FEBRUARY 2025 HIGHLIGHTS

Congressional Testimony

The OIG actively engages with Congress on issues affecting VA programs and operations. The OIG's participation in congressional hearings helps focus legislative action and elevates national attention on topics of concern within the veteran community. In February, OIG leaders testified at three hearings before subcommittees of the House Veterans' Affairs Committee (HVAC). All written statements to Congress can be found on the OIG website. The full hearings can be viewed on the committee website.

Acting Inspector General Testifies on Accountability at VA

Acting Inspector General David Case testified before the HVAC Subcommittee on Oversight and Investigations on February 6. Mr. Case's testimony focused on components of accountability identified by the OIG as often lacking within VA programs and operations. He discussed the need for, among other things, strong governance so all employees understand their roles and responsibilities as well as updated IT systems and effectual business processes.

Acting Assistant Inspector General for Healthcare Inspections Testifies on Oversight of VHA's Community Care Program

Dr. Julie Kroviak's testimony before the HVAC Subcommittee on Health on February 12 detailed the major themes highlighted in more than 50 OIG reports focused on community care. These themes included timeliness and coordination of care, inadequate oversight of the quality of care being delivered, staffing shortages, as well as substandard IT systems and inaccurate and incomplete data. In response to questions, Dr. Kroviak also noted that VA must clearly define roles and responsibilities to establish the authority needed to provide adequate internal oversight and to hold staff accountable.

Acting Inspector General Testifies on VA's New Electronic Health Record Modernization Program

Acting Inspector General David Case testified as well before the HVAC Subcommittee on Technology Modernization on February 24. His testimony focused on issues with the development and deployment of the new electronic health record system, which has been the focus of 22 OIG oversight reports. He reviewed the open recommendations from these reports, including issues with appointment scheduling, medication safety, and the absence of reliable information on the program's cost and schedule. In response to questions, he reiterated that VA must develop an integrated master schedule in order to better understand whether the department can properly deploy the new system safely and timely.

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 in February.

Healthcare Investigations

Former VA Physician Sentenced for Sexually Assaulting a Patient

A VA OIG investigation resulted in charges alleging that between September 2019 and January 2020, a former physician at the Atlanta VA Medical Center sexually assaulted four female patients during medical examinations at the facility involving improper touching. The former physician was found guilty by a jury in the Northern District of Georgia of deprivation of rights under color of law and abusive sexual contact after a two-week trial. The jury found the physician guilty of charges related to one victim and acquitted him of charges pertaining to the other three victims. He was sentenced in the Northern District of Georgia to 24 months' imprisonment and 15 years' supervised release and is also prohibited from practicing medicine while on supervised release.

Former VA Doctor Sentenced for Illegally Distributing More Than 1.8 Million Doses of Opioids and Engaging in a $5 Million Healthcare Fraud Scheme

A former chief of medicine at the Alexandria VA Medical Center in Pineville, Louisiana, illegally distributed more than 1.8 million doses of Schedule II controlled substances, including oxycodone and morphine, to more than 350 VA patients and other non-VA patients without a legitimate medical purpose. He also defrauded healthcare benefit programs of approximately $5.4 million. While working full-time as the facility's chief of medicine, he maintained a clinic more than 200 miles away. He pre-signed patient prescriptions outside the usual course of professional practice and without determining their medical necessity. With his knowledge, patients filled their prescriptions using their insurance benefits, causing healthcare programs to be fraudulently billed. The former chief of medicine was sentenced in the Eastern District of Louisiana to seven years' imprisonment after being found guilty at trial by a federal jury of conspiracy to unlawfully distribute and dispense controlled substances, unlawfully distributing and dispensing controlled substances, maintaining a drug-involved premises, and conspiracy to commit healthcare fraud. A restitution hearing was scheduled for a later date. The VA OIG, Department of Health and Human Services (HHS) OIG, and

Federal Bureau of Investigation (FBI) conducted this investigation.

Pharmacy Owner Sentenced in Connection with Compounding Pharmacy Fraud Scheme

A multiagency investigation resulted in charges alleging that several individuals operated several compounding pharmacies in North Texas and conspired with various doctors to charge government agencies for medically unnecessary compound prescriptions, pain creams, scar gels, and multivitamins primarily to patients covered under the Office of Workers' Compensation Program. A pharmacy owner was sentenced in the Northern District of Texas to 210 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of almost $115.4 million after previously being found guilty at trial on various charges related to this healthcare fraud scheme. The total loss to the government is approximately $62 million, including an approximately $7.5 million loss to VA. The VA OIG, Department of Labor OIG, US Postal Service OIG, and the Internal Revenue Service Criminal Investigation conducted this investigation.

Healthcare Software and Services Company Executive Pleads Guilty in Connection with Healthcare Fraud Scheme

Another multiagency investigation resulted in charges alleging that a healthcare software and services company executive and others conspired to use telemarketers and medical providers to generate templated doctors' orders for medically unnecessary orthotic braces and pain creams in exchange for kickbacks and bribes. It is alleged that the templates for the doctors' orders were largely based on the patients' interactions with soliciting telemarketers, not the prescribing providers. The prescribing providers were allegedly limited in their ability to modify the templated orders. It is also alleged that the prescribing providers, who received a fee in exchange for each order, routinely did not contact the patients. Medicare, VA, and other insurers were billed more than $1 billion and subsequently paid more than $360 million based on these false and fraudulent claims. The loss to VA is more than $1 million. The executive pleaded guilty in the Southern District of Florida to conspiracy to commit healthcare fraud. This investigation was conducted by the VA OIG, Defense Criminal Investigative Service, FBI, and HHS OIG.

Benefits Investigations

Veteran Indicted for Compensation Benefits Fraud Scheme

A VA OIG proactive investigation resulted in charges alleging that a veteran was receiving VA disability compensation benefits due to a 100 percent service-connected rating for legal blindness while maintaining a Florida driver's license. The veteran allegedly made false statements to VA regarding his true visual acuity and did not disclose that he maintained an active driver's license and worked as an armed guard at an elementary school. The loss to VA is approximately

$1.3 million. The veteran was arrested after being indicted in the Middle District of Florida for theft of government funds.

Daughter of Deceased VA Beneficiary Sentenced for VA Fraud Scheme

The daughter of a deceased VA beneficiary continued to collect and withdraw her mother's VA dependency and indemnity compensation benefits following the mother's death in November 2005. She was sentenced in the Middle District of Florida to 12 months and one day of imprisonment and ordered to pay approximately $338,000 in restitution to VA after previously pleading guilty to wire fraud. The VA OIG investigated this case.

Investigations Involving Other Matters

Medical Supply Company Owner Pleaded Guilty to COVID-19 Fraud Scheme

An investigation conducted by the VA OIG and the Food and Drug Administration Office of Criminal Investigations revealed the owner of a medical supply company provided multiple VA medical centers with counterfeit personal protective equipment during the pandemic. Based on false representations made by the owner, VA awarded purchase orders to his company totaling approximately $5.5 million. The medical supply company subsequently provided counterfeit 3M N95 masks and nitrile gloves to VA. The owner pleaded guilty in the Southern District of Florida to major fraud against the government.

Former Contractor at the Palo Alto VA Medical Center Guilty of Sexually Assaulting Coworker

A VA OIG investigation resulted in charges alleging a contracted janitorial supervisor at the Palo Alto VA Medical Center sexually abused his subordinate employee in an examination room at the facility in July 2021. The former supervisor also allegedly lied to a VA OIG agent during a subsequent interview by claiming that he never had sexual intercourse with the victim. He was found guilty by a federal jury in the Northern District of California following a three-week trial on charges of aggravated sexual abuse, sexual abuse, and false statements to a government agency.

Former Seattle VA Regional Office Employee Sentenced for Sending Sexually Explicit Content to a Minor

An investigation by the VA OIG and Seattle Police Department revealed that a former VA employee at the Seattle VA Regional Office sent sexual photos and illicit messages to an undercover officer posing as a 13-year-old child. According to the investigation, the communications occurred during regular duty hours, with some of the photos having been taken in a restroom near the employee's VA office. The former VA employee pleaded guilty in Washington's King County Superior Court to a felony charge of communicating with a minor for

immoral purposes and a misdemeanor charge of *attempting* to communicate with a minor for an immoral purpose. The former VA employee was sentenced to three months' imprisonment for the felony charge and a suspended sentence of 364 days' imprisonment for the misdemeanor charge as well as ordered to register as a sex offender.

Veteran Sentenced for Assault at the Albany VA Medical Center

A VA OIG and VA Police Service investigation revealed that a veteran repeatedly groped an attending paramedic in the back of an ambulance as he was being transported for treatment to the Samuel S. Stratton VA Medical Center in Albany, New York. The assault occurred after the ambulance arrived on the facility's property. The veteran was sentenced in the Northern District of New York to an imprisonment term of time served (approximately 10 months) and 12 months' probation after previously pleading guilty to obstructing emergency medical services and simple assault.

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.

Featured Report

Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services

The OIG assessed VHA's oversight of two third-party administrators (TPAs), Optum and TriWest, to make sure VHA made accurate, timely community care payments for outpatient healthcare and dental services. The OIG estimated VHA accurately paid Optum for outpatient services 98.6 percent of the time, totaling $5.1 billion for 33.1 million transactions, and accurately paid TriWest 99.8 percent of the time, totaling $4.4 billion for 25 million transactions. Though error rates were small, the combined estimated errors meant overpayments of about $178.5 million because VHA either did not charge correct rates or rates were not available. VHA recovered some overpayments. Community providers, VHA, and the TPAs generally met requirements for paying on time, but the OIG estimated VHA paid over $900 million more to the TPAs than the TPAs paid community providers for dental services. This occurred because contracts did not properly limit reimbursement to TPAs. The OIG made seven recommendations.

Financial Efficiency

Financial Efficiency Inspection of the VA Tampa Healthcare System

The OIG inspected the following financial activities and administrative processes at the VA Tampa Healthcare System: managerial cost accounting information, open obligations oversight, purchase card use and oversight, and inventory and supply chain management. Among the findings, the healthcare system could use managerial cost accounting information more effectively to help spend more efficiently and improve its performance measurement process for identifying and correcting cost inaccuracies. The healthcare system did not always perform monthly reviews and deobligate funds no longer needed. Further, it appeared that they used funds from the wrong fiscal year to pay for services, which may have violated the "bona fide needs" rule (government funds can only be used to meet the needs for the period of time for which they were allocated). The healthcare system also did not always process purchase card transactions in accordance with VA policy and did not meet the days-of-stock-on-hand metric or maintain accurate supply chain data. The VA concurred with the OIG's 12 recommendations for improvement, that, if left unaddressed, may eventually interfere with financial efficiency practices and the strong stewardship of VA resources.

Benefits

Lapse in Fiduciary Program Oversight Puts Some Vulnerable Beneficiaries at Risk

VBA's Fiduciary Program protects vulnerable beneficiaries who are unable to manage their own VA benefits. The program appoints and oversees fiduciaries to manage the benefit payments. Each beneficiary must have a record in the program's case management system so that staff can assess beneficiaries' well-being and protect benefits from misuse. The OIG found that VBA did not create records for 311 beneficiaries who received about $24.5 million in compensation and pension benefits without VBA oversight. This lapse generally occurred because records did not migrate from the legacy systems or staff did not manually create the records. Overall, the program failed to oversee these beneficiaries because it lacked controls to identify when beneficiaries found to be incompetent did not have an electronic fiduciary record. VBA implemented the OIG's three recommendations to establish records for the 311 beneficiaries, resume oversight activities to assess the well-being of beneficiaries and the use of funds, and implement controls to flag beneficiaries without records.

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 in February.

National Review

Healthcare Inspection VISN Summary Report: Evaluation of Practitioner Credentialing and Privileging for Fiscal Years 2023 to 2024

VHA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). This report describes the results of a VISN-level oversight evaluation of credentialing and privileging processes for healthcare providers at facilities within VISNs 7, 8, 12, 15, 20, and 23 from December 5, 2022, through February 14, 2024. The six inspected VISNs cover whole or parts of 26 states and territories, including Alabama, Alaska, Arkansas, California, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Oregon, Puerto Rico, South Carolina, South Dakota, Virgin Islands, Washington, Wisconsin, and Wyoming. The OIG issued four recommendations to ensure external practitioners with equivalent training and similar privileges complete timely professional practice evaluations; leaders review state licensing board reporting processes at the VISN level; and responses to annual facility self-assessments reflect accurate data.

Healthcare Inspections

Deficiencies in Invasive Procedure Complexity Infrastructure, Surgical Resident Supervision, Information Security, and Leaders' Response at the Lieutenant Colonel Charles S. Kettles VA Medical Center in Ann Arbor, Michigan

The OIG determined that the facility lacked services required to support the inpatient invasive procedure complexity designation, a VHA model that ensures facilities have the infrastructure to safely support the level of the invasive procedures performed. Waivers were approved; however, the OIG found waiver request delays and raised a concern with monitoring patient transfer timeliness. The inspection identified issues related to the blood utilization committee's engagement and whether an institutional disclosure for a patient should be made. After finding inconsistencies with the interpretation of VHA resident supervision policy, the team also questioned whether the guidance from the Office of Academic Affiliations does not meet the intent of VHA policy. The OIG substantiated an allegation that facility leaders failed to ensure information security related to VA computer access for residents but did not substantiate there were postoperative documentation failures or that facility leaders were unresponsive to patient

safety concerns. There were also weaknesses with monitoring and sustaining related action plans. VA concurred with all three recommendations to the under secretary for health, three recommendations to the VISN director, and six recommendations to the facility director.

Staff Mitigated the Impact of Appointment Cancellations in a Mental Health Clinic at the VA Northern Indiana Healthcare System in Fort Wayne

This healthcare inspection assessed clinic cancellation practices at a mental health clinic in Fort Wayne, Indiana. The OIG found that mental health leaders and a social work supervisor used a standard clinical disposition process to address the needs of a social work mental health provider's patients and to transition patients to alternate treatment following the provider's sudden resignation. No concerns or adverse outcomes were identified related to the cancellations. The inspection team concluded, however, that the chief of mental health and the chief of social work did not notify the chief of staff to seek approval for urgent cancellations of the provider's clinic as required by policy. Moreover, the healthcare system failed to include social work providers assigned to mental health clinics in their review of short-notice clinic cancellations. The OIG made two recommendations to the system director to (1) evaluate the system clinic cancellation policy and chief of staff notification of urgent clinic cancellations and (2) to include social work mental health provider data in the system review of short-notice clinical cancellations within mental health clinics.

Healthcare Facility Inspections

The Healthcare Facility Inspections Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care in five areas: culture, environment of care, patient safety, primary care, and veteran-centered safety net (for vulnerable populations such as those served by homeless programs). The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, in addition to the well-being of patients and staff.

The OIG published one healthcare facility inspection report in February on the VA Salem Healthcare System in Virginia. The OIG issued two recommendations for improvement related to the environment of care: mitigating the impact of construction on patient care in the emergency department and ensuring the toxic exposure screening navigators verify data to track veterans waiting for secondary screenings and address any backlog.