PODCAST TRANSCRIPT
MAY 2020 HIGLIGHTS

This is Quintin Durden, a Deputy Director with the VA Office of Inspector General in Washington, DC. Here are the May highlights.

May was a busy month for the VA Office of Inspector General's Office of Investigations. Significant actions included the sentencing of individuals who participated in bribery and kickback schemes resulting in payments of millions of dollars from numerous VA medical centers throughout the country; the indictment of a VA doctor in West Virginia on charges of deprivation of rights under the color of law and abusive sexual contact, and the indictment of two veterans and at least 16 others, alleging the submission of numerous fraudulent policy claims for Servicemembers' Group Life Insurance Traumatic Injury Protection, or TSGLI, that resulted in a loss to the program of approximately $2 million.

Based on a hotline complaint, a VA OIG investigation resulted in charges that the defendants and 11 other individuals engaged in a bribery and kickback scheme involving multiple vendors and employees of the VA medical centers in West Palm Beach and Miami, Florida. The charges allege that VA employees placed supply orders in exchange for cash bribes and kickbacks from the vendors. In many instances, the prices of supplies were grossly inflated, or the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts.

A former Beckley, West Virginia, VA medical center doctor was indicted in the Southern District of West Virginia on charges of deprivation of rights under the color of law and abusive sexual contact. An investigation resulted in charges alleging the defendant sexually molested six patients during examinations at the facility.

Two veterans and at least 16 others were charged for allegedly submitting numerous policy claims for TSGLI that reflected fraudulent narratives of catastrophic injuries and exaggerated the loss of activities of daily living, generating payouts of $25,000 to $100,000 per claim. Three additional veterans were previously indicted in connection with this investigation in October 2019. One of the previously indicted veterans allegedly recruited a Navy command medical doctor and a Navy nurse to create false medical records and sign the claims. The loss to the TSGLI program is approximately $2 million.

The Office of Audits and Evaluations published one report, VA's Compliance with the Improper Payments Elimination and Recovery Act for Fiscal Year 2019. The OIG reviewed whether VA complied with

Improper Payments Elimination and Recovery Act of 2010 requirements for fiscal year 2019. The OIG determined that VA did not comply because it did not satisfy two of the six requirements. VA did not meet annual reduction targets for a program considered at risk for improper payments and did not report a gross improper payment rate of less than 10 percent for six programs and activities. The OIG also determined VHA understated a program estimate because of insufficient documentation that services were received, and recommended VHA implement appropriate testing procedures. Four programs and activities were noncompliant for five consecutive fiscal years and two activities were noncompliant for three years. VA satisfied the additional reporting requirements for two high-priority programs and another program with a monetary loss of more than $100 million as reported in FY 2018.

The Office of Healthcare Inspections published four reports. In one report, Radiology Concerns at the VA Illiana Health Care System in Danville, Illinois, the OIG assessed facility leaders' response to a radiologist's four alleged errors. The OIG determined that care for one of the four patients met institutional disclosure criteria. Facility leaders conducted two expanded reviews of the radiologist with Veterans Integrated Service Network and National Teleradiology Program assistance. The OIG concluded the Radiology Service lacked early detection and identification processes for radiologic errors, and the radiology service chief inadequately assessed the radiologist's performance. The OIG made six recommendations.

In another report, Death of a Patient, Deficiencies in Domiciliary Safety and Security, and Inadequate Contractual Agreement at the VA Northeast Ohio Healthcare System in Cleveland, the OIG assessed alleged deficiencies in the care of a patient who died. The team also examined safety and security measures and nurse staffing. In response to a congressional request, the OIG evaluated whether Volunteers of America (VOA) met contractual requirements for providing nonclinical staffing and food and cleaning services. The OIG did not substantiate that emergency department staff failed to properly assess the patient; however, no provider ordered an electrocardiogram as recommended by VHA prior to initiating methadone. VOA staff were found to have improperly completed health and safety sheets. The OIG determined nurse staffing was not unsafe and core clinical staffing met or exceeded requirements. VOA substantially met its contractual obligations. Two recommendations were made to the VA Office of Asset Enterprise Management director related to contract modifications, and three were made to the facility director related to electrocardiograms, institutional disclosure, and safety rounds.

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