INSPECTOR GENERAL REPORT

2014-06-0110

December 1, 2014

INDIANA VETERANS' HOME

Inspector General David Thomas and OIG Attorney Jennifer Cooper, after an investigation by Special Agent and Director of Investigations Darrell Boehmer, reports as follows:

This is an investigation by the Indiana Office of the Inspector General (OIG) regarding the Indiana Veterans' Home (IVH). This came to us through a self-reporting by IVH Superintendent Linda Sharp (Sharp). She has held this position since January of 2014.

Upon her assuming this position, she found problems within the IVH pharmacy (Pharmacy) operations. Specifically, the maintenance of medications was being mismanaged, including her determination that medications were co-mingled and ordered in an untimely manner, patient and drug records were maintained incorrectly, and audits were not being performed in an acceptable manner to assure compliance. While all IVH residents were receiving their proper medications and their care was not compromised, the mismanagement of the Pharmacy resulted in financial losses to the IVH. Specifically IVH was paying out-of-pocket for medications that should have been covered under

residents' prescription drug benefits and/or supplied through the federal Veteran's Administration (VA). In 2013, because of the failure to submit claims to Medicare, Medicaid and Tri-Care, and properly use the VA pharmaceutical ordering system, the IVH incurred $293,000.00 in unnecessary costs. In addition, the Pharmacy mismanagement resulted in approximately $33,000.00 in wasted medications due to their being expired or overstock.

Sharp also determined that Medicare and United States Veterans Administration reimbursements were not being fully utilized by Pharmacy operations.

The Pharmacy had been operated through a contract with Comprehensive Therapy Specialists, LLC (CTS) since January of 2012. CTS oversaw these contractual services for the IVH Pharmacy operations. The CTS contract was terminated by Sharp on June 6, 2014.

The OIG responded to these reports by Sharp by instituting an audit of the Pharmacy by the Indiana Professional Licensing Agency Board of Pharmacy Compliance Division (PLA Audit Team).[1] This team went on location and inspected all operations, verifying the above reports by Sharp that the Pharmacy was operating out of compliance. This Audit Team is specifically empowered to review the operations of Indiana pharmacies.

The OIG is authorized by the Indiana Legislature to review wrongdoing within the Indiana Executive Branch and make recommendations to prevent

[1] The OIG has the authority to supervise Executive Branch investigations and because of the Audit Team's expertise in pharmacy audits, empowered this Audit Team to act on behalf of the OIG in conducting the audit. IC 4-2-7-3(1).

future mismanagement. IC 4-2-7-3(8).

Based upon these initial reports by Sharp, the PLA Audit Team's findings, and additional interviews and research, the OIG now finds:

A

That the report by Sharp of mismanagement by the contract services through the oversight of the Pharmacy by CTS is verified. Although the level of mismanagement is immense, we are unable to certify that the conduct is criminal in nature.[2]

B

Corrective measures have already been commenced and implemented by Sharp. In addition to terminating the CTS contract, Sharp also has articulated savings to the State through increased billing reimbursement procedures which will be made through Medicare and United States Veterans Administration programs for medical supplies and drugs.

Accordingly, the OIG now makes the following recommendations.

1

That CTS not be permitted to contract or be employed in the future with the State of Indiana. This is due to its mismanagement of the Pharmacy and the resulting findings above.

2

That the PLA Audit Team report its findings to the PLA Pharmacy Board

[2] However as addressed *infra*, a copy of this report will be supplied to the Tippecanoe Prosecuting Attorney for review and direction.

(Board) for action the Board deems appropriate. The PLA Audit Team reported to the OIG that it would immediately make such a reporting and sought OIG advice on coordinating that report to assist the investigation. The Board is empowered to oversee and license proper pharmacy operations. IC 25-26-13.

3

That the PLA Audit Team conduct a follow-up audit within 180 days to determine if Pharmacy operations are in compliance with all applicable laws and issue its findings to the OIG for further review and reporting.

4

That Sharp consider appointing a temporary compliance officer to internally monitor Pharmacy and other IVH operations. It appears that Sharp, herself, has already detected and implemented the above compliance measures in addition to her report of these issues, and accordingly this recommendation defers to Sharp's judgment.

Conclusion

Although the level of penalty appears to be that of mismanagement and we are unable to certify a criminal offense with a particular individual, the OIG will file a copy of this report with the Tippecanoe Prosecuting Attorney for review and provide investigative records as requested. A copy will also be provided to the United States Inspectors General for the United States Health and Human Services and the United States Veterans Administration. The OIG stands ready to conduct further activity as requested by these authorities. With these parameters,

our investigation will be suspended at this time.

/s/ David O. Thomas, Inspector General