pleaded guilty in the Southern District of Florida to conspiracy to commit healthcare fraud and conspiracy to defraud the United States in connection with a scheme to violate the Anti-Kickback statute. This investigation was conducted by the VA OIG, FBI, DCIS, and HHS OIG.

Benefits Investigations

Individual Charged with Stealing the Identity of a Veteran for Over 20 Years to Fraudulently Obtain VA Benefits

A VA OIG and Social Security Administration (SSA) OIG investigation resulted in charges alleging that a defendant stole the identity of an Army veteran for over 20 years to fraudulently obtain more than $800,000 in VA healthcare and compensation benefits. VA terminated benefit payments several times after the veteran passed away in 2018, but each time the defendant reached out to VA purporting to be the veteran and requested that benefits should continue. The defendant was charged in the Eastern District of Washington with wire fraud, aggravated identity theft, false representation of Social Security number, and theft of government funds.

Barber and Cosmetology School Owner Indicted for Education Benefits Fraud

According to the VA OIG and IRS Criminal Investigation, a barbering and cosmetology school owner allegedly solicited a veteran to recruit other veterans to use their GI Bill benefits to enroll in courses at his educational institution. The school owner also allegedly advised the veterans that they did not have to attend the classes they enrolled in to receive monthly housing and subsistence payments from VA, and then made numerous false statements and misrepresentations to VA regarding veterans' attendance. The loss to VA is approximately $625,000. The school owner was arrested after being indicted in the Western District of Tennessee on charges of conspiracy to defraud the United States and wire fraud.

One of Three Individuals Sentenced for Defrauding VA by Posing as the Spouse of Multiple Deceased Veterans

A VA OIG and Michigan Attorney General investigation revealed that three individuals used aliases to obtain or create fraudulent documents, including vital records such as birth certificates, to make it appear as if they were the surviving spouses of deceased veterans. These documents were used to fraudulently obtain VA Dependency and Indemnity Compensation benefits, VA Survivors Pension benefits, and unclaimed funds from Michigan. One of the defendants was sentenced in the Third Judicial Circuit Court of the State of Michigan to serve between 78 months and 20 years of incarceration and ordered to pay restitution of $470,000 after

previously pleading no contest to conducting a criminal enterprise and false pretenses. Of the restitution amount, VA is due $430,000.

Veteran Pleaded Guilty in Connection with Benefits Fraud Scheme

A VA OIG and SSA OIG investigation found that a veteran submitted multiple false statements and misrepresentations that concealed his work activities in order to continue to receive VA Individual Unemployability benefits and Social Security disability insurance benefits. In 2015, the veteran opened and operated multiple companies under his spouse's name to conceal his ownership from the government. The total loss to the government is over $321,000. Of this amount, the loss to VA is almost $162,000. The veteran pleaded guilty in the Southern District of Mississippi to making false statements and failing to disclose an occurrence of an event that would affect Social Security disability payments.

Investigations Involving Other Matters

Veteran Inpatient Charged with Attempted Murder

A VA OIG investigation resulted in a criminal charge alleging that a veteran inpatient at the Overton Brooks VA Medical Center in Shreveport, Louisiana, attempted to suffocate another inpatient at the facility. The individual accused was charged in the Western District of Louisiana with an attempt to commit murder.

VA Employee Admitted to Fraudulently Obtaining Federal Pandemic Relief Loans

Another VA OIG investigation revealed that a medical support assistant employed at the Michael E. DeBakey VA Medical Center in Houston, Texas, fraudulently obtained a Small Business Administration–backed Paycheck Protection Program loan for over $15,000 and an Economic Injury Disaster loan for $95,000 for a business that was never in operation. The employee pleaded guilty in the Southern District of Texas to wire fraud.

Defendant Pleaded Guilty for Paycheck Protection Act and Economic Injury Disaster Loan Scheme

An investigation conducted by the VA OIG and IRS Criminal Investigation revealed an individual defrauded the government of approximately $1 million by obtaining Small Business Administration–backed Paycheck Protection Program and Economic Injury Disaster loans for nonexistent or defunct businesses that he previously owned. The defendant then used a portion of these funds to purchase two vehicles for his family members. He pleaded guilty in the Eastern District of Louisiana to false statements, theft of government funds, and money laundering. This investigation was the result of a referral from the COVID-19 Pandemic Response Accountability Committee (PRAC). As a PRAC member, the VA OIG assists federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

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 in February.

Noncompliance with Contractors' Employee Vetting Requirements Exposes VA to Risk

The OIG performed this audit to assess VA's compliance with executive orders, federal regulations, and VA requirements for vetting employees of contractors to work on behalf of VA. The audit team found VA officials had a high rate of noncompliance:

- 94 percent of contract files reviewed did not include position designations establishing the investigative requirements for the contract
- 90 percent of contract files did not include language to communicate vetting requirements to the contractor
- 75 percent of employees on the contracts reviewed did not have a fingerprint check
- 79 percent of employees did not have a formal background investigation

To avoid hiring contractor employees who could put VA employees, veterans, information, and information systems at increased risk, the OIG made recommendations to improve vetting by updating and clarifying guidance and conducting compliance inspections.

Financial Efficiency

Financial Efficiency Inspection of the VA Memphis Healthcare System in Tennessee

In its assessment of the Memphis healthcare system's oversight of financial activities (open obligations, which are legally binding commitments of for goods or services that have a balance associated with them, whether undelivered or unpaid; purchase card use; inventory and supply management; and pharmacy operations), the OIG found that 10 open obligations worth approximately $11.5 million were over 90 days past the performance period and four other obligations had residual funds of $7,200. The team also estimated that staff made errors in over 18,500 purchase card transactions, resulting in about $19.8 million in questioned costs. Inadequate training, staffing, oversight, and data validity affected the healthcare system's supply stock levels. Staff could not document required physical inventories or produce the chief supply chain officer's review of the list of personnel with access to the inventory system. Pharmacy

efficiency can be improved by adding scannable barcodes to shelving, increasing inventory turnover rates, and complying with the reconciliation process. The OIG made nine recommendations to the healthcare system director to address these issues.

Benefits

Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied

VBA uses a rating schedule to assess veterans' service-related disabilities and reviews medical documentation to determine benefits. The OIG examined VBA's implementation of the 2021 changes to the disability rating schedule for hip and knee replacements or resurfacing, and found that VBA rating specialists did not always apply the correct convalescence periods or ensure accurate special monthly compensation benefits. The system used to determine convalescence benefits requires dates be manually entered and lacks functionality to calculate proper periods. About 38 percent of reviewed claims yielded improper payments, with questioned costs of about $3.3 million in overpayments and underpayments. Further, VBA did not sufficiently monitor claims decision accuracy, and 75 percent of staff required retraining on disability rating schedule changes. VBA concurred with the OIG's four recommendations to improve the accuracy of claims decisions related to the rating schedule updates for hip and knee replacements or resurfacing.

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.

Healthcare Inspections

Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Medical Center

This healthcare inspection reviewed an allegation that the Behavioral Health Service program manager denied behavioral health community care services for 32 patients at the Oklahoma City VA Medical Center. The OIG substantiated that the program manager did not follow the consult (referral) management process and discontinued behavioral health community care consults for 29 patients. While the allegation of denied care could not be substantiated, the OIG determined that the discontinued consults resulted in a delay of care for seven patients. However, once the

discontinued consults were identified, facility leaders initiated reviews and took action to ensure patients received care. The OIG concluded that the program manager's poor knowledge of the consult management scheduling processes and failure to follow requirements led to the delayed care involving the seven patients. VA concurred with the OIG's recommendation that the facility director review the community care consult management and appointment scheduling processes, identify deficiencies, and take action as warranted.

Chief of Staff's Provision of Care without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena

The OIG conducted an inspection to assess allegations that the healthcare system's chief of staff (COS) provided pregnancy care without privileges and used deficient care. The inspection also evaluated facility leaders' responses to these identified concerns. The OIG team found that not only did the COS practice without privileges when providing pregnancy care during a patient's second and third trimesters, he also failed to follow evidence-based clinical standards when evaluating the patient for potential severe pregnancy-related conditions, placing the patient and her fetus at risk. The COS prescribed an inadequate antibiotic and delayed consultation in his postoperative treatment for another patient, and he also failed to perform expected preoperative testing for surgical procedures in 32 of 35 cases. The OIG found deficiencies in leaders' oversight, including failures to complete required ongoing professional practice evaluations, to follow privileging processes, and to report deficiencies in the COS's care to the state licensing board. VA concurred with the OIG's 10 recommendations related to correcting these deficiencies, ensuring alignment with Veterans Health Administration and facility privileging policies, and reviewing care deficiencies to identify follow-up needs.

Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas

This healthcare inspection assessed allegations that facility staff delayed ordering medications following a patient's discharge from a community hospital. The OIG substantiated that inadequate care coordination led to a delay in ordering discharge medications and found deficiencies in facility staff's response to the patient's subsequent death by suicide. A community care nurse was found to have provided insufficient care coordination. Primary care staff failings in care coordination and providing health education and same-day access contributed to a delay in ordering the patient's medications. Facility staff also did not conduct the required notification to suicide prevention staff, review, and assessment after being notified of the patient's death. The OIG made five recommendations related to reviewing the patient's care, community care coordination, primary care, and actions required following a patient death by suicide.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that 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. February's CHIP reports centered on the following facilities:

- Robert J. Dole VA Medical Center in Wichita, Kansas
- Ralph H. Johnson VA Medical Center in Charleston, South Carolina
- Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin
- Samuel S. Stratton VA Medical Center in Albany, New York
- Battle Creek VA Medical Center in Michigan
- James A. Haley Veterans' Hospital in Tampa, Florida
- Alaska VA Healthcare System in Anchorage
- Minneapolis VA Health Care System in Minnesota
- White River Junction VA Medical Center in Vermont
- Aleda E. Lutz VA Medical Center in Saginaw, Michigan

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.

VA Employee's Mishandling of Classified Material Results in Security Violation

The OIG Hotline received an allegation that a VA Office of Emergency Management and Resiliency employee mishandled classified documents in a secure facility in August 2023. The matter was referred to the VA Office of Operations, Security, and Preparedness, which investigated and substantiated the allegation. They found that, at the time of the incident, the Office of Emergency Management and Resiliency was transitioning secure facility access controls from using a universal code to individually assigned Personal Identification Numbers (PINs). Personnel were instructed on how to gain access without an individually assigned PIN by using a combination lock during the transition. The security violation occurred when an employee printed a classified document from a secure workspace to the printer room. The employee attempted to recover the document but was unable to unlock the printer room, despite

having received instruction on how to do so. The employee took no action to secure the document and left the facility. The classified document remained in the printer room overnight and was found the next morning by a coworker. This constituted a security violation because the printer room is not authorized classified storage space. As a result, the employee was counseled and received retraining on the handling of classified material.

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To listen to the podcast on the February's highlights, go to the monthly highlights page on our website.