JUNE 2020 HIGHLIGHTS

Criminal Investigations Involving Health Care

Former Fayetteville, Arkansas, VA Medical Center Chief of Pathology Pleads Guilty to Involuntary Manslaughter and Mail Fraud

A former Chief of Pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, pleaded guilty in the Western District of Arkansas to involuntary manslaughter and mail fraud. A VA OIG investigation revealed the defendant misdiagnosed thousands of VA patients while under the influence of a potent substance that causes a lengthy intoxication period but no hangover and is undetectable using routine drug and alcohol testing methods. The defendant also circumvented contractually obligated drug and alcohol testing to conceal his chemical dependency.

Former Veterans Health Administration Employee Sentenced in Connection with Fraud Scheme

A former Veterans Health Administration (VHA) Office of Community Care benefits advisor was sentenced in the District of Colorado to 192 months' imprisonment and three years' supervised release and was also ordered to pay restitution of $18,777,135 to VA. Following an eight-day trial, the defendant was previously found guilty by a federal jury of conflict of interest, healthcare fraud, conspiracy, soliciting an illegal gratuity, receiving an illegal gratuity, unlawful monetary transactions, and money laundering. An investigation by the VA OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service Criminal Investigation (IRS-CI) resulted in charges that the defendant referred over 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives in exchange for kickbacks. As a result of these referrals, VA paid the home health agencies approximately $19 million.

Medical Technology Company President Charged with Securities Fraud and Conspiracy to Commit Healthcare Fraud

The president of a medical technology company was arrested after being charged in the Northern District of California with securities fraud and conspiracy to commit healthcare fraud. A VA OIG, Department of Health and Human Services OIG (HHS OIG), U.S. Postal Inspection Service (USPIS), and Defense Criminal Investigative Service (DCIS) investigation resulted in charges alleging the defendant conspired to improperly bill healthcare insurers for approximately $69 million in false and fraudulent claims for allergy and coronavirus (COVID-19) testing. The defendant and others allegedly schemed to manipulate the company's stock price by making false claims concerning the company's ability to provide accurate, fast, and cheap COVID-19 tests in compliance with federal and state regulations. It is further alleged the defendant and others made numerous misrepresentations to potential investors about the COVID-19 tests and used a VA solicitation to further the stock manipulation scheme.

Defendant Arrested for Defrauding VA's Civilian Health and Medical Program

A defendant was arrested after being charged in the District of New Jersey with conspiracy to violate the Anti-Kickback Statute. A VA OIG, HHS OIG, FBI, and IRS-CI investigation resulted in charges alleging that the defendant participated in a telemarketing scheme to solicit genetic cancer screenings to prospective patients and then used telemedicine doctors to generate prescriptions for these patients regardless of medical necessity. It is alleged that the telemedicine doctors had no relationship with the patients, and that the telemarketers then sold the completed orders to a testing laboratory. Many of the companies participating in the scheme billed VA through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The total loss to the government exceeds $1 billion. Of this amount, VA's loss from this scheme is approximately $330,000.

VA Puget Sound Healthcare System Employee Arrested for Theft of Government Property

An employee of the VA Puget Sound Healthcare System in Seattle, Washington, was arrested after being charged in the Western District of Washington with theft of government property. A VA OIG investigation resulted in charges alleging that the defendant stole several pieces of medical equipment, including ventilators and bronchoscopes, and then sold the items on eBay. The approximate value of the stolen items is $181,000.

VA Puget Sound Healthcare System Pharmacist Arrested for Making Threats Against Fellow VA Employees

A VA Puget Sound Healthcare System pharmacist was arrested after being charged in the Superior Court of King County, Washington, with cyberstalking. The defendant allegedly attempted to acquire an AR-15 rifle and threatened in text messages to kill two VA employees. This investigation, which was initiated based upon a hotline complaint, was conducted by the VA OIG, VA Police Service, Kent Police Department, Seattle Police Department, and Albuquerque Police Department, with assistance from the Bureau of Alcohol, Tobacco, Firearms, and Explosives, USPIS, and FBI.

Criminal Investigations Involving Benefits

Defendant Sentenced in Connection with Fiduciary Fraud Scheme

An employee of a former VA-appointed professional fiduciary was sentenced in the District of New Mexico to 71 months' imprisonment, three years' supervised release, and restitution after previously pleading guilty to conspiracy, mail fraud, aggravated identity theft, money laundering, and conspiracy to commit money laundering. A comprehensive order for the restitution, which the defendant will pay jointly and severally with the other three defendants, will be filed after all are sentenced. A VA OIG, Social Security Administration (SSA) OIG, FBI, and IRS-CI investigation revealed that from November 2006 to July 2017, the defendants engaged in a sophisticated financial scheme to use their nonprofit organization to defraud victims of their VA and SSA beneficiary funds. The defendants unlawfully transferred money from their clients' accounts to their own business accounts. The defendants then used

funds from these comingled accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately $3.3 million dollars.

Veteran Pleads Guilty in Connection with Compensation Benefits Fraud Scheme

A veteran pleaded guilty in in the Middle District of North Carolina to theft of public money. A VA OIG proactive investigation revealed the defendant grossly exaggerated the severity of his service-connected conditions in order to receive more than $8,500 per month in VA compensation benefits. The defendant, who retired from the U.S. Army, subsequently worked as a police officer while being compensated by VA for a multitude of falsified ailments. Video footage showed the veteran playing basketball, using stairs, and ambulating without any form of assistance. The loss to VA is approximately $1 million. This loss amount consists of a combination of VA benefits including compensation benefits, a Specially Adapted Housing grant, automobile grants, and education benefits. As a result of this investigation, a beachfront condominium, an automobile, a motorized scooter, and cash were seized from the defendant.

Criminal Investigations Involving Other Matters

Three Individuals Sentenced in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

Two nonveterans and one veteran were sentenced in the District of Massachusetts in connection with a service-disabled veteran-owned small business fraud scheme. The two nonveteran defendants were each sentenced to two years' supervised release, forfeiture of $300,000, and a fine of $300,000. The veteran defendant received the same sentence minus the fine. A VA OIG, Army Criminal Investigation Command, and General Services Administration OIG investigation revealed the defendants defrauded VA's and Department of Defense's set-aside service-disabled veteran-owned small businesses and Historically Underutilized Business Zone-certified businesses. The defendants used a veteran-owned small business to apply for and receive set-aside contracts and then passed through most of the work to an ineligible business not owned by a veteran. The value of these contracts totaled approximately $10 million for VA and $6.4 million for the Department of Defense.

Former Pharmaceutical Company Manager Sentenced for RICO Conspiracy

The former manager of a pharmaceutical company's reimbursement center, who directly supervised employees that contacted insurers and primary benefits managers, was sentenced in the District of Massachusetts to one day of incarceration and 36 months' probation for her role in a Racketeer Influenced and Corrupt Organizations Act conspiracy. A multiagency investigation resulted in charges that the pharmaceutical company's upper management led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe their drug, a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. Through the creation of the reimbursement center, the defendants also conspired to mislead

and defraud health insurance providers by using a variety of fraudulent reimbursement schemes to obtain payment authorization from insurers. CHAMPVA paid the company approximately $3.3 million for this drug. This investigation was conducted by the VA OIG, Department of Labor (DOL) Employee Benefits Security Administration, U.S. Postal Service (USPS) OIG, Food and Drug Administration Office of Criminal Investigations, Drug Enforcement Administration, Office of Personnel Management OIG, HHS OIG, DCIS, USPIS, and FBI.

Former Pharmacy Owner and his Wife Sentenced in Connection with Compounding Pharmacy Scheme

The former owner of a pharmacy was sentenced in the Southern District of Texas to 10 years' imprisonment and ordered to pay over $12 million in restitution to the federal government. The defendant was previously found guilty at trial of various charges, including conspiracy to pay healthcare kickbacks, conspiracy to commit money laundering, conspiracy to commit healthcare fraud, healthcare fraud, and wire fraud. The defendant's wife, who served as the pharmacy's vice president and previously pleaded guilty to related charges, was also sentenced to three years' probation and restitution of over $950,000. A VA OIG, Department of Homeland Security OIG, DOL OIG, and USPS OIG investigation resulted in charges that the defendants conspired with others to pay kickbacks to physicians in order to induce the physicians to write prescriptions for compounded gels and creams dispensed by their pharmacy. The payments for prescriptions were made by the DOL's Office of Workers' Compensation Programs. Between 2011 and 2016, the defendants billed the federal government over $21 million in compounded gels and creams. The loss to VA is approximately $610,000.

Audits and Reviews

VA Improved the Transparency of Mandatory Staffing and Vacancy Data

The OIG assessed reporting of staffing and vacancy data on the VA website. The VA MISSION Act of 2018 requires VA to publicly release this information quarterly. The review team found VA partially complied with Section 505 of the act by reporting time to hire data using a 100-day target instead of the Office of Personnel Management's required 80-day target. However, VA implemented sufficient corrective actions to close three of the five recommendations from the OIG's June 2019 report on this topic. VA also improved transparency and usefulness of its data by posting all quarterly staffing and vacancy publications on its public website, as well as summaries and additional context. The OIG recommended the assistant secretary for human resources and administration ensure time to hire data are reported as required and confer with the Office of General Counsel to ensure that changes in reporting methodology adhere to the Act.

Improvements Needed to Reduce Aging Infrastructure Risks at Northport VA Medical Center in New York

The OIG assessed the merits of a hotline complaint it received in March 2019 regarding building conditions and patient safety at the Northport VA Medical Center in New York. The complaint alleged

that medical center managers did not take adequate action to maintain the center's buildings. According to the complaint, the delivery system for steam heat failed and caused damage that contaminated employee and patient areas with asbestos, lead paint, and other debris. The review team determined that damage occurred in building 65 of the medical center and that four rooms were closed for repairs between February and October 2019. The room closures did not affect patient care because other space was available. The OIG made three recommendations to the Veterans Integrated Service Network 2 director that focused on implementing the master plan to reduce the medical center's footprint and on work orders for recurring and preventive maintenance.

VA's Implementation of the FITARA Chief Information Officer Authority Enhancements

The OIG examined whether VA implemented key elements of Section 831 of the Federal Information Technology Acquisition Reform Act (FITARA) on Chief Information Officer Authority Enhancements. Specifically, the audit team evaluated whether VA met requirements involving the role of the VA chief information officer during fiscal year (FY) 2018. These included the chief information officer role in (1) reviewing and approving all information technology (IT) asset and service acquisitions across the VA enterprise and (2) planning, programming, budgeting, and executing functions for IT, including governance, oversight, and reporting. The team found that VA did not meet these FITARA requirements and identified several causes, such as policies and processes that limit the chief information officer's ability to review IT investments. The OIG made 10 recommendations to help VA meet FITARA requirements. The recommendations focus on IT governance and oversight processes, acquisition processes, internal controls, policies and procedures, and training programs.

FY 2019 Risk Assessment of VA's Charge Card Program

The OIG conducted an annual risk assessment of VA's charge card program by evaluating the three types of charge cards—purchase cards (including convenience checks), travel cards, and fleet cards—for transactions during FY 2019. Among its findings, the OIG determined that the Purchase Card Program remains at medium risk of illegal, improper, or erroneous purchases. Data mining of purchase card transactions identified potential misuse of the cards. Also, OIG investigations and reviews continue to identify patterns of purchase card transactions that do not comply with the Federal Acquisition Regulation and VA policies and procedures. The assessment also found that VA's Travel Card Program and Fleet Card Program both remain at low risk for illegal, improper, or erroneous purchases. The risk assessment team assigned a low risk level to both programs primarily because data mining showed a low percentage of potential duplicate and split purchases.

Disability Compensation Benefit Adjustments for Hospitalization Need Improvement

This audit examined whether veterans received accurate compensation when hospitalized by VA for more than 21 days for service-connected disabilities. These veterans are entitled to receive temporary increases in benefits. Veterans Benefits Administration (VBA) employees process increases using hospital admission and discharge reports. The OIG estimated VA regional office employees did not adjust or incorrectly adjusted disability compensation benefits in about 2,500 of the 5,800 cases eligible

for adjustments, creating an estimated $8 million in improper payments in calendar year 2018. Errors occurred because employees did not generate required reports and maintain report logs, and managers provided ineffective oversight. Employees processing adjustments lacked proficiency because they handled such cases infrequently and lacked training to maintain their knowledge. The OIG made six recommendations to the under secretary for benefits, including ensuring proper admission and discharge reporting, as well as making certain that employees receive refresher training when needed.

Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Northern California Institute for Research and Education

The OIG evaluated a complaint alleging the former executive director of the VA-affiliated Northern California Institute for Research and Education spent about $740,000 on a project without review by the board of directors. The OIG also examined whether San Francisco VA Medical Center officials adequately controlled and oversaw VA payments to the institute. The audit team found the board was aware of project costs to expand or relocate some or all of the medical center research and clinical activities. As a result, the OIG did not substantiate the allegation. However, the nonprofit's board did not ensure its activities and expenditures complied with restrictions in federal law and VHA policy that limited its purpose to supporting VA-approved research and education. The OIG found that the institute's directors did not ensure activities and expenditures complied with these restrictions and that medical center officials could not be sure payments to the institute were valid or accurate. The OIG made two recommendations to the medical center director concerning confirmation of the receipt of services or goods prior to approving payment and periodic reviews of invoices authorized for payment.

Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Middle Tennessee Research Institute

The OIG evaluated the merits of a complaint alleging that the Middle Tennessee Research Institute (MTRI) overbilled the Nashville, Tennessee, VA Medical Center by at least $342,000. MTRI is a VA-affiliated nonprofit corporation and the bills were for Intergovernmental Personnel Act agreement reimbursements from 2014 through 2017. The OIG did not substantiate the May 2018 allegation. However, the audit team determined that both the medical center and MTRI made payments that lacked proper supporting documentation. The medical center made about $720,000 in such payments to MTRI from January 2014 through April 2018, and MTRI made about $337,000 in such payments from January 2017 through June 2018. The OIG recommended that the VA Tennessee Valley Healthcare System director ensure the appropriate staff (1) establish procedures for verifying the supporting documentation for expenditures, (2) confirm that services or goods were received, and (3) periodically review invoices that were authorized for payment.

VA Police Information Management System Needs Improvement

VA has worked to improve its police program governance in response to a December 2018 OIG report that found overall weaknesses. This audit examined whether VA's police information systems have provided the information needed to further advance governance of police operations in its medical

facilities. The OIG found VA did not have an effective strategy to update its police information system. Persistent weaknesses included inadequate planning that stalled new system implementation, limited officers' access to information, and created incompatible parallel systems. As a result, VA employees could not get law enforcement information needed to do their jobs. Information security controls were also lacking, putting individuals' sensitive personal information at risk. The OIG recommended VA consider the Law Enforcement Training Center's role in overseeing police records management, a working group to evaluate whether the updated system meets police needs, and a strategy to fully implement the system or its replacement.

Controls Appear to Have Addressed Prior Overpayments of Post-9/11 GI Bill Monthly Housing Allowance

The OIG analyzed 10 years of Post-9/11 GI Bill monthly student housing allowance data and identified potential overpayments. VBA made substantial overpayments to 16 students, totaling $961,000, as a result of control deficiencies that allowed some payments to continue beyond required limits. The number of individual overpayments was minimal, as more than two million students were enrolled in classes using Post-9/11 GI Bill benefits during the review period. VBA's Education Service has added controls that appear to have been effective in reducing the risk of overpayments, as no similar overpayments were identified since the last control was implemented in June 2017. The OIG did not make any recommendations because VBA's existing and planned controls appeared to address the errors found in this review but encouraged additional measures, such as monthly student certifications, to further reduce the risk of future long-term overpayments.

Overtime Use in the Office of Community Care to Process Non-VA Care Claims Not Effectively Monitored

VA's Office of Community Care (OCC) intended to use overtime to reduce an increasing backlog of non-VA care claims. The OIG examined how that overtime was used, its effect on the backlog, and whether it was abused. OCC officials did not establish a policy requiring employees to use overtime exclusively to process backlog claims, detail appropriate uses for overtime, or implement controls to ensure employees used overtime primarily to reduce the backlog. Employees were paid an estimated $11.6 million for overtime hours for which there was no evidence of claims-related activity. The OIG recommended the under secretary for health review certain employees' overtime activities to determine whether disciplinary or other corrective action is warranted, ensure supervisors have the tools to effectively monitor overtime productivity to reduce the risk of fraud and abuse, clarify nurse productivity standards and requirements, and implement controls on the appropriate use of overtime.

Summary of FY 2019 Preaward Reviews of Healthcare Resources Proposals from Affiliates

VA spends millions of taxpayer dollars annually on healthcare resources procured without competition from affiliated institutions. This report provides a summary of the OIG's 27 reviews of healthcare resource proposals in FY 2019 before VA awarded the contracts (preaward reviews). Preaward reviews

are used by contracting officers to negotiate fair and reasonable prices. Due to the sensitive commercial proprietary information included in the proposals, reports issued to VA to help obtain the best pricing are not published. This report, however, summarizes the OIG's findings for the 27 healthcare resource proposals and identifies the monetary benefit to VA without disclosing any sensitive commercial information. The OIG's lower pricing recommendations collectively reflected approximately $198 million in estimated cost savings to VA. More than $26 million has been sustained by VA. The 27 proposals included 77,701 annual hours of physician services and services priced per procedure and ordered as needed.

A Synopsis of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in FY 2019

VA and other government agencies spend billions of taxpayer dollars annually through VA's Federal Supply Schedule (FSS) contracting program. This report summarizes the OIG's 19 FSS reviews of pharmaceutical proposals before VA awarded the contracts (preaward reviews) during FY 2019. Due to the sensitive commercial proprietary information included in the FSS proposals, reports issued to VA are not published. This report presents the OIG's findings for the 19 FSS proposals and identifies the monetary benefit to VA without disclosing sensitive commercial information. The OIG determined that commercial pricing disclosures were not reliable for negotiations for 14 of the 19 proposals and recommended VA obtain revised disclosures before awarding the contracts. The OIG's FSS lower pricing recommendations collectively reflected more than $1 billion in estimated cost savings to VA. Nearly $203 million has been sustained by VA as of May 8, 2020. The 19 proposals included 862 drug items.

VA Should Examine Options to Expand Retail Pharmacy Drug Discounts

The OIG estimated that VA could have saved about $69 million of the $181 million that CHAMPVA paid for retail pharmacy claims in FY 2018 if CHAMPVA qualified for federal price discounts. Federal law allows VA to receive at least a 24 percent discount on direct prescription drug purchases for its facilities. However, VA pays the higher contracted average wholesale price for prescription drugs when purchased through retail pharmacies. VA could save about $345.1 million over the next five years if CHAMPVA could buy drugs through retail pharmacies at the same discounted prices as VA pharmacies. Other VA programs could also save money if this authority was expanded to include them. The OIG recommended the under secretary for health determine how VA could require that drug manufacturers provide the discounted prices and pursue related statutory or other changes needed.

Healthcare Inspections

Coordination of Care and Employee Satisfaction Concerns at the Community Living Center, Loch Raven VA Medical Center, in Baltimore, Maryland

This inspection evaluated allegations at the community living center (CLC) involving managers' interactions with staff and inadequacies with staffing, laboratory, medication delivery, and

environmental temperature regulation. Additional concerns involved employee dissatisfaction and critical laboratory result notifications. Although allegations regarding manager interactions with staff were not substantiated, leaders acknowledged persistent dissatisfaction could impact resident care. The CLC maintained adequate nurse and provider staffing. Laboratory specimen handling led to inaccurate potassium results and unnecessary treatments, and laboratory staff failed to investigate and resolve the cause. Also, providers were inconsistently notified of critical laboratory results. The lack of an on-site pharmacy likely contributed to medication delivery delays. However, during the inspection, the System Director announced plans for an on-site pharmacy. The OIG did not substantiate additional allegations of an inability to regulate environmental temperatures as staff provided timely responses to periodic temperature issues. The OIG made five recommendations regarding employee satisfaction, laboratory processes, and medication delivery.

Deficiencies in Nursing Care and Management in the Community Living Center at the Coatesville VA Medical Center in Pennsylvania

An inspection was initiated regarding deficiencies in the CLC at the Coatesville VA Medical Center. The OIG substantiated the allegation that a nurse left medication in a patient's room. The OIG found deficiencies, which included inconsistent documentation of compliance with medication order instructions, pain assessments, and pain management plans; fall prevention and post-fall assessments; fall prevention measures; nursing wound prevention processes; and inconsistent use of the fall prevention measure of answering call bells. The OIG identified other findings not specifically related to the allegations, including the failure to follow the approval procedure for a new hourly rounding form, ineffective implementation of a new nurse rounding procedure, incomplete fact-finding reviews, inconsistent facility committee documentation, and inoperable safety equipment. One possible contributing factor for the identified deficiencies was an outdated policy that did not follow staffing methodology requirements. The OIG made nine recommendations related to documentation, procedural compliance, and ensuring operational safety equipment for transfers.

Deficiencies in Virtual Pharmacy Services in the Care of a Patient

The OIG evaluated concerns related to a Virtual Pharmacy Services (VPS) pharmacist's discontinuation of one of two antidepressant medications for a Minneapolis VA Health Care System patient who died by suicide six weeks later. The OIG found that the pharmacist did not access the patient's electronic health record or notify the psychiatrist when discontinuing the medication. The OIG was unable to determine whether the discontinuation of the antidepressant medication contributed directly to the patient's death; however, possible worsening of the underlying depressive illness may have been a contributing factor. Other findings included that VPS pharmacists were unable to fully perform the duties as described in their functional statement and the 95 prescriptions-per-hour productivity target may be unreasonable. Also, pharmacy benefits management leaders failed to monitor VPS prescription processing accuracy and outline program management and quality assurance objectives and processes. The OIG made five recommendations to the under secretary for health.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews 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 reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

(1) Leadership and Organizational Risks
(2) Quality, Safety, and Value
(3) Medical Staff Privileging
(4) Environment of Care
(5) Medication Management
(6) Mental Health
(7) Care Coordination
(8) Women's Health
(9) High-Risk Processes

VA Eastern Kansas Health Care System in Topeka

Special Reviews

Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel

The Office of Special Reviews substantiated a hotline allegation that a VA Office of General Counsel (OGC) attorney was using VA time and resources to work on matters related to his outside law practice. The review team also determined the attorney represented private clients in U.S. bankruptcy court who owed money to the federal government. This representation implicated criminal conflict of interest laws prohibiting federal government employees from representing third parties when the United States is a party or has a direct and substantial interest. The review revealed OGC officials received complaints about the attorney using VA time and resources for his law practice as early as 2012 but failed to adequately supervise him or meaningfully investigate his conduct. After the OIG informed OGC about this review's initial findings, OGC investigated the attorney and removed him from federal service in March 2020. VA's OGC concurred with the OIG's seven recommendations.

Improper Pay to Fee-Basis Providers Adequately Addressed by VA San Diego Healthcare System

The OIG investigated allegations that staff at the VA San Diego Healthcare System manipulated the timecards for seven fee-basis medical providers in order to pay these individuals on a salary or wage basis rather than a per-procedure basis. In addition, the allegations contended that a fee-basis care provider was told he would be converted to a full-time employee after working full time as a fee-basis

provider for one year. The OIG substantiated that certain fee-basis care providers at the VA San Diego Healthcare System were being paid for their time, rather than on a per-procedure basis, as required by law and VA policy. The OIG did not substantiate that a fee-basis professional had been promised conversion to full-time status. The OIG did not make any recommendations because the medical center took corrective action, including disciplinary action with respect to the supervisor who was accountable for this conduct.

Alleged Misconduct by Employees of the Greater Los Angeles Healthcare System Addressed by VA

The OIG investigated alleged misconduct by two employees of the VA Greater Los Angeles Healthcare System in California. A complainant alleged that a supervisory health system specialist misused his/her public office for private gain by improperly participating in matters related to a contract maintained by the healthcare system with a vendor whose vice president was the supervisor's significant other and roommate. The supervisor resigned during the investigation, and the OIG removed this allegation from the scope of the investigation. The complainant also alleged that a former medical center director failed to make proper rental payments while residing in the healthcare system's quarters. Although the director underpaid VA by $158, the OIG determined the cause was a coding error and identified no evidence of misconduct on the part of the director. Because corrective action had already been taken by the healthcare system, the OIG made no recommendations.

To listen to the podcast on the OIG's June 2020 activity highlights, go to www.va.gov/oig/podcasts.