



SEMIANNUAL REPORT to Congress

Issue 95 | October 1, 2025–March 31, 2026



US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL



U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

MISSION

To conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

VISION

To perform audits, inspections, investigations, and reviews that enhance the efficiency, effectiveness, and integrity of VA and its services to the veteran community.

The Office of Inspector General (OIG) will

- issue accurate, timely, and evidence-driven reports with recommendations that help VA deliver high-quality health care, benefits, and services to eligible veterans and other beneficiaries;
- work to deter and address VA-related fraud and other crimes, waste, and abuse, as well as advance efforts to hold individuals responsible for their misconduct; and
- maintain transparency of its oversight work by disclosing to veterans, the public, VA, and Congress identified risks and opportunities to make better use of taxpayer dollars.

VALUES

- Honor veterans by putting their interests first and continually striving for excellence
- Uphold the highest standards of integrity, professionalism, and accountability
- Safeguard the OIG's independence and objectivity
- Protect individuals alleging wrongdoing and treat them with respect and dignity
- Promote a culture that attracts and retains skilled and dedicated staff

MISSION

VISION

VALUES

A MESSAGE FROM THE INSPECTOR GENERAL



It is a privilege to provide this semiannual report to Congress on behalf of the Office of Inspector General (OIG) for the Department of Veterans Affairs (VA), reflecting our work during the reporting period of October 1, 2025, through March 31, 2026. Leading the OIG since August 2025, I have emphasized strategies to ensure our oversight remains independent, fact-based, and firmly grounded in our statutory mission. Every member of the OIG is dedicated to combating fraud, waste, and abuse while improving the effectiveness and efficiency of VA operations and programs that provide for the health and welfare of veterans, their families, caregivers, and survivors.

We achieve this mission by operating as one OIG and leveraging expertise across the organization. During this reporting period, we made significant strides in fighting fraud and other crimes nationwide, resulting in 127 arrests, 100 convictions, and more than \$2.17 billion in monetary benefits from investigations. Our criminal investigative updates highlight how OIG special agents work with VA personnel and law enforcement partners to stop and deter fraudulent schemes involving VA education and training, health care, benefits, mortgage assistance, procurement, and fiduciary misuse of vulnerable veterans' funds.

Although special agents are the tip of the OIG spear, they do not tackle fraud alone. Our audits and inspections often reveal insufficient controls, weak monitoring, and unclear accountability structures within VA that create vulnerabilities for fraud, waste, and crime. In response, OIG works closely with VA offices to provide training on identifying and reporting fraud—efforts that strengthen internal safeguards and generate valuable tips and complaints for further action.

Our Office of Data and Analytics mines information from myriad sources to identify outliers and patterns that signal potential fraud. Hotline staff, who received 21,365 contacts this period alone, triage information and identify emerging trends. Healthcare inspectors and auditors identify risks that endanger veterans or allow fraud or other

criminal activity to take hold. Our counselor’s office provides legal guidance, and our Office of Management and Administration ensures OIG systems, personnel, and resources remain aligned to power fast-paced work. Administrative investigators also hold VA personnel accountable when they engage in misconduct. Public affairs staff ensure our findings are promptly shared with the public and stakeholders, and our congressional relations team keeps Congress informed through briefings and testimony on the impact of our work. Fraud is only one area where our staff is working more effectively than ever.

VA OIG also works collaboratively with our OIG colleagues across the federal government—including those at the departments of Education, Health and Human Services, Housing and Urban Development, Justice, Labor, and War; the Social Security Administration; the Small Business Administration; the Federal Housing Finance Agency; and partners within the Intelligence Community, to name a few—to investigate and root out fraud. These partnerships, combined with strong working relationships and best practices developed with the Department of Justice and its US Attorneys’ Offices, contribute to the successful prosecution of many of our cases.

This report demonstrates our commitment to oversight that benefits the veteran community. Our team is addressing issues such as VA suicide screening, mental health treatment, access to community care, benefit accuracy and timeliness, and stewardship of taxpayer dollars. During this period, the OIG published 102 reports and other products with 333 recommendations for improvement while simultaneously refining internal processes to improve report quality and publication timeliness. The OIG’s follow-up team closed 481 recommendations based on evidence showing VA’s progress in implementing corrective actions. Over the six months the OIG’s monetary impact totaled more than \$2.26 billion for a return on investment of \$18 for every dollar spent on oversight.

Despite VA’s ongoing transformation and reorganization efforts, the OIG remains agile and prepared for future challenges. OIG leaders and staff value the candid and cooperative communication with VA personnel and are grateful to Congress, veterans service organizations, and the veteran community for their support and engagement, without which we could not carry out our mission.



CHERYL L. MASON
Inspector General

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HONORING SACRIFICE

Approximately 30 percent of VA OIG employees are veterans, and many others are spouses or family members of those who have served. This shared connection to military service reinforces the OIG's deep commitment to veterans, their families, survivors, and caregivers through effective, independent oversight.

VA OIG employees regularly volunteer to honor those who gave their lives in service to our country. Shown here are staff members participating in multiple events to wash the Korean War and Vietnam Veterans Memorials in Washington, DC.



The Inspector General and the entire staff also extend their sincere gratitude to the OIG employees listed below, who are currently serving on active military duty or have returned from such service during this reporting period:

- Resident Agent in Charge Felix Beltran, US Army
- Auditor Matthew Clark, US Army
- Special Agent in Charge Craig Cruz, US Coast Guard
- Auditor Cesar Garcia, US Army

ORGANIZATIONAL OVERVIEW



About the Department of Veterans Affairs

The Department of Veterans Affairs (VA) serves America's veterans and their families with dignity and compassion, acting as their principal advocate to ensure they receive the care, benefits, and recognition earned through service to the nation.

VA operates three major administrations:

- The **Veterans Health Administration (VHA)** provides comprehensive healthcare services and manages the nation's largest integrated healthcare system.
- The **Veterans Benefits Administration (VBA)** delivers monetary benefits and readjustment programs to support veterans and their families.
- The **National Cemetery Administration** honors veterans through interment and memorial benefits.

As the second-largest federal employer, VA manages a \$441 billion budget for fiscal year 2026 and employs approximately 450,000 personnel serving an estimated 18 million veterans. VA maintains facilities in every state, the District of Columbia, and US territories, including Puerto Rico, Guam, American Samoa, and the US Virgin Islands.

About the VA Office of Inspector General



The VA Office of Inspector General (OIG) is an independent oversight organization dedicated to promoting accountability and integrity across VA programs and operations. Established under the Inspector General Act of 1978 (as amended), the mission of the OIG is to conduct independent oversight of VA that combats fraud, waste, and abuse and improves the

effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.¹

STATUTORY AUTHORITY AND RESPONSIBILITIES

The Inspector General Act of 1978 provides the foundation for the OIG’s oversight role, while the Veterans Benefits and Services Act of 1988 specifically charges the OIG to monitor the quality of medical care delivered by VHA.² These statutes grant the inspector general broad authority to safeguard efficiency, effectiveness, and integrity throughout VA programs and operations. Under these statutes, the inspector general is responsible for the following:

- Deterring and preventing fraud that targets VA programs, operations, and services to veterans and VA.
- Conducting and supervising audits and investigations involving VA programs and operations.
- Making recommendations to promote the efficiency and effectiveness of VA operations.
- Detecting and stopping VA-related criminal activity, waste, abuse of authority, and mismanagement.
- Reviewing the actions of VA personnel and people or entities engaged in VA grants, contracts, or other agreements.
- Inspecting and evaluating VA medical facilities and reviewing allegations associated with risks to patient safety and the quality and timeliness of VHA health care.
- Keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies, as well as the need for related corrective action.

CORE OVERSIGHT AREAS

Oversight work is guided by the objectives set out in the OIG statute, the Inspector General Act of 1978, as amended and codified at 5 USC Section 401 et. seq.

¹ Inspector General Act of 1978, 5 U.S.C. §§ 401–424, as amended by Pub. L. No. 117-263 § 5273 (2022). The amendments in Pub. L. No. 117-263 have not yet been codified. However, reporting requirements applicable to semiannual reports are to be incorporated into § 405(b) pursuant to Pub. L. No. 117-286, § 5(b), 136 Stat. 4196, 4360 (2022).

² Veterans Benefits and Services Act of 1988, Pub. L. No. 100-322, 102 Stat. 487.

In carrying out this mission, the OIG works to fulfill several key objectives:

- Help ensure veterans receive prompt access to exemplary patient-centered care by qualified providers in VA facilities and in the community.
- Make actionable recommendations to facilitate the swift delivery of benefits and services to eligible veterans, their families, and caregivers.
- Identify procedures and strategies for making the most responsible use of VA's appropriated funds and assets, including reducing fraud, waste, and misuse of resources.
- Address accountability in governance and leadership, including noncompliance with laws and other requirements and lack of accountability.
- Encourage innovation and recommend enhancements to VA's infrastructure and systems.

STAFFING, FUNDING, AND LOCATIONS

The VA OIG employs more than 900 staff members organized into four specialized directorates: the Offices of Investigations, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline). The OIG also has offices for the counselor to the inspector general, data and analytics, congressional relations, and public affairs.

The OIG is funded through a dedicated line item in VA's budget. OIG funding is included in the Military Construction, Veterans Affairs, and Related Agencies funding bill. In fiscal year 2026, ongoing appropriations provided \$296 million to support OIG operations.

Along with its headquarters in Washington, DC, the OIG maintains a nationwide presence through strategically located field offices, often near or embedded within VA facilities, to strengthen oversight and accessibility. OIG staff are dedicated to performing their duties fairly, objectively, and with the highest professional integrity. To learn more, visit the [VA OIG's website](#).

900+
Employees

\$296M
Operating Budget

**VA OIG Staffing and Funding
Levels from Fiscal Year
2026 Appropriations**

VA OIG Principal Offices and Directorates

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The inspector general and deputy inspector general provide leadership for a nationwide team conducting independent oversight of VA. Staff in this office manage executive correspondence, congressional relations, stakeholder engagement, recommendation follow-up, and media inquiries. The office also leads strategic planning and data services, including advanced analytics, to guide oversight and detect fraud.

THE OFFICE OF THE COUNSELOR TO THE INSPECTOR GENERAL

Attorneys in this office deliver legal advice for investigations, audits, and inspections while handling contracting, administrative law, and employee relations matters. They represent the OIG in litigation, advise on legislation, and review whistleblower reprisal allegations. The office also oversees information release.

THE OFFICE OF INVESTIGATIONS

Special agents investigate crimes and misconduct involving VA employees, contractors, and beneficiaries. Their work includes addressing healthcare, education, mortgage loan, and benefits fraud; contracting schemes; cybercrime; bribery; and violent offenses. Using analytics and covert strategies, the office protects veterans and VA resources while promoting accountability through prosecutions.

THE OFFICE OF AUDITS AND EVALUATIONS

This office conducts audits and reviews to strengthen VA program integrity and compliance. It examines such areas as healthcare delivery, benefits administration, financial management, acquisitions, and information technology security. Staff also review contracts before and after award to ensure fair pricing and recover overcharges.

THE OFFICE OF HEALTHCARE INSPECTIONS

Healthcare Inspections staff evaluate the quality and timeliness of VA medical care through targeted inspections and proactive reviews. They assess medical centers, mental health units, and clinical programs nationwide, helping VA improve patient outcomes and reduce risk. Clinical experts also support OIG investigations and audits.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

This office provides essential business operations, including human resources, finance, information technology, and facilities management. It also oversees the OIG hotline, which screens allegations of wrongdoing and prioritizes cases that pose the greatest risk to veterans and VA.

STAKEHOLDER ENGAGEMENT

Under the Inspector General Act, the OIG is charged with keeping the VA Secretary and Congress fully and currently informed about issues affecting VA programs and opportunities for improvement. This responsibility requires active engagement with a diverse network of stakeholders, including VA leaders, Congress, veteran service organizations (VSOs), other federal agencies, and law enforcement partners. Through these relationships, OIG leaders and staff promote transparency, accountability, and integrity across VA operations.

The OIG carries out this responsibility through coordination and collaboration that includes

- apprising the Secretary, VA leaders, Congress, and the veteran community about identified problems and discussing opportunities for improvements;
- regularly consulting VSOs and other groups for their insights;
- testifying before Congress and routinely briefing committee and members' staff;
- working with law enforcement partners to investigate and report criminal and civil violations of law to the Department of Justice for potential prosecution and litigation;
- coordinating with other OIGs and oversight entities;
- operating a hotline for complainants and triaging allegations for proper disposition with internal and external subject matter experts; and
- providing accessible, credible, and clear reports to the public and media.

Inspector General and Deputy Engagements

The inspector general and deputy play a central role in strengthening these relationships by engaging directly with stakeholders across VA and the federal oversight community. Their engagements foster communication, alignment, and integrity across programs and operations.

Key engagements during this reporting period included the following:

- **Testimony before Congress.** [Inspector General Mason appeared](#) before the Senate Veterans Affairs Committee (SVAC), discussing the role of the OIG in combating fraud in VBA's compensation programs.
- **Participation in a House roundtable.** [Deputy Inspector General David Case joined a discussion](#) organized by the House Veterans' Affairs Committee minority on preventing scams targeting veterans and their families.
- **Meetings with lawmakers.** Inspector General Mason met individually with members of Congress, including SVAC Chairman Jerry Moran (Kansas), SVAC Ranking Member Richard Blumenthal (Connecticut), and Representative Don Bacon (Nebraska) to discuss oversight of VA programs and services.
- **Engagement with VA leaders.** Inspector General Mason routinely meets with VA senior leaders—including the Secretary, deputy secretary, under secretaries, and assistant secretaries—and attends weekly VA senior leader meetings to monitor VA initiatives and transformation efforts that affect OIG oversight.
- **Engagement with Department of Justice leaders on national fraud initiatives.** Inspector General Mason met with leaders from the National Fraud Enforcement Division to discuss the OIG's ongoing contributions to government-wide fraud-prevention efforts and opportunities for strengthened collaboration. In a related engagement, Inspector General Mason, Deputy Inspector General Case, and other OIG staff met with officials from the Executive Office for US Attorneys to discuss the OIG's integral role in the new National Fraud Detection Center.
- **Collaboration with VSOs and other veterans groups.** Inspector General Mason met with nearly a dozen VSOs, including Veterans of Foreign Wars, Wounded Warrior Project, Disabled American Veterans, Paralyzed Veterans of America, Military Officers Association of America, Iraq and Afghanistan Veterans of



America, Minnesota Department of Veterans Affairs, Ohio Department of Veterans Services, America's Warrior Partnership, National Association of State Directors of Veteran Affairs, and the National Association of County Veteran Service Officers to strengthen partnerships and share oversight priorities.

- **Coordination with other inspectors general and oversight entities.** Inspector General Mason participates in monthly Council of the Inspectors General on Integrity and Efficiency meetings and collaborates with other inspectors general on fighting fraud.
- **Speaking engagements.** Inspector General Mason spoke on the importance and value of independent oversight at the National Association of Independent Review Organizations annual conference in Orlando, Florida. She also spoke at the Mid-Winter Training Conference for the National Association of State Directors of Veterans Affairs, where she highlighted the OIG's latest oversight work and urged members to collaborate with the VA OIG on fraud prevention.

Additional Engagements by OIG Staff

Beyond the inspector general and deputy inspector general engagements noted above, OIG staff regularly interact with Congress, VSOs, oversight bodies, and other stakeholders to facilitate transparency and support informed decision-making. During this reporting period

- **OIG leaders served as expert witnesses** in two congressional hearings focused on [medication management in VA health care](#) and [community care network contracts](#). These hearings underscored the impact of OIG work and the demand for independent oversight. OIG testimony helps identify areas for potential legislative action and elevates the national debate on issues affecting veterans.
- **The OIG conducted 66 briefings** on oversight reports and activities, many of which included IG Mason. Topics addressed included suicide-risk screening in audiology clinics, management of insulin pumps as a potential lethal means in emergency and inpatient settings, VA's community-based outpatient clinic contracting practices, and efforts to improve use of US Department of Housing and Urban Development—VA Supportive Housing (HUD—VASH) housing vouchers.
- **The congressional relations team responded to 85 inquiries** from House and Senate offices, several of which led to ongoing OIG projects, such as concerns about improper denials of non-VA emergency care reimbursement claims and a review of conditions in a VA inpatient mental health unit.

- **The team also managed liaison responsibilities with other oversight bodies,** including the Government Accountability Office (GAO) and the Council of the Inspectors General on Integrity and Efficiency’s Legislation Committee. Engagements with GAO–29 in total—proved invaluable for coordinating efforts and avoiding duplication. In some cases, GAO referred investigative matters to the OIG for follow-up based on its own findings.

Reviews of Proposed Legislation and Regulations

As required by the Inspector General Act, the OIG reviews existing and proposed legislation and regulations related to VA programs and operations and provides recommendations on their impact on economy, efficiency, and the prevention and detection of fraud and abuse.³ During this reporting period, the OIG reviewed 12 legislative or regulatory proposals and submitted two comments.

OIG personnel reviewed two bills aimed at safeguarding veterans’ compensation benefits and health care to identify any unintended consequences that could affect the OIG’s ability or authority to conduct oversight of VA programs and personnel or for addressing fraud:

- S.3466, the *Honor Our Promise to Veterans Act of 2025*, is a wide-reaching bill proposing improvements to healthcare delivery in VHA and the community. It seeks to bolster transparency about community care and also strengthen VHA’s infrastructure. The OIG noted that mandatory community care provider training on their obligations when engaging with the OIG would also enhance oversight.
- H.R. 5723 and S. 3000, *Fraud Reduction and Uncovering Deception in Department of Veterans Affairs Disability Act of 2025* (FRAUD in VA Disability Exams Act of 2025), addresses suspected fraud involving disability benefits questionnaires. OIG feedback provided information about scams field agents have observed.



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³ 5 U.S.C. § 405(a)(2) (as amended by Pub. L. No. 117-263).

OVERSIGHT PLANNING AND SOURCES

Under the Inspector General Act, the inspector general has authority to review all VA programs, employee activities, and actions by individuals or entities operating under grants, contracts, or other agreements. The act also established the OIG hotline as the mechanism for receiving complaints from VA employees and the public.

The OIG conducts oversight through a balanced approach that combines reactive and proactive strategies. Reactive oversight addresses allegations of fraud, waste, abuse, gross mismanagement, or misconduct that has a nexus to VA—most often conveyed through the OIG hotline. Proactive oversight is strategically planned based on impacts to veterans, emerging developments, new programs, legislative changes, and data analysis to identify vulnerabilities before they escalate. This approach enables the OIG to resolve urgent issues while anticipating and mitigating future risks, promoting accountability and efficiency across VA.

Factors Guiding Oversight Decisions

The OIG's actions must align with its statutory authorities and mission. The OIG prioritizes its resources to maximize impact for veterans, their families, and VA. When determining whether to pursue a matter, the OIG considers a wide range of factors, including

- the actual or potential effect on veterans,
- the actual or potential effect on VA,
- stewardship of taxpayer dollars,
- the pervasiveness of the issue, and
- the availability of other remedies.

Hotline Operations

The OIG hotline serves as a critical channel for reporting allegations of criminal activity, fraud, waste, abuse, misconduct, and major mismanagement in VA programs and operations. Each year, the hotline receives roughly 36,000 contacts on average, which are triaged and assessed for appropriate action. By reviewing and addressing complainant

concerns, the hotline helps safeguard VA resources, uphold integrity, and ensure accountability across the department.

During the six-month reporting period, hotline staff conducted the following:

- Screened 21,365 contacts from complainants and referred higher-risk matters to OIG offices and directorates for case evaluation.
- Referred 351 cases to VA offices or officials and required written responses for OIG experts to review.
- Made 1,114 non-case referrals to the appropriate VA offices for contacts that did not rise to the level of a case but for which the hotline determined some VA action was warranted.
- Closed 374 cases—substantiating 42 percent of allegations—contributing to 359 nonmonetary benefits through administrative sanctions and corrective actions and more than \$2.6 million in monetary benefits.

Allegations Relating to Human Trafficking

The Trafficking Victims Prevention and Protection Reauthorization Act of 2022 requires inspectors general to report at least annually on the number of human trafficking allegations received, any resulting investigations, and any recommended actions to improve agency programs and operations. During this reporting period, the OIG received two allegations related to human trafficking that are under review. The OIG did not close any investigations pertaining to allegations received during a previous reporting period. The OIG made no recommendations to improve VA programs and operations pursuant to this information.

21,365

Contacts to the Hotline

359

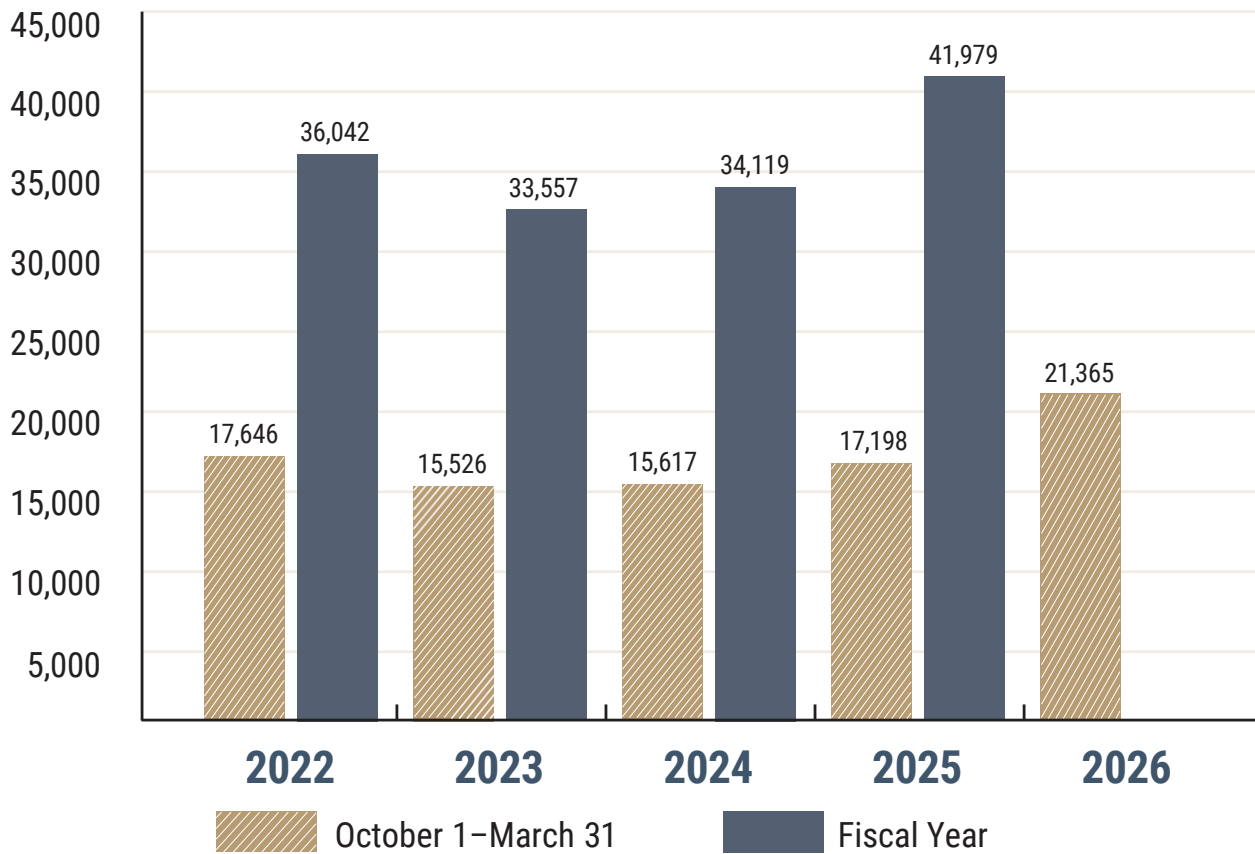
Administrative Sanctions and Corrective Actions

42%

Allegation Substantiation Rate

VA OIG Hotline Results for the Six-Month Period

Hotline Contact Volume by Fiscal Year





FINDINGS AND IMPACT



VA is the second-largest department in the federal government and operates the nation's largest integrated healthcare system. It manages a vast and complex portfolio to deliver health care, benefits, and services to veterans, their families, survivors, and caregivers. The veteran community, VA leaders and personnel, Congress, and taxpayers look to the OIG to root out potential crimes, fraud, waste, and abuse of authority while suggesting significant improvements to VA through data- and evidence-driven recommendations and findings.

This section highlights the most significant oversight findings, recommendations, and impacts from the reporting period—issues that directly affect the efficiency and effectiveness of VA operations and the quality of care and benefits provided to veterans. These findings reveal systemic challenges and vulnerabilities that require corrective action. They form the basis for practical recommendations aimed at reducing risks related to patient care, VA resources, personnel, and systems. Each recommendation reflects a shared commitment to continuous improvement by the OIG and VA and to implement lasting solutions to persistent problems.

The impacts described in this section represent the steps VA takes in response to OIG recommendations, including clarifying or updating guidance, strengthening compliance with laws and regulations, improving processes and practices, and enhancing the security and reliability of systems.

This section also summarizes notable investigations with significant judicial actions during the reporting

period, particularly those involving fraud and other serious risks to VA programs and operations. These investigative results not only identify wrongdoing but also prompt reforms that reinforce accountability and improve the delivery of services to veterans.

The Office of Investigations

The Office of Investigations (OI) serves as the OIG’s fraud command center by working closely with the Office of Data Analytics, OHI, and OAE. OI participates in multiple fraud task forces and coordinates with external law enforcement partners and the Department of Justice on high-impact cases to help ensure that veterans, VA employees, and VA assets are protected.

Examples of impacts from OI’s work include the following:

- Investigations of criminal activity—including drug offenses, crimes of violence, and cyberthreats, as well as civil violations of law—collectively result in arrests, convictions, and civil litigation and help deter future wrongdoing.
- Investigations of fraud in such areas as VA benefits, construction, education, procurement, and health care help prevent losses to the department, increase veteran safety, and stop the use of counterfeit or substandard goods and services by VA.

This reporting period marks 15 years since OI’s first successful conviction in a case involving service-disabled veteran-owned small business (SDVOSB) fraud. SDVOSB fraud is the attempt by ineligible individuals or entities to obtain, perform, or improperly profit from VA contracts set aside for small businesses that are owned and controlled by veterans with military service-connected disabilities. The Veterans Benefits Act of 2003 established the procurement program that authorized federal contracting officers to restrict competition to eligible SDVOSBs and award a sole source or set-aside contract where certain criteria are met. OI appealed to US Attorneys’ Offices to prioritize these cases by stressing that the victims of this fraud were the service-disabled veterans that owned small businesses who were deprived of these contracting opportunities. Since that first criminal prosecution, OI’s SDVOSB fraud investigations have resulted in a total of 77 arrests, 79 indictments, 72 convictions, and \$60.7 million in court-ordered restitution, fines, and forfeiture.

Pension Benefits Fraud. Among many successful criminal investigations that directly impacted VA and veterans, OI investigators [disrupted a pension application fraud scheme](#) being committed by a charity founder and four employees submitting falsified documentation, costing VA \$20 million dollars and improperly demanding payments from

veterans for pension benefits for which they were not actually entitled.

Grant Fraud. As the result of an OI investigation, the former CEO of a nonprofit corporation was sentenced to 42 months' imprisonment for diverting approximately \$180,000 in VA and Department of Labor grant funds away from a veterans homeless shelter and service facility he was operating. The CEO spent the funds on personal items such as a vehicle, lawn equipment, and rental property.

Fraud Committed by VA Employees. OI's criminal investigations also hold VA employees accountable who betray the public trust by engaging in corruption schemes. For example, the former executive director of the Office of Electronic Health Record Modernization was indicted for alleged failure to disclose receipt of thousands of dollars in cash, casino chips, gift cards, and other gifts from contractors while leading this \$16 billion project.⁴ In another example, a former veterans service representative at the Huntington VA Regional Office was sentenced to five months' imprisonment after taking money from veterans in exchange for assistance in obtaining a higher service-connected disability rating, resulting in more VA monthly compensation benefits—with the employee charging the veterans approximately 10 to 20 percent of any retroactive payment they received from VA. The former employee was also ordered to pay restitution of more than \$24,000 to the victims. In another example, a former VA firefighter assigned to the Lyons VA Medical Center in New Jersey fraudulently received workers' compensation benefits for a back injury incurred while on duty in 2014. He falsely

Quantitative Metrics at a Glance

> **127**
Arrests

> **111**
Convictions, Pretrial
Diversions, and Deferred
Prosecutions

> **\$2.17B**
Monetary Benefits for VA and
Non-VA Entities

> **283**
Cases Closed

Office of Investigations
Results for the Six-Month Period

⁴ An indictment is merely an allegation. All defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

Fraud-Related Investigative Results

84

of the 127 total **arrests** were fraud-related (66%).

83

of the 100 total **convictions** were fraud-related (83%).

\$2.17B

in **investigative monetary impact** tied to fraud, with only \$651K from non-fraud cases.

certified annually he was not working or volunteering elsewhere. He was sentenced to 12 months' home confinement and ordered to pay restitution of approximately \$479,000 to VA. Despite claiming that he could not return to work in any capacity, the former VA employee performed voluntary firefighting duties for a local municipality and was paid as a long-haul truck driver. In addition, a former inventory management specialist at the Cleveland VA Medical Center was [sentenced to one year in prison](#) for misusing his VA-issued purchase card to procure electronics and other items valued at approximately \$198,000 for his personal use.

Healthcare Fraud. Investigators aggressively pursue allegations of healthcare fraud that negatively impact both VA and veterans. An [OI investigation](#) led to the arrest of an owner of a home health company who is charged with obtaining more than \$7 million in payments from VA for services that were never actually rendered, including home care to veterans recorded as delivered weeks after their deaths. OI also joined in a [multiagency investigation](#) that led to 11 members of a transnational criminal organization being charged with submitting billions of dollars in fraudulent claims to federal health insurance programs for durable medical equipment that was never prescribed or issued to the beneficiaries. The allegations include that VA paid approximately \$1.8 million as a result of this scheme. Two of the defendants pleaded guilty to conspiracy to commit money laundering during this reporting period.

Education Benefits Fraud. OI continues to conduct education benefits investigations involving schools that do not provide promised services to eligible veterans, service members, and their qualified family members. The owner of a barbering and cosmetology school was sentenced to 96 months' imprisonment and ordered to pay restitution to VA of approximately \$2.9 million after being found guilty by a federal jury of [enrolling veterans in classes without providing any actual instruction or training](#). The owner also made numerous false statements (including falsified records) and misrepresentations to VA regarding veterans' attendance.

Fraud Committed Against Vulnerable Beneficiaries. Among the most tragic cases, OI personnel investigate allegations of crimes committed by VA-appointed fiduciaries,

caregivers, and other trusted individuals against vulnerable beneficiaries. The nephew of a quadriplegic veteran, who was supposedly residing with and providing care for his uncle, was sentenced to 156 months' imprisonment after [concealing his uncle's death for several years and stealing over \\$1.8 million](#) of the veteran's VA and Social Security benefits. In another case, a woman was sentenced to 48 months' imprisonment for conspiring to defraud an elderly, disabled veteran by [arranging a sham marriage](#) between her and the veteran. After submitting false applications to VA which resulted in her control of his disability payments, the woman obtained more than \$29,000 from the veteran. As the result of yet another investigation, a defendant pleaded guilty to [stealing VA compensation benefits](#) totaling approximately \$225,000 that were intended for an elderly veteran who was unable to manage his own money.

Threats Against VA and Other Federal Employees. Working with prosecutors, OI advanced cases in which individuals made threats of violence against VA and other federal employees. In one instance, a veteran was sentenced to 15 months' imprisonment after pleading guilty to threatening during a telephone call to the Veterans Crisis Line to injure a VA police officer, murder a US Postal Service employee, and sexually assault the immediate family members of a VA employee. In another case, a veteran pleaded guilty after making threats to kill a VA police officer and spitting in his face while he was being transferred to a VA medical center for a 72-hour psychiatric hold.

In addition to investigative work, OI staff routinely conduct fraud awareness briefings to VA staff around the country that complement its [online fraud toolkit](#). These briefings and related resources alert VA personnel to the indicators for potential fraud schemes. During this reporting period, OI conducted 56 fraud awareness briefings with a total attendance of approximately 2,809 VA employees. [Crime alerts](#) are also widely disseminated to the veteran community to encourage reporting to the OIG hotline and prevent victimization.

Read more criminal investigative updates on the [OIG website](#).



The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) focuses on oversight that has a positive impact on veterans, their families, beneficiaries, and caregivers and increases accountability, efficiency, and effectiveness across VA.

OAE conducted audits and reviews of VA programs, services, and operations to recommend significant improvements in the following areas:

- Veterans' access to health care both within VA and in the community
 - Veterans' receipt of benefits and services to which they are entitled
 - VA's efficiency and stewardship of taxpayer dollars
 - VA's safeguarding of assets and sensitive veteran information
-

OAE's impact for the six-month reporting period includes helping VA advance its community care program management and the continuity of care for veterans. For example, VHA changed its processes consistent with OIG recommendations to facilitate veterans more quickly receiving special-authorization drugs prescribed by community care providers. In addition, VHA executed a [contract modification recommended by the OIG](#) to support better tracking and retrieval of medical records from community care visits through electronic transmissions instead of relying on faxing records. As an example of the OIG's focus on vulnerable veterans, OAE published [an audit of VHA's Homeless Program](#) that found weaknesses in the referral and follow-up processes that put veterans experiencing homelessness (or without stable housing) at risk for not receiving assistance.

OAE's impact affects a broad range of beneficiaries. For example, as the result of auditors examining [funding fee refunds](#) for veterans using dual entitlements (two or more veterans using some or all of their combined benefits) for VA joint home loans, the OIG found some veterans with disabilities exempt from paying funding fees were inappropriately charged by lenders at loan closings. Also, those veterans with retroactive disability determinations using dual entitlement were not identified by VBA to provide funding fee refunds. In response, VA agreed to update its systems and began the review and refunding process to address the approximately 250 veterans wrongfully charged fees, with potential refunds averaging \$6,100 each, totaling \$1.5 million.

Also during this reporting period, VBA has taken many other actions in response to OIG recommendations to strengthen guidance and processes to improve the accuracy and

timely delivery of disability and other benefits to veterans. This included increasing controls to ensure claim awards and denials comply with the law. For example, after the OIG determined [survivors of veterans exposed to toxic substances](#) did not always receive accurate retroactive benefits under more expansive PACT Act criteria, VBA reviewed reopened Dependency and Indemnity Compensation claims to ensure beneficiaries received the benefits they were due and were correctly notified of their claims decisions.⁵

To leverage in-house expertise and strengthen collaborations, OAE has continued to work with the Office of Investigations by sharing technical knowledge on benefit claims, systems, and program risks that can signal potential fraud or related crimes. The impact of these collaborations was noted by Congress when [Inspector General Cheryl Mason testified](#) in October 2025 on combating fraud in VBA's compensation and pension programs.

OAE persistently monitors VA's stewardship of taxpayer dollars by verifying that funds are used effectively and in accordance with laws, regulations, and contracts. OAE also assists with False Claims Act cases and meets with VA leaders on the findings of VA's financial statement audits. The publication of the OIG [audit of VA's financial statements for fiscal year 2025](#) provided a clean opinion. However, the audit

Quantitative Metrics at a Glance

> 40

Reports and Other Products

> \$90M

Potential Monetary Impact of Recommendations Made

> 49

Recommendations Issued to VA for Corrective Action

> 111

Recommendations Closed Based on VA Corrective Actions

Office of Audits and Evaluations
Results for the Six-Month Period

⁵ Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Pub. L. No. 117-168, § 1(a), 136 Stat. 1759.

noted two material weaknesses and three significant deficiencies in internal controls and instances of noncompliance with laws and regulations.

OAE has also helped ensure contract integrity. For example, [a March 2026 audit](#) found that VHA did not effectively oversee contractor-operated community-based outpatient clinics because program office oversight ended once a vendor was awarded a contract. As a result, VHA paid full price for healthcare services that did not meet requirements and may have adversely affected veterans. Another example of OAE's commitment to ensuring contract integrity includes its oversight of contracts governing the community care network. As [congressional testimony](#) by Deputy Assistant Inspector General Leigh Ann Searight emphasized, implementing OIG recommendations and addressing oversight risks is critical for VA to build a robust next-generation community care contract that prevents fraud, waste, and abuse while ensuring quality health care for veterans.

As to safeguarding VA assets and sensitive information, OAE completed audits focused on systems such as the [Integrated Financial and Acquisition Management System \(iFAMS\)](#), which contains acquisition information like pricing and labor rates. The OIG found access controls to iFAMS did not sufficiently limit VA staff, and many users had exceptionally broad access to sensitive information. OAE promptly informed VA of issues impacting security and continues to monitor remedial actions. VA has also taken steps to secure sensitive information and prevent disruption of mission-critical systems and operations in response to two OIG information security inspections. Further, in response to recommendations regarding the new federal electronic health record system, VA updated the notification and resolution process for major performance incidents and provided the OIG with evidence that a review had been completed of patient safety events identified during the audit to determine if further action was warranted.

These highlights help demonstrate that OAE efforts are driven by the OIG mission, consistent with the Inspector General Act.

The Office of Healthcare Inspections

Drawing on the expertise of physicians, nurses, social workers, pharmacists, and other healthcare professionals, the Office of Healthcare Inspections (OHI) continues to play a vital role in improving outcomes for veterans across VA's diverse healthcare programs. During this reporting period, OHI advanced the OIG mission to conduct independent oversight that enhances the effectiveness and efficiency of VHA programs and operations. Multidisciplinary teams performed cyclical inspections, national reviews, and for-cause evaluations related to allegations of wrongdoing to uncover systemic vulnerabilities. The resulting recommendations for VA corrective actions focus on

strengthening patient safety, improving the quality of care provided at VA and in the community, and enhancing operational reliability across VHA.

Examples of impacts from OHI's work include the following:

- Changes to policies, governance structures, and how leaders fulfill their roles and responsibilities
 - Enhancements to mental health and suicide prevention and patient safety
 - More effective care coordination between VHA and community care providers
 - Identification of risks to systems that support healthcare operations and keep information secure
-

OHI continues its efforts to apprise VHA leaders of urgent risks so they can mitigate or resolve issues and address identified concerns. OHI's impact on clinical management and community care coordination has influenced enhancements in patient safety processes, documentation standards, and oversight of community care programs.

An OHI team conducted a mental health inspection at the [VA NY Harbor Healthcare System](#) and found inconsistent safety plan documentation for patients being discharged. VHA agreed to require staff to address lethal means beyond firearms and opioids when completing the safety plan template. Another inspection, conducted at the [Martinsburg VA Medical Center](#), revealed staff did not perform involuntary holds or admissions for veterans experiencing mental health crises due to facility leaders' incorrect interpretation of West Virginia state law. The Veterans Integrated Service Network (VISN) director committed to ensuring the establishment of state-compliant involuntary hold procedures.

In a review of leaders' actions affecting clinical services at the [Syracuse VA Medical Center](#), OHI inspectors substantiated that facility neurosurgery services to veterans were terminated without required national approvals and that contracts for infectious disease and endocrinology lapsed without contingency plans. These actions contributed to veterans having difficulty with accessing specialty care and to eight physicians' resignations. The OIG findings prompted leaders' engagement at multiple levels to restore compliance with restructuring requirements, improve communication strategies, and strengthen oversight of infrastructure and contracting processes.

An OHI [national review](#) revealed that audiologists were misclassified for suicide risk training, resulting in 80 percent completing only nonclinical training. Consequently, there were 24,000 missed opportunities to assess the risk for suicide in veterans seeking

Quantitative Metrics at a Glance



audiologic care over two years. In response to OIG recommendations, VHA agreed to clarify training requirements, implement a directive defining responsibilities, and introduce a performance metric to monitor adherence. These steps improve screening consistency and safeguard veterans at risk for suicide.

In a review of the care provided to a patient of the [Marion, Illinois, VA Healthcare System](#) who died by suicide, OHI inspectors identified gaps in VA's traumatic brain injury care coordination with community hospital and rehabilitation providers who diagnosed and treated the condition. There were also lapses in fall prevention practices and suicide risk management for the patient. Facility leaders committed to updating protocols, improving referral processes, and strengthening communication with community providers, which collectively increase safety and the continuity of care for high-risk veterans.

Following a healthcare inspection, the [VA Eastern Colorado Health Care](#)

[System](#) director committed to reinforcing patient safety reporting and documentation requirements. Inspections also led to several facilities—including those in [Biloxi, Mississippi](#); [Clarksburg, West Virginia](#); [San Antonio, Texas](#); and [Palo Alto, California](#)—to adopt workflows for timely communication of patients' test results. In response to recommendations from OHI inspection teams, leaders in two VHA regions (then [VISNs 4](#) and [16](#)) ensured that community care oversight councils integrated patient safety trends and corrective actions into their meetings, reducing delays and improving continuity of care for veterans using non-VA services in these two VHA network regions.

Among recommendations closed this reporting period, OHI closed recommendations for VHA facilities in [Nashville](#) and [Tampa](#). These recommendations, which focused on

preventive maintenance and infection control, strengthened safety measures that protect both veterans and staff.

Throughout these efforts, OHI consistently advanced the inspector general's ACER principles—Accountability, Collaboration, Efficiency, and Resolution—by ensuring rigorous oversight, fostering strong governance, making actionable recommendations for corrective actions and process changes, and driving sustainable improvements for VA to deliver better care and services to veterans.

Investigations of Senior Government Employees

The Inspector General Act requires OIGs to include in their semiannual reports information on each criminal or administrative investigation in which allegations of misconduct against a senior government employee were *substantiated*.⁶ Required reporting includes the individual's name if it has been previously disclosed, a description of the facts and circumstances, and the status and disposition of the matter, including the date of any referral to the Department of Justice and, if applicable, the date of declination. The OIG has nothing responsive to report for this period.

The act also requires OIGs to disclose any criminal or administrative investigation involving a senior government employee that closed during the reporting period but was not otherwise made public, regardless of whether the allegations were substantiated.⁷ The VA OIG may close such investigations without public disclosure when the allegations are unsubstantiated or when the matter is referred to another entity. During this reporting period, the VA OIG closed the following matters involving allegations against senior government employees that were unsubstantiated—both administrative and those with the potential for criminal prosecution:

- An allegation submitted to the OIG stated that several VHA senior executives had conflicts of interest involving multiple companies and may have illegally steered some contracts for award. The investigation found evidence that the VHA senior executives disclosed potential conflicts of interest as required and some sought and received ethics guidance from VA's Office of General Counsel regarding their outside activities. There was no evidence identified of any steering of contracts. The complainant also alleged that senior VHA executives abused the VA travel policy and engaged in "travel fraud" by scheduling official VA travel around personal commitments. It was further alleged that one senior executive frequently traveled to a city in another state to help plan a close relative's wedding in April 2024 and that other VA leaders may have abused VA travel policy to attend the

⁶ 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-286).

⁷ 5 U.S.C. § 405(b)(16)(B) (as amended by Pub. L. No. 117-286).

wedding. The investigation determined that this senior executive did not travel to the alleged location in April 2024. The senior executive traveled to that location on four occasions between April 2023 and December 2024. For each trip, the senior executive provided a justification that was approved by their supervisor. The complainant did not provide any actionable information related to their broad allegations of abuse of VA travel policy by other senior leaders. On September 25, 2025, the US Attorney's Office for the District of Columbia also declined to investigate further.

- The OIG received an email, forwarded by two VA officials, alleging that a senior VA employee who joined VA in 2025 maintained an improper continuing connection with their former employer in violation of ethics rules. Administrative investigators initially evaluated the allegations by reviewing emails and other available records related to the senior government employee and prior employer, and interviewed several VA officials. Shortly after the OIG began its review, the senior employee resigned from VA, leaving no meaningful administrative remedies. As a result, the OIG decided not to pursue further administrative action. Following this decision, OIG criminal investigators also evaluated the allegations and evidence and presented potential criminal violations to the US Attorney's Office for the District of Columbia, which declined further action on January 14, 2025.
- An anonymous complainant alleged that two senior government employees engaged in misconduct related to improperly justifying retention incentives for their staff. A preliminary evaluation of the allegations, including reviewing emails and other records related to the incentives, revealed insufficient evidence of misconduct relating to the justifications to support further review. Because one of these officials was also a member of the group who received the incentive, the OIG referred that matter as a potential criminal financial conflict of interest to the US Attorney's Office for the District of Columbia, which declined prosecution on September 25, 2025.
- A confidential source reported that a then-senior government employee committed ethics violations with respect to a contract awarded by the senior employee's VA office. A review of emails and other records related to the employee and the subject contract, as well as an interview with a VA employee positioned to have relevant knowledge, produced insufficient evidence to warrant further review. In addition, the employee had resigned and the alleged misconduct was reported to have occurred several years prior.
- Another anonymous complainant asserted that a VA medical center director stored or viewed pornographic material on their government-issued device. The allegation also stated that an unnamed VA employee observed the director

engage in inappropriate behavior related to that material. The OIG’s preliminary evaluation of these allegations included inspecting the director’s government-issued hard-drive and found no evidence of prohibited materials or internet access of the same. Due to the lack of forensic evidence and the inability to interview the anonymous complainant or potential witness, this matter was closed.

- The OIG received an allegation that a former high-level employee, who departed VA under the deferred resignation program (DRP), attended and participated in a congressional roundtable meeting on behalf of their new employer (a private contracting company) while still getting paid under the DRP. The preliminary evaluation found there was insufficient evidence of wrongdoing to justify any further review.
- The OIG also received allegations that a former senior VA official and another VA employee who participated in the DRP may have violated procurement and ethics rules. The complainant asserted that both employees pursued employment with companies seeking contracts with VA and provided information or an advantage to those companies. During its preliminary evaluation, OIG investigators learned VA completed an internal review and took remedial action regarding the relevant contract, precluding the need for further OIG review. On September 25, 2025, the US Attorney’s Office for the District of Columbia declined prosecution as well.
- The OIG conducted a preliminary evaluation of allegations that government property was being stolen from a VA medical facility and assessed concerns raised about the law enforcement equipment being used by VA police. The complainant alleged that VA leaders, including a former VISN director, facility associate director, chief of police, and deputy chief of police, did not appropriately respond to both these concerns. During the OIG’s preliminary evaluation, the complainant did not know if the facility property was actually stolen and could not provide information that their concerns with the police equipment caused safety risks. Further, because the complainant had no direct knowledge and could not explain the basis for the allegations, there was insufficient information to proceed.

Other Work Closed Without Public Release

The Inspector General Act requires inspectors general to report any inspection, evaluation, or audit report closed during the reporting period but not disclosed to the public.⁸ The VA OIG publishes all reports unless law or regulation prohibits disclosure and lists all completed reports—public or nonpublic—in [appendix A](#). Notifications are also posted on the [OIG website](#) when a final report is not completed, such as when

⁸ 5 U.S.C. § 405(b)(16)(A) (as amended by Pub. L. No. 117-263).

work concludes due of legislative changes, VA reforms, or other superceding events. Therefore, the OIG closed no reports that remain undisclosed.

The subsections below provide additional detail on categories of OIG work that may be closed without public release under applicable statutory requirements.

PREAWARD AND POSTAWARD CONTRACT AUDITS

The Office of Audits and Evaluations reviews VA’s contracts with outside entities through preaward and postaward audits of Federal Supply Schedule, construction, and healthcare provider contracts. Preaward audits help VA contracting officers negotiate fair and reasonable prices, while postaward audits assess compliance with contract terms and identify overcharges for recovery. These reports are submitted only to VA because they contain nonpublic, confidential, and proprietary business data, including trade secrets protected under 18 U.S.C. § 1905. They are also exempt from mandatory disclosure under the Freedom of Information Act (5 U.S.C. § 552), and contractor proposals are protected from release under 41 U.S.C. § 4702. To promote transparency, the OIG lists all completed preaward and postaward audits in [appendix A](#) and annually publishes summary reports with high-level findings.

INVESTIGATIONS OF ALLEGED WHISTLEBLOWER RETALIATION

The Inspector General Act requires inspectors general to report information on officials found to have retaliated against whistleblowers, as well as any consequences imposed by the department to hold those officials accountable.⁹ The VA OIG refers VA employees alleging whistleblower reprisal to the VA Office of Accountability and Whistleblower Protection or the US Office of Special Counsel because those offices have statutory authority that the OIG does not to address these claims and provide direct relief for substantiated cases. Therefore, the OIG has nothing to report for this requirement.

The VA OIG is required, however, to investigate allegations of whistleblower reprisal involving employees of *VA contractors or grantees*, with limited exception.¹⁰ Federal law prohibits the OIG from disclosing information about individuals alleging reprisal except as necessary to conduct the investigation; therefore, the OIG does not publicly release case details. During the reporting period, the VA OIG received 17 new allegations of whistleblower reprisal and closed two investigations. Consistent with statutory requirements, the OIG refers the findings of completed investigations to the VA Secretary, who decides whether to grant or deny relief to the complainant.¹¹

⁹ 5 U.S.C. § 405(b)(14) (as amended by Pub. L. No. 117-286).

¹⁰ 41 U.S.C. § 4712(b)(2).

¹¹ 41 U.S.C. § 4712(c).

PERFORMANCE METRICS

AT-A-GLANCE SUMMARY FOR THE REPORTING PERIOD



* Figure Includes testimony and briefings.

‡ Figure includes combined results from the OIG Hotline Division and the Office of Investigations.

Table 1. Monetary Impact and Return on Investment

TYPE	THIS PERIOD
Better Use of Funds	\$66,448,979
Dollar Recoveries	\$5,596,593
Fines, Penalties, Restitution, and Civil Judgments ¹²	\$2,125,076,178
Fugitive Felon Program	\$16,790,586
Savings and Cost Avoidance	\$26,969,464
Questioned Costs	\$23,745,762
Total Dollar Impact	\$2,264,627,562
Cost of OIG Operations ¹³	\$126,508,378
Return on Investment¹⁴	\$18:1

Table 2. Recommendations Inventory

	THIS PERIOD
Beginning Balance of Open Recommendations	720
Issued	333
Closed	481
Ending Balance	572

¹² This category includes investigations conducted solely by the VA OIG and in partnership with other law enforcement agencies. The amount reported reflects the total monetary recovery to date and amounts payable to all government entities, nongovernment entities, and private individuals as a result of these investigations. Of the total amount reported for this period, the monetary impact to VA is \$340,117,069. This amount includes forfeited funds for which VA could submit a petition for remission.

¹³ The six-month operating costs for OHI (\$21,491,622), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

¹⁴ The return on investment is calculated by dividing total dollar impact by cost of OIG operations.

Table 3. Reports and Other Products

REPORTS	THIS PERIOD
Audits	6
Care in the Community Inspections	1
Healthcare Facility Inspections	24
Healthcare Inspections	11
Information Security Inspections	2
Mental Health Inspections	4
National Healthcare Reviews	5
Postaward Contract Audits*	8
Preaward Contract Audits*	19
Reviews	3
Vet Center Inspections	5
Subtotal	88
OTHER WORK PRODUCTS	THIS PERIOD
Budget Request	1
Congressional Testimonies	3
Major Management Challenges	1
Management Advisory Memoranda	1
Monthly Highlights	2
Preliminary Result Advisory Memoranda	5
Whistleblower Reprisal Investigation Memoranda*	1
Subtotal	14
Total	102

* Indicates products restricted from public release under federal law.

Table 4. Selected Office of Investigations Activities

TYPE¹⁵	THIS PERIOD
Arrests ¹⁶	127
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	7
Indictments	95
Indictments and Informations Resulting from Prior Referrals to Authorities	75
Criminal Complaints	47
Convictions	100
Pretrial Diversions and Deferred Prosecutions	11
Case Referrals to the Department of Justice for Criminal Prosecution ¹⁷	166
Case Referrals to State and Local Authorities for Criminal Prosecution ¹⁸	45
Administrative Sanctions and Corrective Actions	151
Cases Opened	232
Cases Closed	283

¹⁵ Pursuant to 5 U.S.C § 405(b)(12) (as amended by Pub. L. No. 117-263), all investigative data reported and analyzed were collected via the OIG’s case management system. Although 5 U.S.C. § 405(b)(11) requires federal inspectors general to list the total number of investigative reports issued during the reporting period, the VA OIG does not publish or issue investigative reports related to criminal investigations. Any reports of noncriminal investigations are disclosed in tables 3 and A.2. Selected criminal investigative updates are available on the [OIG website](#).

¹⁶ This figure includes nine arrests of fugitive felons made by VA OIG agents during the reporting period and excludes arrests made by other agencies with VA OIG assistance.

¹⁷ 5 U.S.C. §405(b)(11) (as amended by Pub. L. No. 117-263) requires federal inspectors general to report the “total number of persons” referred to federal authorities for criminal prosecution. However, the VA OIG’s case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

¹⁸ 5 U.S.C. §405(b)(11) (as amended by Pub. L. No. 117-263) also requires federal inspectors general to report the “total number of persons” referred to state and local authorities for criminal prosecution. However, the VA OIG’s case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

Table 5. Selected Office of Healthcare Inspections Activities

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	0
Clinical Consultations to Other Federal Entities	3
Hotline Referrals Reviewed	2,155

Table 6. Selected Hotline Division Activities

TYPE	THIS PERIOD
Contacts	21,365
Cases Opened	351
Cases Closed	374
Administrative Sanctions and Corrective Actions	359
Allegation Substantiation Rate	42%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	37
Individuals Provided Office of Special Counsel Contact Information	37
Individuals Provided Merit Systems Protection Board Contact Information	9
Individuals Provided Office of Resolution Management Contact Information	59

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

- ▶ Crimes and violations of rules/regulations
- ▶ Mismanagement or a gross waste of funds
- ▶ Abuse of authority
- ▶ Risks to patients, employees,
and property

SUBMIT A COMPLAINT

ONLINE: www.vaogig.gov/hotline

FAX: 202.495.5861

MAIL: VA Inspector General Hotline (53H)

810 Vermont Ave, NW

Washington, DC 20420

PHONE: 800.488.8244

**SCAN HERE FOR
VA OIG HOTLINE**



**U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL**

FOLLOW-UP AND RESOLUTION

OMB Circular A-50, as revised, provides guidance to agencies and inspectors general to ensure timely resolution of recommendations, emphasizing that follow-up is an “integral part of effective management” and a “shared responsibility” between agency leadership and OIG officials.¹⁹ Corrective actions are essential for managing risk and improving departmental operations. The circular requires agencies to establish processes for prompt resolution and implementation of OIG recommendations. The OIG’s follow-up process with VA is based on these principles.

Follow-Up Process for OIG Recommendations

When undertaking audits, inspections, and reviews, the OIG focuses on identifying remedial measures and opportunities for improvement and then monitoring timely implementation. Draft reports are shared with VA management for comment, allowing them to respond and outline implementation plans before the report is issued. The goal is for all recommendations to be implemented within one year of the issuance of the final report, with exceptions made only when circumstances prevent timely completion, such as changes to information systems, new legislation affecting planned actions, or other unforeseen events that delay progress.

OIG staff worked proactively with VA to close a number of long-standing recommendations. On a quarterly basis, follow-up staff request status updates from the responsible VA office. These updates summarize actions taken during the preceding 90 days and indicate whether the office believes it has met the intent of any open recommendations and is requesting closure.

While OIG follow-up staff track progress, the OIG team that issued the report are the subject-matter experts and must provide written concurrence before a recommendation can be closed.

Recommendation Inventory This Period

720

Beginning Balance
as of October 1, 2025

333

Recommendations
Issued This Period

481

Recommendations
Closed This Period

572

Ending Balance as of
March 31, 2026

¹⁹ OMB Revised Circular A-50, [Audit, Inspection, or Evaluation Follow-Up](#), November 7, 2024.

Management Decisions on Prior Reports

The Inspector General Act requires federal inspectors general to report information regarding any management decision made during the *current* reporting period with respect to any audit, inspection, or evaluation issued during a *previous* reporting period.²⁰ The VA OIG has no information responsive to this requirement.

Unimplemented (Open) Recommendations

The figures below highlight key trends in the recommendation inventory, and [appendix B](#) provides a list of all recommendations from prior reporting periods for which corrective actions remain incomplete. In addition, the [OIG website](#) offers real-time data on open recommendations and allows users to filter by status, date range, topic area, responsible action office, and other criteria.

Distribution of Open Recommendations by Age as of March 31, 2026

420

Open Less Than One Year

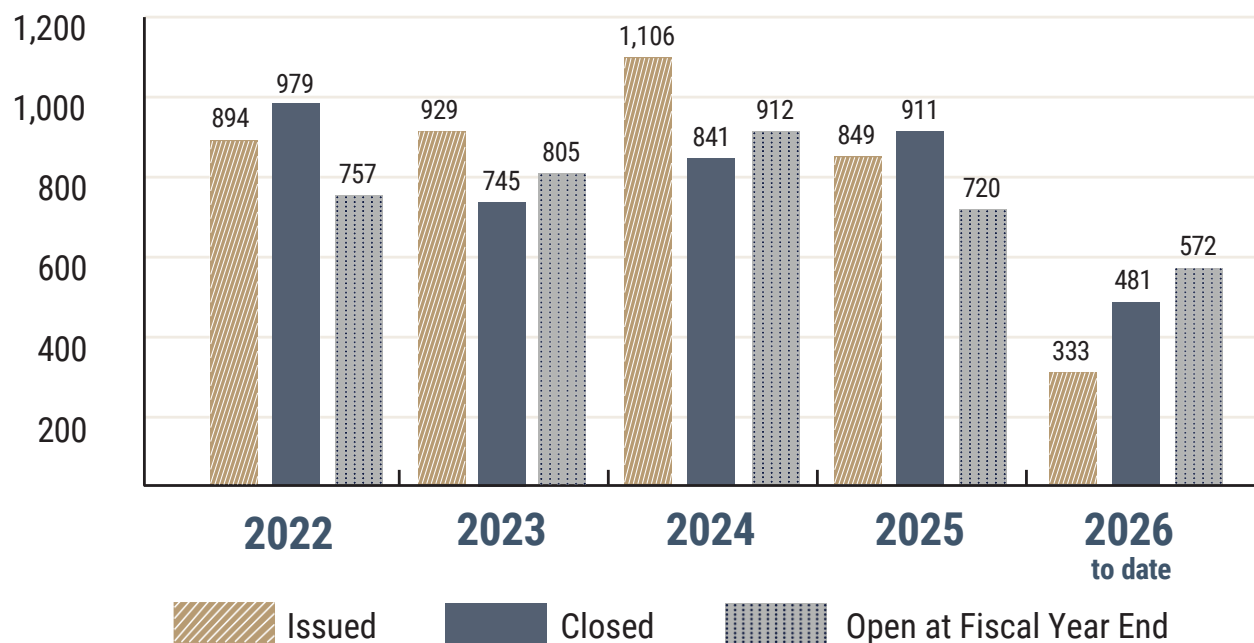
148

Open Between One and Five Years

4

Open More Than Five Years

Recommendations Volume by Fiscal Year



²⁰ 5 U.S.C. § 405(b)(6) (as amended by Pub. L. 117-263).

OTHER REQUIRED DISCLOSURES

This section lists disclosures required by law and other reporting requirements that have not been discussed elsewhere in this report.

Attempts to Interfere with the Independence of and Refusals to Provide Information or Assistance to the OIG

The Inspector General Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information.²¹ It also authorizes the OIG to have access to all VA records, documents, or other materials related to VA programs and operations, as well as to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the act. When such information or assistance is unreasonably refused or not provided by VA, the inspector general is required to report that to the head of the agency.²² All federal OIGs are required by the Inspector General Act to provide a summary of each such report.²³ The VA OIG reports no such instances occurring during this reporting period.

Instances of the OIG Exercising Testimonial Subpoena Authority

The VA OIG is authorized by the Strengthening Oversight for Veterans Act of 2021 to require by subpoena the attendance and testimony of witnesses as necessary in the performance of its functions.²⁴ The act also requires the VA OIG to disclose certain information in its semiannual report to Congress about its use of this authority.

The OIG did not serve any testimonial subpoenas during this reporting period, nor did staff conduct any interviews of individuals pursuant to a testimonial subpoena served during the prior reporting period. The US Attorney General did not object to any proposed subpoenas. The OIG has not encountered any challenges or concerns exercising the authority, and there are no other matters to report.

²¹ 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

²² 5 U.S.C. § 405(b)(15)(A)(i) (as amended by Pub. L. No. 117-263).

²³ 5 U.S.C. § 405(b)(15)(B) (as amended by Pub. L. No. 117-263).

²⁴ Pub. L. No. 117-136 § 2(a) (codified at 38 U.S.C. § 312(d)) (authority extended by Pub. L. No. 119-37, div. G, title IV, § 7401 (Nov. 12, 2025)).

Peer Reviews

The VA OIG’s offices of Audits and Evaluations, Healthcare Inspections, and Investigations are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by these offices meets the applicable requirements and standards. The Inspector General Act, as amended, requires inspectors general to report the results of any peer review of its operations conducted by another office of inspector general during the reporting period or identify the date of the last such review, in addition to any outstanding recommendations that have not been fully implemented.²⁵ This information is presented in table 7. The Inspector General Act also requires inspectors general to report the results of any peer review they completed of another office of inspector general during the reporting period, as well as any outstanding recommendations that have not been fully implemented.²⁶ This information is presented in table 8. If the VA OIG did not complete any peer reviews of another office this period, the table lists the most recent peer review completed.

Table 7. Most Recent Peer Reviews Conducted of the VA OIG

TYPE	DATE	REVIEWING OIG	RATING	RECOMMENDATIONS
Audits	3/24/2025	Department of Agriculture	Pass	None
Inspections and Evaluations	9/22/2023	Department of the Interior	Pass	None
Investigations	2/3/2025	Small Business Administration	Pass	None

Table 8. Most Recent Peer Reviews Completed by the VA OIG

TYPE	DATE	OIG REVIEWED	RATING	RECOMMENDATIONS
Audits	9/18/2024	Treasury Inspector General for Tax Administration	Pass	None
Inspections and Evaluations	9/14/2021	Department of War	Pass	None
Investigations	11/21/2023	Federal Deposit Insurance Corporation	Pass	None

²⁵ 5 U.S.C. § 405(b)(8)(A), § 405(b)(8)(B), and § 405(b)(9) (as amended by Pub. L. No. 117-263).

²⁶ 5 U.S.C. § 405(b)(10) (as amended by Pub. L. No. 117-263).

APPENDIX A: INVESTIGATIONS AND REPORTS

Significant Criminal Investigations with Judicial Actions

Table A.1 lists significant investigations that resulted in judicial action this reporting period, with links to previously published case summaries or press releases. While the Inspector General Act requires federal inspectors general to report only on significant *closed* investigations, this table includes judicial actions from both open and closed criminal investigations to better reflect the scope of VA OIG's efforts during the period.

The Inspector General Act also requires disclosure of any investigation involving substantiated allegations of misconduct by senior government officials.²⁷ There are no such criminal investigations to report this period; however, any future reports meeting this criterion will be marked with an asterisk (*) in the table.

Table A.1. Significant Criminal Investigations with Judicial Actions This Period

DATE	TITLE
VHA INVESTIGATIONS	
CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS AND OTHER HEALTHCARE FRAUD	
11/18/2025	Anchorage Doctor and Husband Plead Guilty to Multi-Million Dollar Health Care Tax Fraud Schemes
12/3/2025	CEO of Fresno-based Health Care Company Arrested at San Francisco Airport for an Alleged \$7 Million Scheme to Defraud the Department of Veterans Affairs
12/22/2025	CEO of Health Care Software Company Sentenced for \$1B Fraud Conspiracy
2/4/2026	Multicare Health System to Pay Millions to Settle Fraud Case
2/17/2026	Zynex Inc. Agrees to Criminal Resolution Addressing Claims of Millions of Dollars of Health Care Fraud, Securities Fraud and Related Offenses
2/17/2026	Local Home Healthcare Company Owner Admits Over \$200,000 Fraud

²⁷ 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

Table A.1. Significant Criminal Investigations with Judicial Actions This Period (Continued)

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS AND OTHER HEALTHCARE FRAUD (CONTINUED)	
2/20/2026	<i>Former NFL Player and Laboratory Owner Convicted in \$328M Genetic Testing Fraud Scheme</i>
2/20/2026	<i>Former VA Employee Sentenced to Prison for Stealing Almost \$200k in Unauthorized Purchases on Work-Issued Credit Card</i>
2/24/2026	<i>Texas Doctor Sentenced to 8.5 Years in Prison for \$145 Million Health Care Fraud Scheme</i>
2/27/2026	<i>Former New York National Sales Director Sentenced to Three Years in Prison for Kickback Scheme</i>
2/27/2026	<i>Founders/Owners of Hertel & Brown Physical and Aquatic Therapy Each Sentenced to Six Years in Prison and Fined \$250,000 for Wire and Healthcare Fraud Conspiracy</i>
3/6/2026	<i>Massachusetts Man Arrested and Charged with Falsely Impersonating US Army Veteran for Over 30 Years</i>
THEFT OF GOVERNMENT PROPERTY AND FALSE DOCUMENTATION	
10/14/2025	<i>Former Inventory Management Specialist at the Cleveland VA Medical Center and Coconspirator Pleaded Guilty to Purchase Card Theft Scheme</i>
10/15/2025	<i>Former Nurse at Texas VA Medical Center Sentenced for Falsely Claiming She Had Checked on a Patient Who Ultimately Died</i>
2/20/2026	<i>Former VA Employee Sentenced to Prison for Stealing Almost \$200k in Unauthorized Purchases on Work-Issued Credit Card</i>
3/25/2026	<i>Veterans Affairs Senior Executive Charged With Concealing Gifts and Cash Received from Government Contractors</i>
VBA INVESTIGATIONS	
THEFT OF GOVERNMENT FUNDS AND FIDUCIARY FRAUD	
10/9/2025	<i>Former VA Fiduciary Sentenced for False Statements</i>
10/10/2025	<i>Deceased Veteran’s Nephew Pleaded Guilty to Concealing Veteran’s Death to Steal VA and Social Security Benefits</i>
10/23/2025	<i>Veteran Sentenced for VA Disability Compensation Benefits Fraud</i>
10/22/2025	<i>Bath Man Indicted for Stealing Approximately \$225,000 From an Elderly Disabled Veteran</i>

Table A.1. Significant Criminal Investigations with Judicial Actions This Period (Continued)

THEFT OF GOVERNMENT FUNDS AND FIDUCIARY FRAUD (CONTINUED)	
11/21/2025	<i>Clay County Man Found Guilty of "Stolen Valor" and \$140,000 in Benefits Fraud</i>
12/1/2025	<i>Tulsa Woman Sentenced for Stealing Disabled Army Veteran's Identity</i>
12/5/2025	<i>Harrison County Woman Admits to Theft of Public Money</i>
1/8/2026	<i>Missouri Man Who Neglected Veteran and Concealed His Corpse Sentenced to 156 Months in Prison</i>
1/9/2026	<i>Rankin County Woman Pleads Guilty to Misappropriation by a VA Fiduciary</i>
1/21/2026	<i>Montgomery County Man Who Fraudulently Obtained More Than \$240,000 in Disability Benefits from the VA Sentenced to 18 Months in Prison</i>
2/2/2026	<i>Bath Man Pleads Guilty to Stealing Over \$225,000 From an Elderly Disabled Veteran</i>
2/2/2026	<i>Cincinnati Woman Admits Stealing More Than \$158,000 From Elderly or Ill Veterans</i>
2/23/2026	<i>The Founder of Senior Veterans Administration Services Sentenced for Scamming the Department of Veterans Affairs of Approximately \$20 Million in Fraudulent Benefits</i>
3/3/2026	<i>Man Sentenced to Federal Prison for Theft of Funds From the Department of Veterans Affairs</i>
3/17/2026	<i>Kent Washington Woman Sentenced to Prison for Defrauding VA Programs Designed to Help Severely Disabled Veterans</i>
ILLEGAL RECEIPT OF GRATUITIES AND EDUCATION BENEFITS FRAUD	
10/29/2025	<i>Owner of Barbering and Cosmetology School in Tennessee Convicted of GI Bill Fraud Scheme</i>
11/14/2025	<i>Former VA Employee Charged with Running Criminal Scheme to Obtain VA Benefits for Others</i>
11/20/2025	<i>Huntington Man Sentenced to Prison for Unlawfully Receiving Gratuities While Salaried Federal Employee</i>
2/4/2026	<i>Memphis Woman Sentenced to 8 Years in Federal Prison for Defrauding Department of Veterans Affairs of Over \$2.9 Million</i>
2/20/2026	<i>Grand Jury Indicts Columbus Man for Defrauding the US Through GI Bill, Student Aid and Disabled Veteran Loan Forgiveness Program</i>

Table A.1. Significant Criminal Investigations with Judicial Actions This Period (Continued)

OTHER INVESTIGATIONS	
WORKERS' COMPENSATION BENEFITS FRAUD, COMPUTER CRIMES, AND GRANT FRAUD	
10/22/2025	<i>Former VA Firefighter Sentenced for Workers' Compensation Benefits Fraud</i>
12/3/2026	<i>Two Virginia Men Arrested for Conspiring to Destroy Government Databases</i>
12/19/2025	<i>Former Veterans Shelter Executive Sentenced to 42 Months for Grant Fraud</i>
1/16/2026	<i>Tennessee Man Pleads in Hacking US Supreme Court, AmeriCorps, and VA Health System</i>
DRUG TRAFFICKING, ROBBERY, BURGLARY, AND THREATS	
1/28/2026	<i>MSP Arrest Perryville Man in Drug Trafficking Operation in Cecil County</i>
2/13/2026	<i>Serial Burglar Gets 80 Months in Prison for Multiple Burglaries in 2025</i>
3/10/2026	<i>St. Louis Man Accused of Robbing Vietnam Veteran at Veterans Administration Hospital</i>
3/23/2026	<i>Self-Proclaimed Terrorist Sentenced to Prison for Threatening Calls to VA Employees</i>
FRAUD RELATED TO COVID-19	
10/3/2025	<i>Pembroke Man Pleads Guilty for Misusing CARES Act Funds to Purchase a Golf Course</i>
10/9/2025	<i>Woman Sentenced for Role in Unemployment Insurance Fraud Scheme</i>
11/3/2025	<i>Cleveland VA Medical Center Employee Sentenced for COVID-19 Fraud Scheme</i>
2/19/2026	<i>Pembroke Man Sentenced for Misusing CARES Act Funds to Purchase the Angus Lea Golf Course</i>
OTHER WORK CLOSED WITH A PUBLIC RELEASE	
3/12/2026	<i>Letter to Congress Regarding NIHCS Investigation</i>

Reports and Other Products Issued This Reporting Period

Table A.2 lists VA OIG reports and memoranda issued during this period and, where applicable, shows the total dollar value of questioned costs (including a separate category for unsupported costs) and the dollar value of recommendations for funds to be put to better use.²⁸

The OIG questions costs when VA actions or inactions—such as spending or failure to fully compensate eligible beneficiaries—are determined to violate a law, regulation, contract, grant, cooperative agreement, or other agreement; lack adequate documentation; or are unnecessary or unreasonable under governing authorities. Unsupported costs are a subset of questioned costs and refer to those lacking sufficient documentation at the time of audit. “Funds put to better use” are amounts that could be used more efficiently if management implements an OIG recommendation.

Some OIG reports cannot be publicly released under federal law; these are marked with an asterisk (*) in table A.2.²⁹ The Inspector General Act also requires disclosure of any reports involving substantiated allegations of misconduct by senior government officials.³⁰ While there are no such investigations to report this period, any future reports meeting this criterion will be marked with a double dagger (‡) in table A.2.

Table A.2. Oversight Reports and Memoranda Issued This Period

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
OFFICE OF AUDITS AND EVALUATIONS				
AUDITS AND REVIEWS				
10/8/2025	<i>Review of Clinical Contact Centers to Assess Leadership and Oversight</i>	25-00228-214	\$17,273,700	—

* Denotes products prohibited from public release pursuant to federal law.

²⁸ 5 U.S.C. §§ 405(b)(5)(A) and (B) (as amended by Pub. L. No. 117-263).

²⁹ Preaward and postaward reports are submitted only to VA. They contain nonpublic, confidential, and proprietary data relating to the contractors’ business and include trade secret information protected from public release by 18 U.S.C. § 1905. The reports are also exempt from mandatory public disclosure under the Freedom of Information Act, 5 U.S.C. § 552. Information on contractor proposals are protected from disclosure by 41 U.S.C. § 4702. To improve transparency, the OIG publishes summaries of these reports. Federal law prohibits OIGs from disclosing “any information from or about any person alleging the reprisal” except as needed to conduct its investigation, which exempts § 4712 investigation reports from public release.

³⁰ 5 U.S.C. § 405(b)(13) (as amended by Pub. L. No. 117-263).

Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
AUDITS AND REVIEWS (CONTINUED)				
12/2/2025	<i>Audit of Funding Fee Refunds for Veterans Using Dual Entitlement on VA Joint Home Loans</i>	25-00824-227	—	\$866,000
12/9/2025	<i>Audit of Homeless Screening Clinical Reminder Process</i>	25-00077-215	—	—
12/16/2025	<i>Independent Audit Report of Pharma Logistics LLC’s Billing Compliance</i>	23-02182-185	—	\$4,138,382 <i>(\$526,520 unsupported costs)</i>
1/13/2026	<i>Supplemental Review of VHA Recruitment, Relocation, and Retention Incentive Service Obligations</i>	25-00631-211	—	\$17,511,510 <i>(\$17,511,510 unsupported costs)</i>
1/27/2026	<i>Audit of VA’s Financial Statements for Fiscal Year 2025</i>	25-01268-16	—	—
2/17/2026	<i>Audit of Integrated Financial and Acquisition Management System Access Controls</i>	25-00529-219	—	—
2/23/2026	<i>Independent Review of VA’s Special Disabilities Capacity Report for Fiscal Year 2023</i>	25-01863-31	—	—
3/6/2026	<i>Audit of Community-Based Outpatient Clinic Contracts</i>	24-00900-230	—	—

* Denotes products prohibited from public release pursuant to federal law.

Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
INFORMATION SECURITY INSPECTIONS				
1/29/2026	<i>Follow-Up Inspection of Information Security at the VA Beckley Healthcare System in West Virginia</i>	24-03708-141	—	—
2/18/2026	<i>Inspection of Information Security at the VA Spokane Healthcare System in Washington</i>	25-00975-234	—	—
MANAGEMENT ADVISORY MEMORANDA				
2/18/2026	<i>Desk Review of the Single Audit Reporting Package for the Year Ended June 30, 2024, for US VETS</i>	25-03511-49	—	—
PRELIMINARY RESULT ADVISORY MEMORANDA				
2/19/2026	<i>VHA Facilities' Collection and Oversight of Specialty Care Call Data</i>	25-03621-68	—	—
POSTAWARD CONTRACT AUDITS*				
10/3/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-00037-01	—	\$4,988
10/6/2025	Independent Audit Report of Compliance Submitted Under a Contract	25-01791-04	—	—

* Denotes products prohibited from public release pursuant to federal law.

Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
POSTAWARD CONTRACT AUDITS (CONTINUED)*				
12/4/2025	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	25-00033-06	–	\$65,543
2/4/2026	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	25-00764-45	–	\$1,526
2/20/2026	Independent Audit Report of Compliance with Public Law Submitted Under a Contract	25-00766-69	–	\$11,149
2/25/2026	Independent Audit Report of Compliance Submitted Under a Contract	25-02938-79	–	\$12,928
3/9/2026	Independent Audit Report of Compliance Submitted Under a Contract	24-02749-88	–	\$658,266
3/16/2026	Independent Audit Report of Compliance Submitted Under a Contract	25-00520-93	–	\$475,470
PREAWARD CONTRACT AUDITS*				
10/17/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03646-03	\$2,008,680	–

* Denotes products prohibited from public release pursuant to federal law.

Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS (CONTINUED)*				
10/24/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03979-02	\$1,435,734	—
10/24/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03605-17	\$3,992,480	—
12/2/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-04041-24	—	—
12/17/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-04185-28	\$409,650	—
12/22/2025	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02756-35	—	—
1/12/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-04314-41	\$689,585	—
1/29/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-04327-249	\$228,273	—
2/4/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03471-54	—	—

* Denotes products prohibited from public release pursuant to federal law.

Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS (CONTINUED)*				
2/9/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03691-63	\$12,850,680	—
2/17/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03555-74	—	—
2/19/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	26-00932-66	\$930,535	—
2/25/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03554-80	—	—
2/25/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03645-81	\$10,768,031	—
2/26/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-02916-46	\$1,280,418	—
3/6/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03607-85	\$14,181,903	—
3/11/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03135-76	—	—

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PREAWARD CONTRACT AUDITS (CONTINUED)*				
3/17/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	26-01232-86	\$399,310	—
3/19/2026	Independent Audit Report of a Proposal Submitted Under a Solicitation Number	25-03556-94	—	—
OFFICE OF HEALTHCARE INSPECTIONS				
CARE IN THE COMMUNITY INSPECTIONS				
3/18/2026	<i>Care in the Community Inspection of Medical Facilities in VISN 17: VA Heart of Texas Healthcare Network</i>	25-00107-75	—	—
HEALTHCARE FACILITY INSPECTIONS				
10/10/2025	<i>Eastern Oklahoma VA Health Care System in Muskogee</i>	25-00194-239	—	—
10/17/2025	<i>VA Louisville Healthcare System in Kentucky</i>	24-03205-235	—	—
10/17/2025	<i>VA Detroit Healthcare System in Michigan</i>	24-00607-241	—	—
11/19/2025	<i>Minneapolis VA Health Care System in Minnesota</i>	24-03416-237	—	—
11/19/2025	<i>Miami VA Healthcare System in Florida</i>	25-00196-05	—	—
11/19/2025	<i>VA Tennessee Valley Healthcare System in Nashville</i>	25-00197-236	—	—

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE FACILITY INSPECTIONS (CONTINUED)				
12/3/2025	<i>VA Altoona Healthcare System in Pennsylvania</i>	25-00206-14	–	–
12/10/2025	<i>VA Sioux Falls Health Care System in South Dakota</i>	24-03420-18	–	–
12/10/2025	<i>South Texas Veterans Health Care System in San Antonio</i>	25-00192-15	–	–
12/10/2025	<i>VA Tampa Healthcare System in Florida</i>	25-00199-19	–	–
12/17/2025	<i>VA Clarksburg Healthcare System in West Virginia</i>	24-03206-21	–	–
12/17/2025	<i>VA Gulf Coast Healthcare System in Biloxi, Mississippi</i>	25-00205-26	–	–
1/28/2026	<i>VA Central Alabama Health Care System in Montgomery</i>	24-03419-34	–	–
2/3/2026	<i>VA Southern Nevada Healthcare System in North Las Vegas</i>	25-00215-32	–	–
2/3/2026	<i>VA Indiana Healthcare System in Indianapolis</i>	25-00207-36	–	–
2/3/2026	<i>VA Battle Creek Healthcare System in Michigan</i>	25-00238-44	–	–
2/12/2026	<i>VA Sierra Nevada Health Care System in Reno</i>	25-00243-56	–	–

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE FACILITY INSPECTIONS (CONTINUED)				
2/12/2026	<i>VA Central California Health Care System in Fresno</i>	25-00214-61	—	—
2/24/2026	<i>VA Eastern Colorado Health Care System in Aurora</i>	25-00200-48	—	—
2/24/2026	<i>VA Beckley Healthcare System in West Virginia</i>	25-00245-60	—	—
3/12/2026	<i>Lovell Federal Healthcare System in North Chicago, Illinois</i>	24-00614-72	—	—
3/12/2026	<i>VA Loma Linda Healthcare System in California</i>	25-00208-64	—	—
3/12/2026	<i>VA Palo Alto Health Care System in California</i>	25-00241-73	—	—
3/20/2026	<i>VA Fayetteville Coastal Healthcare System in North Carolina</i>	25-00195-65	—	—
HEALTHCARE INSPECTIONS				
10/17/2025	<i>Review of Response to Changes in a Patient's Condition and Quality Reviews at the VA Greater Los Angeles Healthcare System in California</i>	24-03531-09	—	—
11/20/2025	<i>Review of Quality of Care for Patients Seeking Acute Mental Health Care at the Lexington VA Healthcare System in Kentucky</i>	25-00349-10	—	—

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
12/2/2025	<i>Review of VISN 21 Clinical Resource Hub Sleep Medicine Physician Privileging</i>	25-00302-243	–	–
12/8/2025	<i>Evaluation of Specimen Readings for Accuracy and Quality Assurance in the Laboratory at the John D. Dingell VA Medical Center in Detroit, Michigan</i>	25-01187-244	–	–
12/11/2025	<i>Review of Allegations Related to Nurse Practitioner Supervision and Controlled Substance Prescribing in Pain Management at the VA Central Texas Healthcare System in Temple</i>	25-02145-25	–	–
1/8/2026	<i>Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois</i>	24-02987-27	–	–
1/15/2026	<i>Review of Leaders’ Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York</i>	25-02192-39	–	–

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
HEALTHCARE INSPECTIONS (CONTINUED)				
1/22/2026	<i>Review of the Inpatient Mental Health Unit Environment of Care, Staffing, and Administrative Processes at the VA Nebraska-Western Iowa Health Care System in Omaha</i>	25-00421-37	—	—
1/27/2026	<i>Review of Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia</i>	24-02347-40	—	—
2/19/2026	<i>Assessment of Cytopathology Processing at the Oklahoma City VA Medical Center in Oklahoma</i>	25-00814-62	—	—
3/5/2026	<i>Review of Availability of On-Call Interventional Radiology Services and a Related Patient Transfer at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana</i>	25-01515-67	—	—

* Denotes products prohibited from public release pursuant to federal law.

Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
MENTAL HEALTH INSPECTIONS				
12/18/2025	<i>Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia</i>	24-03520-20	–	–
12/18/2025	<i>Mental Health Inspection of the VA NY Harbor Healthcare System in New York</i>	25-00729-23	–	–
2/24/2026	<i>Mental Health Inspection of the VA Tampa Healthcare System in Florida</i>	24-03542-57	–	–
3/11/2026	<i>Lexington VA Healthcare System in Kentucky</i>	24-03543-78	–	–
NATIONAL HEALTHCARE REVIEWS				
11/18/2025	<i>Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the VA Boston Healthcare System in Massachusetts, Fiscal Year 2024</i>	25-02447-08	–	–
11/20/2025	<i>Management of Personally Owned Insulin Pumps for Patients at Risk for Suicide in Emergency Departments and Inpatient Units</i>	25-03462-12	–	–

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
NATIONAL HEALTHCARE REVIEWS (CONTINUED)				
12/4/2025	<i>Review of Veterans Health Administration's National Teleradiology Program</i>	25-01255-242	—	—
1/13/2026	<i>National Review of Mental Health Integration and Suicide Risk Identification in Audiology Clinic Settings</i>	24-00560-29	—	—
1/29/2026	<i>Review of Data Security and Oversight Processes of a Veterans Health Administration National Cancer Prevention, Treatment, and Research Program</i>	24-00568-38	—	—
PRELIMINARY RESULT ADVISORY MEMORANDA				
10/14/2025	<i>Concerns Around Acute Ischemic Stroke Practice</i>	25-03401-11	—	—
12/11/2025	<i>Review of Fire System and Life Safety Programs/Processes at the East Orange VA Medical Center in New Jersey</i>	26-00105-22	—	—
12/18/2025	<i>Environmental Suicide Hazards at the VA Boston Healthcare System in Brockton, Massachusetts</i>	25-03934-33	—	—

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Table A.2. Oversight Reports and Memoranda Issued This Period (Continued)

DATE	TITLE	REPORT NUMBER	BETTER USE OF FUNDS	QUESTIONED COSTS
PRELIMINARY RESULT ADVISORY MEMORANDA (CONTINUED)				
1/15/2026	<i>Review of VHA’s Use of Generative Artificial Intelligence</i>	26-00182-42	–	–
VET CENTER INSPECTIONS				
10/14/2025	<i>Inspection of Midwest District 3 Vet Center Operations</i>	24-00392-240	–	–
3/31/2026	<i>Select Vet Centers in North Atlantic District 1 Zone 4</i>	25-00373-95	–	–
3/31/2026	<i>Select Vet Centers in North Atlantic District 1 Zone 3</i>	25-00372-96	–	–
3/31/2026	<i>Select Vet Centers in North Atlantic District 1 Zone 2</i>	25-00371-97	–	–
3/31/2026	<i>Select Vet Centers in North Atlantic District 1 Zone 1</i>	25-00369-98	–	–
Total			\$66,448,979	\$23,745,762 <i>(\$18,038,030 unsupported costs)</i>

* Denotes products prohibited from public release pursuant to federal law.

Note: Dollar figures may not sum due to rounding.

APPENDIX B: RECOMMENDATIONS PENDING RESOLUTION

The Inspector General Act requires federal inspectors general to identify each recommendation made during a prior reporting period for which corrective action has not been completed by the department, including any potential cost savings associated with the recommendation.³¹ Table B.1 identifies recommendations made prior to this reporting period that were open (unimplemented) as of March 31, 2026. In addition, the [OIG website](#) offers real-time data on open recommendations and allows users to filter by status, date range, topic area, responsible action office, and other criteria.

Table B.1. Open Recommendations from Prior Reporting Periods

DATE	TITLE	REPORT NUMBER	OPEN RECOMMENDATIONS	POTENTIAL COST SAVINGS
12/13/2018	<i>Inadequate Governance of the VA Police Program at Medical Facilities</i>	17-01007-01	1	—
2/10/2021	<i>Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi</i>	20-01036-70	2	—
2/25/2021	<i>Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement</i>	19-07053-51	6, 11	—

* Denotes products prohibited from public release pursuant to federal law.

³¹ 5 U.S.C. § 405(b)(2) (as amended by Pub. L. 117-263).

Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
5/25/2021	<i>Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program</i>	20-03178-116	5	—
6/10/2021	<i>Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency</i>	20-00541-133	1-4	—
6/15/2021	<i>Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs</i>	20-01487-142	2	\$129,700,000
7/7/2021	<i>Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program</i>	20-03185-151	2-6	—
8/19/2021	<i>Review of Veterans Health Administration Staffing Models</i>	20-01508-214	1	—
9/9/2021	<i>Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus</i>	20-03465-243	1, 3-4	—

* Denotes products prohibited from public release pursuant to federal law.

Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/23/2021	<i>Better Oversight of Prosthetic Spending Needed to Reduce Unreasonable Prices Paid to Vendors</i>	20-01802-234	2	\$20,000,000
12/8/2021	<i>VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services</i>	20-01099-249	3	\$341,700,000
12/8/2021	<i>VHA Risks Overpaying Community Care Providers for Evaluation and Management Services</i>	21-01807-251	1	\$59,600,000
1/20/2022	<i>Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020</i>	21-01507-61	1-2, 4	—
4/7/2022	<i>Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities</i>	20-00827-126	2	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
4/25/2022	<i>The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule</i>	21-02889-134	1-4	—
5/24/2022	<i>VHA Continues to Face Challenges with Billing Private Insurers for Community Care</i>	21-00846-104	2-3	—
6/22/2022	<i>Mission Accountability Support Tracker Lacked Sufficient Security Controls</i>	21-03080-142	3	—
7/21/2022	<i>Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure</i>	21-02704-135	2-3	—
7/28/2022	<i>VBA Improperly Created Debts When Reducing Veterans' Disability Levels</i>	21-01351-151	2, 4	—
8/3/2022	<i>The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring</i>	21-02401-190	3	—
12/8/2022	<i>VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments</i>	21-03063-04	2, 4-5	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
1/18/2023	<i>Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama</i>	22-01854-13	7	—
1/24/2023	<i>Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California</i>	21-03734-32	4	—
5/25/2023	<i>Vet Center Inspection of North Atlantic District 1 Zone 3 and Selected Vet Centers</i>	21-03233-122	11	—
5/25/2023	<i>Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers</i>	21-03269-123	1-2, 8-9	—
6/7/2023	<i>Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania</i>	22-02960-70	4	—
6/8/2023	<i>Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota</i>	22-02961-71	1	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN-DATIONS	POTENTIAL COST SAVINGS
7/11/2023	<i>Inspection of Information Security at the Northern Arizona VA Healthcare System</i>	22-04104-112	2	—
7/19/2023	<i>Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff</i>	21-03544-111	3	—
9/7/2023	<i>VHA Faces Challenges Implementing the Appeals Modernization Act</i>	22-02064-155	1–14	—
9/21/2023	<i>Information Security Inspection at the VA Beckley Healthcare System in West Virginia</i>	23-00089-144	2, 8–9	—
9/22/2023	<i>Comprehensive Healthcare Inspection Program Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities</i>	23-01177-215	1	—
9/27/2023	<i>VA Should Strengthen Enterprise Cloud Security and Privacy Controls</i>	22-03525-195	3	—
9/27/2023	<i>Inspection of Information Security at the VA El Paso Healthcare System in Texas</i>	23-01179-204	2, 5, 7	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/28/2023	<i>Inspection of Information Security at the VA Dublin Healthcare System in Georgia</i>	23-01138-203	5	—
12/12/2023	<i>Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault</i>	21-01445-30	8	—
12/14/2023	<i>VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds</i>	22-00410-197	1	—
1/17/2024	<i>VA Should Enhance Its Oversight to Improve the Accessibility of Websites and Information Technology Systems for Individuals with Disabilities</i>	22-03909-19	1–3, 5	—
2/8/2024	<i>Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk</i>	21-03255-02	3, 5	—
2/21/2024	<i>Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied</i>	23-00153-41	1	\$3,300,000

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
3/21/2024	<i>Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death</i>	23-00382-100	2	—
4/4/2024	<i>Deficiencies in Attention Deficit Hyperactivity Disorder Diagnostic Assessment, Evaluation of Stimulant Medication Risks, and Policy Guidance</i>	22-03013-129	2, 5	—
4/24/2024	<i>Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care</i>	23-00540-146	3	—
5/30/2024	<i>Follow-Up Information Security Inspection at the VA Financial Services Center in Austin, Texas</i>	23-02186-97	2	—
6/5/2024	<i>Inspection of Information Security at the VA Bedford Healthcare System in Massachusetts</i>	23-02330-127	9	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
6/27/2024	<i>VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits</i>	23-01266-78	1	\$1,008,400,000
7/16/2024	<i>Better Collection of Family Preference Data May Minimize Risk of Burial Scheduling Delays</i>	23-01773-166	1	—
7/17/2024	<i>VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability</i>	23-01772-162	1	\$100,000,000
7/23/2024	<i>Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia</i>	23-00995-211	1–3, 6	—
8/8/2024	<i>Unauthorized Community Care Dental Procedures Risked Improper Payments</i>	23-00749-171	5	\$325,500,000
8/28/2024	<i>Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida</i>	23-03677-237	2	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/3/2024	<i>Follow-Up Financial Efficiency Inspection of the Southeast Louisiana Veterans Health Care System in New Orleans</i>	23-02907-216	5	—
9/12/2024	<i>Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management</i>	23-02123-202	1–2, 4–6	—
9/18/2024	<i>Additional Controls Are Needed to Improve the Reliability of Grant and Per Diem Program Data</i>	23-02610-226	1–3	—
9/23/2024	<i>VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents</i>	22-03591-231	1–2, 4	—
9/25/2024	<i>Alleged Mismanagement of Contracts for Wheelchair-Accessible Transportation Services by the Health Administration Service at the Dallas VA Medical Center in Texas</i>	23-03128-213	2	\$3,739,068
9/25/2024	<i>VHA Needs to Establish Controls for Its Ambulatory Care Budget Estimate</i>	23-01624-243	1–2	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/26/2024	<i>Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama</i>	23-02393-250	2	—
9/30/2024	<i>Inspection of Select Vet Centers in Pacific District 5 Zone 2</i>	24-00388-266	2, 11	—
10/24/2024	<i>Heart Transplant Program Review: Facility Leaders Failed to Ensure a Culture of Safety and the Section Chief Engaged in Unprofessional Conduct at the Richmond VA Medical Center in Virginia</i>	23-03526-07	2-3	—
11/13/2024	<i>Inspection of Information Security at the Health Eligibility Center in Atlanta, Georgia</i>	24-01232-02	1	—
11/14/2024	<i>VBA Did Not Ensure Employees Sent Some Letters Using Its Package Manager Application</i>	23-00547-187	1	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
12/18/2024	<i>Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration’s Suicide Risk Screening and Evaluation Deficiencies</i>	23-02939-13	2–4	–
1/8/2025	<i>Inspection of Pacific District 5 Vet Center Operations</i>	24-00390-41	4–5	–
1/16/2025	<i>Care in the Community Inspection of VA Desert Pacific Healthcare Network (VISN 22) and Selected VA Medical Centers</i>	23-01739-26	5, 9	–
1/22/2025	<i>Care in the Community Inspection of VA Sierra Pacific Network (VISN 21) and Selected VA Medical Centers</i>	24-00566-16	5, 11	–
1/30/2025	<i>Atlanta Call Center Staffing and Operational Challenges Provide Lessons for the New VISN 7 Clinical Contact Center</i>	23-01609-14	4	–

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
2/4/2025	<i>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</i>	24-00234-53	8	—
2/20/2025	<i>Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services</i>	23-00748-28	1, 3-5	\$980,300,000
3/5/2025	<i>Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego</i>	22-03076-65	1-3	—
3/18/2025	<i>Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas</i>	24-00166-35	6	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
3/19/2025	<i>Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight</i>	24-01143-44	1, 3, 5–8	—
3/19/2025	<i>Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022</i>	24-02106-80	1	—
3/26/2025	<i>Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia</i>	24-00603-86	2, 5	—
3/27/2025	<i>The Causes and Conditions That Led to a \$12 Billion Supplemental Funding Request</i>	24-03127-66	1, 3–4	—
3/31/2025	<i>Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities</i>	23-02350-95	1–2, 4	—
4/3/2025	<i>VHA Should Improve Monitoring of Underground Storage Tanks to Minimize Environmental and Health Risks at VA Medical Facilities</i>	24-00295-49	3, 5, 7	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
4/8/2025	<i>Independent Audit Report on a Transportation Company's Billing Practices Under a VA Healthcare System Contract</i>	22-02369-48	1	\$1,811,694
4/10/2025	<i>Healthcare Facility Inspection of the VA Western Colorado Healthcare System in Grand Junction</i>	24-00595-93	4, 7	—
4/17/2025	<i>Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth</i>	24-00990-99	3	—
4/24/2025	<i>Integrated Financial and Acquisition Management System Interface Development Process Needs Improvement</i>	24-00645-84	1, 2	—
5/1/2025	<i>Former Orlando VA Medical Center Executive Violated Ethics Rules</i>	23-02157-106	3	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
5/20/2025	<i>Healthcare Facility Inspection of the VA North Florida/South Georgia Veterans Health System in Gainesville</i>	24-00604-121	4, 7	—
5/21/2025	<i>Deficiencies in Emergency Care for a Female Veteran at Martinsburg VA Medical Center in West Virginia</i>	24-02359-123	1–2, 4	—
5/22/2025	<i>Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia</i>	24-00617-118	3–5	—
5/27/2025	<i>Inspection of Select Vet Centers in Midwest District 3 Zone 2</i>	24-00394-122	8	—
5/28/2025	<i>Better Communication and Oversight Could Improve How the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program Manages Funds</i>	24-00524-104	3–5	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
5/29/2025	<i>VBA's Special Monthly Compensation Calculator in the Veterans Benefits Management System for Rating Did Not Always Produce Accurate Results</i>	24-01083-112	1	—
6/12/2025	<i>Recruitment, Relocation, and Retention Incentives for VHA Positions Need Improved Oversight</i>	23-01695-94	1-6, 8	\$345,532,795
6/12/2025	<i>Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia</i>	24-00606-137	2-4, 6-7	—
6/18/2025	<i>Federal Information Security Modernization Act Audit for Fiscal Year 2024</i>	24-01233-90	1-23	—
6/26/2025	<i>Mental Health Inspection of the VA Salem Healthcare System in Virginia</i>	24-01861-144	2	—
6/26/2025	<i>Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania</i>	24-01862-151	1, 3-4, 8-9	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
7/1/2025	<i>VA Needs to Prioritize Accessibility for Individuals with Disabilities When Procuring Information Technology Systems</i>	24-02142-105	1-4	—
7/9/2025	<i>Healthcare Facility Inspection of the VA Connecticut Healthcare System in West Haven</i>	24-00610-164	1-2	—
7/10/2025	<i>Healthcare Facility Inspection of the VA Boston Healthcare System in Massachusetts</i>	24-00613-162	11	—
7/10/2025	<i>Healthcare Facility Inspection of the Sheridan VA Health Care System in Wyoming</i>	24-00615-163	1-3	—
7/16/2025	<i>Care in the Community Deficiencies and Ineffective VISN Oversight at the VA Maryland Health Care System in Baltimore</i>	24-02031-171	1-3	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMENDATIONS	POTENTIAL COST SAVINGS
7/17/2025	<i>Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington</i>	24-02690-167	4-6	—
7/29/2025	<i>Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan</i>	24-00824-174	8-9, 11-13	—
7/30/2025	<i>Implementation of a Military Sexual Trauma Operations Center Resulted in Minimal Change Despite Planned Intent to Improve Claims-Processing Accuracy</i>	24-01429-145	3	—
7/30/2025	<i>Care in the Community Inspection of Medical Facilities in VISN 4: VA Healthcare</i>	24-00825-176	5, 7-10, 12	—
7/31/2025	<i>Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque</i>	24-02059-177	1-3, 5-14	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
8/6/2025	<i>Healthcare Facility Inspection of the VA Cincinnati Healthcare System in Ohio</i>	24-00605-182	4, 6–7, 9	–
8/7/2025	<i>Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans’ Electronic Health Records</i>	24-02154-154	5, 10	–
8/13/2025	<i>VA Can Strengthen Appeals Processing and Tracking by Improving Caseflow Program Management</i>	24-01457-114	2	–
8/14/2025	<i>Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight</i>	24-01618-198	5	–
8/20/2025	<i>Pharmacy Automated Dispensing Cabinets Need Improved Monitoring for Accountability over High-Risk Medications</i>	24-00765-184	1, 3	–

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
8/20/2025	<i>Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana</i>	25-00400-189	2, 4	—
8/21/2025	<i>Former Acquisition Academy Executive Violated Ethical Standards and VA Policy</i>	23-03768-204	1-2	—
9/4/2025	<i>Improved Oversight of VHA's Nonexpendable Equipment Is Needed</i>	24-01676-153	1-6	\$210,900,000
9/4/2025	<i>Facilities Need to Fully Implement VHA's Strategic Planning and Request Process for Nonexpendable Medical Equipment</i>	24-02295-155	1, 3	—
9/10/2025	<i>Weak Governance Threatens the Viability of a Major Construction Project at the Palo Alto VA Medical Center in California</i>	23-03189-148	1-3	\$1,624,411,962

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/10/2025	<i>The Emergency Department Construction Project at the Audie L. Murphy Memorial Veterans’ Hospital in San Antonio, Texas, Did Not Follow VA and Industry Equipment Design Standards</i>	24-00982-147	1-4	—
9/11/2025	<i>Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes</i>	23-02507-210	1-4	—
9/11/2025	<i>Healthcare Facility Inspection of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington</i>	24-00599-202	2, 8-9	—
9/11/2025	<i>Healthcare Facility Inspection of the VA Alexandria Healthcare System in Pineville, Louisiana</i>	24-03418-205	1	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/23/2025	<i>Deficiencies in Consult Management in the Endocrinology Service at the VA Fayetteville Coastal Healthcare System in North Carolina</i>	24-02634-229	1, 3-4	—
9/24/2025	<i>Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians</i>	24-03319-213	1-3	—
9/25/2025	<i>Loma Linda Healthcare System's Oversight of Community-Based Outpatient Clinic Contracts Needs Strengthening</i>	23-00324-170	1-2, 5-9	—
9/26/2025	<i>VHA Did Not Effectively Oversee the Use of Manual Journal Vouchers</i>	25-00451-200	1-4	—
9/29/2025	<i>Inadequate Oversight Allowed a Senior Benefits Representative to Inaccurately Authorize Thousands of Decisions</i>	24-03608-203	1-2	\$2,200,000
9/30/2025	<i>Better Controls Needed to Accurately Determine Decisions for Veterans' Nonpresumptive Conditions Involving Toxic Exposure Under the PACT Act</i>	23-03357-156	3	—

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Table B.1. Open Recommendations from Prior Reporting Periods (Continued)

DATE	TITLE	REPORT NUMBER	OPEN RECOMMEN- DATIONS	POTENTIAL COST SAVINGS
9/30/2025	<i>The Accuracy of Veteran Readiness and Employment Claims Cannot Be Assessed Because of Insufficient Documentation</i>	23-03328-197	1-2, 4-5	\$309,500,000
9/30/2025	<i>Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens</i>	24-01092-228	5-6	—
Total				\$5,466,595,519

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Track VA’s progress in implementing OIG recommendations on the OIG website.

APPENDIX C: REPORTING REQUIREMENTS AND DEFINITIONS

Reporting Requirements Under the Inspector General Act of 1978, as amended

§ 404. DUTIES AND RESPONSIBILITIES

(a) It shall be the duty and responsibility of each Inspector General, with respect to the establishment within which the Inspector General's Office is established—

(2) to review existing and proposed legislation and regulations relating to programs and operations of such establishment and to make recommendations, including in the semiannual reports required by section 5(a), concerning the impact of such legislation or regulations on the economy and efficiency in the administration of programs and operations administered or financed by such establishment or the prevention and detection of fraud and abuse in such programs and operations;

See [Stakeholder Engagement](#)

§ 405. REPORTS

(b) Each Inspector General shall, not later than April 30 and October 31 of each year, prepare semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to—

(1) a description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of such establishment and associated reports and recommendations for corrective action made by the Office;

See [Findings and Impact](#)

(2) an identification of each recommendation made before the reporting period, for which corrective action has not been completed, including the potential cost savings associated with the recommendation;

See [Appendix B](#)

(3) a summary of significant investigations closed during the reporting period;

See [Findings and Impact](#), [Appendix A](#)

(4) an identification of the total number of convictions during the reporting period resulting from investigations;

See [Performance Metrics](#)

(5) information regarding each audit, inspection, or evaluation report issued during the reporting period, including—

(A) a listing of each audit, inspection, or evaluation;

(B) if applicable, the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs) and the dollar value of recommendations that funds be put to better use, including whether a management decision has been made by the end of the reporting period;

See [Appendix A](#)

(6) information regarding any management decision made during the reporting period with respect to any audit, inspection, or evaluation issued during a previous reporting period;

See [Follow-Up and Resolution](#)

(7) the information described under section 804(b) of the Federal Financial Management Improvement Act of 1996;

See [Audit of VA's Financial Statements for Fiscal Year 2025](#), also listed in **[Appendix A](#)** (*October–March issue only*)

(8)(A) an appendix containing the results of any peer review conducted by another Office of Inspector General during the reporting period; or

(B) if no peer review was conducted within that reporting period, a statement identifying the date of the last peer review conducted by another Office of Inspector General;

See [Other Required Disclosures](#)

(9) a list of any outstanding recommendations from any peer review conducted by another Office of Inspector General that have not been fully implemented, including a statement describing the status of the implementation and why implementation is not complete;

See [Other Required Disclosures](#)

(10) a list of any peer reviews conducted by the Inspector General of another Office of the Inspector General during the reporting period, including a list of any outstanding recommendations made from any previous peer review (including any peer review

conducted before the reporting period) that remain outstanding or have not been fully implemented;

See [Other Required Disclosures](#)

(11) statistical tables showing—

- (A) the total number of investigative reports issued during the reporting period;
- (B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period;
- (C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and
- (D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities;

See [Performance Metrics](#)

(12) a description of the metrics used for developing the data for the statistical tables under paragraph (17)³²;

See [Performance Metrics](#)

(13) a report on each investigation conducted by the Office where allegations of misconduct were substantiated involving a senior Government employee or senior official (as defined by the Office) if the establishment does not have senior Government employees, which shall include—

- (A) the name of the senior Government employee, if already made public by the Office; and
- (B) a detailed description of—
 - (i) the facts and circumstances of the investigation; and
 - (ii) the status and disposition of the matter, including—
 - (I) if the matter was referred to the Department of Justice, the date of the referral; and
 - (II) if the Department of Justice declined the referral, the date of the declination;

See [Findings and Impact](#)

(14)(A) a detailed description of any instance of whistleblower retaliation, including information about the official found to have engaged in retaliation; and

³² As so in original. Probably should be “paragraph (11).”

(B) what, if any, consequences the establishment actually imposed to hold the official described in subparagraph (A) accountable;

See [Other Required Disclosures](#)

(15) information related to interference by the establishment, including—

(A) a detailed description of any attempt by the establishment to interfere with the independence of the Office, including—

(i) with budget constraints designed to limit the capabilities of the Office; and

(ii) incidents where the establishment has resisted or objected to oversight activities of the Office or restricted or significantly delayed access to information, including the justification of the establishment for such action; and

(B) a summary of each report made to the head of the establishment under section 6(c)(2) during the reporting period;

See [Other Required Disclosures](#)

(16) detailed descriptions of the particular circumstances of each—

(A) inspection, evaluation, and audit conducted by the Office that is closed and was not disclosed to the public; and

(B) investigation conducted by the Office involving a senior Government employee that is closed and was not disclosed to the public.

See [Findings and Impact](#)

Reporting Requirements Under the Strengthening Oversight for Veterans Act of 2021, as amended

§ 2. TESTIMONIAL SUBPOENA AUTHORITY OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF VETERANS AFFAIRS

(6)(A) Along with each semiannual report submitted by the Inspector General pursuant to section 5(b) of the Inspector General Act of 1978 (5 U.S.C. § 405(b)), the Inspector General shall include a report on the exercise of the authority provided by 38 U.S.C. § 312(d)(1).

(B) Time period. Each report submitted under subparagraph (A) shall include, for the most recently completed six-month period, the following:

(i) The number of testimonial subpoenas issued and the number of individuals interviewed pursuant to such subpoenas.

(ii) The number of proposed testimonial subpoenas with respect to which the Attorney General objected under paragraph (3)(B).

(iii) A discussion of any challenges or concerns that the Inspector General has encountered exercising the authority provided by paragraph (1).

(iv) Such other matters as the Inspector General considers appropriate.

See [Other Required Disclosures](#)

Definitions

As defined in the Inspector General Act:

Questioned cost means a cost that is questioned by the Office because of—

(A) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds;

(B) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or

(C) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable;

Unsupported cost means a cost that is questioned by the Office because the Office found that, at the time of the audit, such cost is not supported by adequate documentation;

Disallowed cost means a questioned cost that management, in a management decision, has sustained or agreed should not be charged to the Government;

Recommendation that funds be put to better use means a recommendation by the Office that funds could be used more efficiently if management of an establishment took actions to implement and complete the recommendation, including—

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

(C) withdrawal of interest subsidy costs on loans or loan guarantees, insurance, or bonds;

(D) costs not incurred by implementing recommended improvements related to the operations of the establishment, a contractor or grantee;

(E) avoidance of unnecessary expenditures noted in preaward reviews of contract or grant agreements; or

(F) any other savings which are specifically identified;

Management decision means the evaluation by the management of an establishment of the findings and recommendations included in an audit report and the issuance of a final decision by management concerning its response to such findings and recommendations, including actions concluded to be necessary;

Final action means—

(A) the completion of all actions that the management of an establishment has concluded, in its management decision, are necessary with respect to the findings and recommendations included in an audit report; and

(B) in the event that the management of an establishment concludes no action is necessary, final action occurs when a management decision has been made; and

Senior government employee means—

(A) an officer or employee in the executive branch (including a special Government employee as defined in section 202 of title 18, United States Code) who occupies a position classified at or above GS–15 of the General Schedule or, in the case of positions not under the General Schedule, for which the rate of basic pay is equal to or greater than 120 percent of the minimum rate of basic pay payable for GS–15 of the General Schedule; and

(B) any commissioned officer in the Armed Forces in pay grades 0–6 and above.

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The cover features a wreath crafted from donated military uniforms that won first place for artwork in the 2024 National Veterans Creative Arts Competition, held across 116 VA facilities. Photo courtesy of the artist, Nicole Zettlemoyer.

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