MAY 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. All written statements to Congress can be found on the OIG website. The full hearings can be viewed on the committee website.

Deputy Assistant Inspector General for Audits and Evaluations Testifies on VA's Improper Payments

Brent Arronte, deputy assistant inspector general for the Office of Audits and Evaluations, testified on May 14 before the House Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs. His testimony focused on the OIG's independent oversight of VA's compensation and benefits programs, specifically how inadequate staff training combined with often unclear and inadequate guidance contribute to incorrect payments being made to veterans. In response to questions, Mr. Arronte also discussed actions VBA can take to implement OIG recommendations to reduce processing errors related to determining accurate retroactive effective dates for disability benefits for toxic exposure associated with the PACT Act.

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 May.

Healthcare Investigations

Former Nurse at Texas VA Medical Center Indicted for Falsely Claiming She Had Checked on Patient Who Ultimately Died

A VA OIG investigation resulted in charges alleging a former nurse at the Michael E. DeBakey VA Medical Center in Houston made false entries in the VA's Computerized Patient Record System in which she claimed to have observed a male patient on several occasions during her shift on July 26–27, 2024. It is further alleged that contrary to these entries, the former nurse did not have any contact with the patient at those times. In the early morning hours of July 27, medical personnel found the patient unresponsive and ultimately pronounced him deceased. The former nurse was arrested after being indicted in the Southern District of Texas for making or using false writings or documents.

Former Consulting Firm Senior Partner Sentenced for Obstruction of Justice

A multiagency investigation focused on allegations that a consulting firm offered improper advice to a large pharmaceutical manufacturer on techniques the company could use to "turbocharge" the sales of their extended-release opioid drug. Moreover, the consulting firm intentionally destroyed records to obstruct the government's investigation. From 2014 to 2017, VA purchased approximately $88 million of the promoted drug. The consulting firm had previously entered into a global resolution with the Department of Justice under which the company agreed to pay $650 million and enter into a five-year deferred prosecution agreement to resolve a criminal and civil investigation into their conduct. Of the $650 million, VA is due approximately $3.3 million. A former senior partner at the consulting firm was sentenced in the Western District of Virginia to six months' imprisonment, 24 months' supervised release, and ordered to pay a fine of $40,000 and to complete 1,000 hours of community service after previously pleading guilty to obstruction of justice. This investigation was conducted by the VA OIG, Federal Bureau of Investigation (FBI), Department of Health and Human Services (HHS) OIG, and Office of Personnel Management OIG.

Four Defendants Sentenced for Roles in $110 Million Healthcare Kickback Scheme

The former owner of a pharmacy and three marketers conspired to fraudulently bill federal and private healthcare insurance programs, including VA's Civilian Health and Medical Program (CHAMPVA), more than $110 million. They recruited medical providers to refer prescriptions for compounded pain creams, which were often medically unnecessary, to the pharmacy. The marketers also helped the medical providers create prescriptions for the creams, which were mixed with specific ingredients to have the largest reimbursement amounts. As a result of this scheme, the pharmacy owner paid more than $6 million in illegal kickbacks to medical providers and patients, as well as the marketers who both solicited the patients and recruited the providers. The loss to VA is more than $2.8 million. They were sentenced in the Southern District of Texas. The former owner was sentenced to 60 months' imprisonment and ordered to pay restitution of almost $23.9 million. Two marketers were each sentenced to 46 months' imprisonment and ordered to pay combined restitution of more than $7.3 million. A third marketer was sentenced to 30 months' imprisonment and ordered to pay restitution of more than $1.6 million. All four defendants were sentenced to 36 months' supervised release. This multiagency investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), FBI, HHS OIG, US Postal Service OIG, Department of Labor (DOL) OIG, and Texas Health and Human Services.

Former Inventory Management Specialist at Tennessee VA Medical Center Sentenced for Stealing Dental Equipment

A VA OIG and VA Police Service investigation revealed that a former inventory specialist at the

Mountain Home VA Medical Center in Tennessee stole dental equipment, including various high-speed handpieces and other dental tools, from the facility and subsequently sold it online. The former VA employee was sentenced in the Eastern District of Tennessee to six months' imprisonment, 36 months' supervised release, and ordered to pay restitution to VA of approximately $385,000 after previously pleading guilty to theft of government property.

Benefits Investigations

San Juan VA Regional Office Supervisor, Seven Veterans, and Two Others Indicted in Connection with Disability Benefits Fraud Scheme

An investigation by the VA OIG and FBI, which was responsive to a complaint to the OIG hotline, resulted in charges alleging that ten defendants participated in a scheme to arrange for fraudulent disability claims to be submitted to VA and approved based on false medical conditions. The VA supervisor communicated which false medical conditions should be claimed by veterans to fraudulently obtain disability benefits to a facilitator who identified veterans without a 100% disability rating and offered to help them obtain a 100% rating for an upfront cash fee plus a percentage of any back pay the veteran received. The facilitator instructed seven veterans on what false information to provide when attending medical evaluations and completing their disability application paperwork. Another defendant, a nonveteran related to three of the seven veterans, also helped facilitate this scheme on behalf of the veterans. In return, the veterans knowingly received fraudulent disability ratings based upon their participation in this scheme. The ten defendants were indicted in the District of Puerto Rico on various charges to include conspiracy to commit wire and mail fraud.

School Official Pleaded Guilty to $2.9 Million Scheme to Defraud VA's Education Programs

A VA OIG investigation revealed that from approximately July 2022 to May 2024, the career services manager for a school offering training programs to veterans used false records to defraud VA of millions of dollars. The manager fabricated veteran employment offer letters, falsified certifications, and forged veterans' signatures on employment certification forms to make it appear as if veterans had attained the meaningful employment needed for the educational institution to receive tuition payments from VA. On behalf of the school, the manager caused hundreds of false documents to be submitted to VA that fraudulently claimed more than $2.9 million in tuition payments for approximately 189 students. Of this amount, VA paid more than $2 million. The manager pleaded guilty in the Eastern District of Virginia to wire fraud.

Disabled Veteran's Nephew Accused of Concealing Veteran's Death to Steal VA and Social Security Benefits

A multiagency investigation resulted in charges that an individual stole VA and Social Security

benefits intended for his uncle, a quadriplegic veteran who was last seen around 2019. Among the allegations, the nephew, who was supposedly residing with and providing care for his uncle, concealed his uncle's death in order to steal his benefits. In addition, he used the funds to purchase exotic reptiles, fund lavish vacations, and enrich himself. The loss to the government is approximately $726,000. Of this amount, the loss to VA is approximately $650,000. The nephew was indicted in the Eastern District of Missouri on charges of wire fraud, theft of government funds, aggravated identity theft, and being a felon in possession of firearms. This investigation was conducted by the VA OIG, Social Security Administration (SSA) OIG, Salem (Missouri) Police Department, and Bureau of Alcohol, Tobacco, Firearms and Explosives.

Veteran Indicted for Alleged Compensation Benefits Fraud Scheme

A veteran allegedly received about $200,000 in VA compensation benefits based on fraudulent claims that he suffered from a posttraumatic stress disorder and other ailments due to combat service in Iraq. The veteran was a patient at an Army hospital in Hawaii during the period he claimed to have been deployed to Iraq and his military records indicated that he did not serve on a combat deployment in the Middle East. The veteran was indicted in the District of Rhode Island after being charged with making false statements. The VA OIG, VA Police Service, and DCIS conducted this investigation.

Former VA Fiduciary Indicted for False Statements

A VA OIG and SSA OIG investigation resulted in charges that between February 2021 and January 2024, the daughter of a veteran, who served as the veteran's VA-appointed fiduciary, withdrew more than $116,000 in VA compensation benefits and almost $74,000 in Social Security benefits from the veteran's account without permission. She used the funds for personal purchases including at restaurants, convenience stores, and online stores, and to pay for streaming services and personal household bills. The daughter was charged in the Southern District of Ohio with false statements.

Investigations Involving Other Matters

Defendant Pleaded Guilty for Role in Unemployment Insurance Fraud Scheme

A VA OIG and DOL OIG joint investigation revealed that a woman both defrauded and attempted to defraud various states by submitting for herself and other individuals approximately 100 fraudulent unemployment insurance applications. She charged individuals for whom she made filings between $1,200 to $1,500 per fraudulent application. Through this scheme, she obtained more than $267,000. She pleaded guilty in the Eastern District of Louisiana to conspiracy to commit mail fraud, conducting mail fraud, and making false statements. The VA OIG conducted the investigation, which 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.

Veteran Charged for Threats Against a West Los Angeles VA Medical Center Employee

A VA OIG and Los Angeles Police Department investigation resulted in charges that a veteran made multiple threats to kill a West Los Angeles VA Medical Center employee. The defendant was arrested after being charged in Los Angeles County Superior Court with making criminal threats.

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 May.

Featured Report

Better Communication and Oversight Could Improve How the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program Manages Funds

Congress enacted the Comprehensive Addiction and Recovery Act (CARA) of 2016 to improve opioid therapy and pain management for veterans. Within CARA, the Jason Simcakoski Memorial and Promise Act (Jason's Law) requires Veterans Health Administration (VHA) medical facilities to have pain management teams. The Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP) helps ensure the legislative requirements are met. In fiscal years (FYs) 2022 through 2024, the PMOP received $647 million in specific purpose funds. About $126.7 million was returned unused in FYs 2022 and 2023. The OIG conducted this audit to evaluate the PMOP's management of these specific purpose funds. The OIG found the PMOP could improve funding communication with VISNs, medical centers, and key officials. Additionally, VHA and the PMOP need to strengthen oversight of pain management teams. VA concurred with the five recommendations in the report and requested closure of recommendations 1 and 2. The VA OIG found VA's actions taken for recommendations 1 and 2 responsive to the recommendations' intent and considers those two recommendations closed.

Financial Efficiency

Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2024

The VA OIG conducted this review to determine whether VA complied with the requirements of the Payment Integrity Information Act of 2019 (PIIA) for FY 2024. VA reported improper and unknown payment estimates totaling $2.2 billion for seven programs: about $1.1 billion representing a monetary loss, and the remaining $1.1 billion considered an unrecoverable nonmonetary loss or an unknown payment. These results represent a reduction of about $1 billion (32 percent) from FY 2023 results. VA satisfied five of the six requirements under PIIA but did not meet the last requirement because it did not report an improper and unknown payment rate of less than 10 percent for two programs. VA met additional requirements for high-priority programs by providing quarterly updates to the Office of Management and Budget with plans to prevent and recover losses from improper payments. The OIG made two recommendations to address this deficiency.

Information Technology

Inspection of Information Security at the Battle Creek Healthcare System in Michigan

The OIG's information security inspection program assesses whether VA facilities are meeting federal security requirements for three control areas the OIG determined to be at the highest risk: configuration management controls, security management controls, and access controls. For this inspection, the OIG selected the Battle Creek Healthcare System in Michigan and found deficiencies in all three areas inspected. Configuration management controls were deficient in vulnerability remediation, system baseline configurations, and unauthorized software remediation. Security management controls had one deficiency—biomedical staff relied on incomplete security remediation reports to manage vulnerabilities on medical devices. Finally, the team found the Battle Creek facility was deficient in three access controls: physical access, environmental controls, and network segmentation. The OIG made six recommendations to address identified issues.

Benefits

Failure to Flag Fiduciaries Who Were Removed Results in Risk to Vulnerable Beneficiaries

VBA's Fiduciary Program appoints and oversees individuals who are authorized to receive and distribute VA funds on behalf of veterans or other beneficiaries unable to manage their financial affairs. Fiduciaries can be removed and barred from future service for certain offenses (such as

theft or drug convictions), and in such cases, staff are required to flag them in VBA's electronic system to prevent reappointment. The OIG conducted this review to determine whether VBA's oversight ensures individuals and entities barred from serving as a VA fiduciary are identified and flagged. The review team found that in 68 percent of the 129 cases in its statistical sample, VBA did not flag removed fiduciaries when required. The program's manual lacked clear procedures about who should place the flag and when. Training and oversight of staff were also insufficient. Failure to properly flag barred fiduciaries increases the risk they will be reappointed. The OIG made three recommendations for corrective action.

VBA's Special Monthly Compensation Calculator in the Veterans Benefits Management System for Rating Did Not Always Produce Accurate Results

VBA awards special monthly compensation (SMC) to veterans for certain severe disabilities or combinations of disabilities. When this review began, VBA had two versions of an SMC calculator for use by claims processors, one of which was the Veterans Benefits Management System for Rating (VBMS-R) calculator. In November 2023, the VA OIG received an allegation that the VBMS-R calculator did not always generate accurate results. The review team substantiated this allegation. In some instances, the VBMS-R calculator errors were the type that could cause incorrect payments to veterans. Additionally, the VBMS-R calculator sometimes produced no results and instead generated a failure message. VBA and VA's Office of Information and Technology could not determine the cause of the errors or how long they had been occurring. In October 2024, the VBMS-R calculator was disabled and remained inactive as of February 2025. The OIG made two recommendations to the under secretary for benefits to make certain that all erroneous scenarios in the VBMS-R calculator identified in this review are corrected and establish a plan to conduct additional testing of the tool to ensure its accuracy.

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 released the following reports in May.

Healthcare Inspections

Deficiencies in Emergency Care for a Female Veteran at Martinsburg VA Medical Center in West Virginia

The OIG conducted a healthcare inspection to assess allegations related to the care of a female patient who presented with "near constant" vaginal bleeding to the Martinsburg VA Medical

Center emergency department. The OIG found deficiencies in the quality of care provided to the patient, opportunities to evaluate the equipment for gynecologic exams, avoidable delays in the patient's transfer to a higher level of care, and additional patient transport concerns. The OIG also identified failures in leaders' response to a factfinding involving emergency department nursing care and transportation concerns.

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. May's healthcare facility inspections reports examined the following facilities:

- VA North Florida/South Georgia Veterans Health System in Gainesville
- VA Augusta Health Care System in Georgia
- VA Oklahoma City Healthcare System in Oklahoma

Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life.

In May, the OIG published a report focused on aspects of the quality of care delivered in Midwest district 3 zone 2. This inspection report evaluated four randomly selected vet centers in Evanston, Illinois; Gary Area, Indiana; and La Crosse and Milwaukee, Wisconsin. The inspection focused on four review areas: (1) suicide prevention; (2) consultation, supervision, and training; (3) outreach; and (4) environment of care. Regarding suicide prevention, three of four vet center directors did not ensure the attendance of a licensed staff member at the supporting VA medical facility's mental health executive council meetings as required. Among other findings, all four vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant from the supporting VA medical facility. Although external clinical consultation for complex cases occurred at all four vet centers, none of the four vet center directors ensured completion of at least four hours of consultation per month. The OIG

found all four vet centers had outreach plans, but three of four plans lacked one or more required strategic components. The team also found that the inspected vet centers complied with select requirements concerning safety in the physical environment. The OIG issued a total of eight recommendations for improvement.

Office of Special Reviews

This office conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. The Office of Special Reviews released the following report in May.

Former Orlando VA Medical Center Executive Violated Ethics Rules

An OIG administrative investigation of alleged ethics violations by the former deputy director of the Orlando VA Medical Center in Florida found that Tracy Skala violated federal government ethics rules. On multiple occasions, she used her public office to promote VA procurement of navigation software from her son's employer (without disclosing their relationship) for veterans to use at her facility and VISN-wide, knowing her son could receive bonus pay for a new contract. Her conduct reflected an apparent conflict of interest. The OIG also noted that although Ms. Skala informed VA she received a critical skills incentive payment of more than $32,000, VA had not initiated the process to recover any debt from her retirement in April 2024—before her term of service had been completed. Because Ms. Skala retired, the OIG made no recommendations regarding her conduct. Three recommendations involved addressing potential conflicts before vendor presentations and recovering critical skill incentive debts.

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To listen to the podcast episode on the May 2025 highlights, go to the podcasts page on the OIG website.