INSPECTOR GENERAL'S FRAUD WATCH

JUNE 2026

The VA OIG fights fraud through close collaboration with VA personnel, federal law enforcement partners, the Department of Justice, and multiple fraud task forces, including the Fraud Task Force established by the President's March 2026 Executive Order. VA OIG staff investigate and deter fraudulent and criminal conduct and disrupt complex fraud schemes that impact veterans' healthcare, education, and benefits.

Recent enforcement actions and audit reports summarized below highlight this impact. You can find more information on the VA OIG's oversight work, along with full investigative updates and reports, by visiting the VA OIG website.

2026 National Health Care Fraud Takedown

Inspector General Mason participated in the National Health Care Fraud Takedown press conference in Washington, DC. As part of the takedown, the VA OIG conducted thirteen investigations, resulting in charges against eighteen individual defendants and one corporation for fraud schemes involving kickbacks and billing for services and equipment that were not provided or medically necessary. These schemes resulted in approximately $21.4 million in losses to VA.

Fraud Referrals

In June 2026, the OIG made six fraud-related referrals to the Department. Of those, three involved benefits fraud, one involved theft of government funds, and two involved healthcare fraud.

Investigations – Recent Activity and Ongoing Cases

Healthcare Fraud

Healthcare fraud by VA-paid healthcare providers and vendors in the community is the intentional misrepresentation of information to gain payment, inconsistent with the type, scope, or nature of the treatment, service, or product provided.

- A multiagency investigation resulted in charges alleging that the owner of a local transportation company and others participated in a healthcare fraud scheme in which telemarketers solicited durable medical equipment and cancer genetic testing to prospective patients. Telemedicine doctors, with whom the patients did not have an existing relationship, wrote the resulting prescription orders. Many of the companies identified in the scheme billed CHAMPVA. In total, the defendant and others caused losses to Medicare and other healthcare benefit programs of approximately $13.9 million. The total loss to VA is approximately $330,000. To date, investigative efforts have led to 24 arrests and 22 convictions. The defendant was sentenced in the District of New Jersey to 36 months' supervised release and ordered to forfeit approximately $965,198 for his role in this scheme. This investigation was conducted by VA OIG, FBI, Department of Health and Human Services (HHS) OIG, and Defense Criminal Investigative Service (DCIS).

- Another multiagency investigation resulted in charges alleging that from January 2007 to October 2021, a former physical therapy assistant and other practice staff conspired to commit fraud through various means such as using unlicensed technicians to provide physical therapy treatment that was billed as if performed by a licensed physical therapist or a physical therapy assistant. It is further alleged the defendant regularly billed for treatment time greater than the actual treatment time spent with patients. From 2013 to 2021, the Erie VAMC referred approximately 442 veterans to this practice for physical therapy through VA's Office of Community Care. The total loss to the government is estimated to be over $20.3 million. Of this amount, the total loss to VA is approximately $500,000. The defendant was sentenced in the Western District of Pennsylvania to 12 months' supervised release and ordered to pay restitution of approximately $85,000 after previously pleading guilty to conspiracy to commit wire fraud and conspiracy to commit healthcare fraud. The defendant is the sixteenth of 19 defendants who either pleaded guilty or were found guilty at trial. The remaining defendants are scheduled to be sentenced through August 2026. This investigation was conducted by VA OIG,

Pennsylvania Office of Attorney General, Office of Personnel Management OIG, DCIS, HHS OIG, and FBI.

- An investigation by several agencies resulted in charges alleging that a defendant purchased existing durable medical equipment (DME) companies without notifying Medicare of the change in ownership. The defendant then fraudulently submitted healthcare claims to federal healthcare programs, including Medicare and its associated cost sharing plans (i.e., CHAMPVA) for DME equipment and supplies, specifically glucose monitoring systems, that were never actually dispensed. The defendant and her coconspirator billed over $40.5 million to the federal government and were paid over $11.6 million. Of these amounts, VA was billed approximately $532,000 and paid almost $60,000. The defendant pleaded guilty in the Middle District of Florida to conspiracy to commit money laundering. This investigation was conducted by VA OIG, Department of Defense (DOD) OIG, Office of the Attorney General of Texas Medicaid Fraud Control Unit, HHS OIG, and FBI.

- A VA OIG and FBI investigation resulted in charges alleging that the owner of a home health company submitted false and fictitious claims for payment to VA's third-party administrator for home health services that were not actually provided. It is further alleged that the defendant and his company submitted false claims for a greater number of care hours than those actually provided to infirm veterans. The loss to VA is almost $372,000. The home health company and the owner were indicted in the Northern District of Iowa on charges of healthcare fraud.

- Another VA OIG and FBI investigation revealed that the owner of a former massage therapy practice submitted fraudulent claims to CHAMPVA for sessions for the same patients several times per week, including weekends, when the patients only received massage therapy once per week. When interviewed the defendant acknowledged overbilling VA. On June 17, the defendant pleaded guilty in the Southern District of West Virginia to theft of government money. The loss to VA is approximately $173,000.

- A VA OIG investigation resolved allegations that a sleep laboratory submitted claims to VA and Medicaid for sleep studies and polysomnogram reports that were prepared and signed by unqualified, non-physician staff. The laboratory entered into a civil settlement in the Southern District of West Virginia under which it agreed to pay $120,000 to resolve these allegations. Of this amount, VA will receive almost $39,000.

- Another investigation by the VA OIG resolved allegations that a defendant used two companies that he owned to submit fraudulent claims to the HHS, VA, and private insurers for sleep tests that were allegedly conducted in the office when they were actually conducted either at home or not at all. The total loss to the insurers is over $2.1 million. The loss to VA is still being calculated. The defendant was charged in the District of Oregon with conspiracy to commit healthcare fraud.

- A multi-agency investigation resulted in charges alleging that several members of the same transnational criminal organization submitted billions in fraudulent claims to America's health insurance programs, including CHAMPVA and Medicare, for durable medical equipment that was never prescribed nor issued to beneficiaries. The transnational criminal organization's illicit activities resulted in payments of about $900 million from Medicare supplemental insurers, of which approximately $1.8 million was paid through CHAMPVA.

- A company owner was indicted in the Northern District of Texas for his role in connection with a scheme to defraud government insurance programs by fraudulently billing for transcranial magnetic stimulation treatments. The treatments were not provided, not provided as represented, and medically unnecessary. As a result, the defendant billed government insurance programs approximately $26 million, of which approximately $17 million was paid. VA was billed approximately $466,000 and paid approximately $89,000 in connection with this alleged scheme. A VA OIG, FBI, DCIS, and Texas Attorney General investigation resulted in the charges

- Charges of conspiracy to commit money laundering were unsealed against two individuals in the District of New Hampshire. A VA OIG, FBI, and HHS OIG investigation resulted in charges alleging the defendants conspired in a nationwide healthcare fraud scheme in which $3 billion in claims were submitted for durable medical equipment that was not medically necessary or provided as represented. As a result of those claims, Medicare and Medicare Supplemental Insurers paid approximately $12.5 million to the suspect company. This money was then laundered using cashier's checks, deposits, and bank transfers to foreign accounts in China. The approximate $10 million in claims submitted to VA came from approximately 3,900 claims, each of which represents an instance where the scheme used a CHAMPVA recipient and a

provider's information to submit fictitious claims for a urinary catheter that was not prescribed nor delivered to the beneficiary.

- The owner of a physical therapy clinic pleaded guilty in the Southern District of Texas to conspiracy to defraud the United States and to pay and receive healthcare kickbacks. A multiagency investigation resulted in charges alleging that from 2017 until 2020, the defendant and a pharmacy owner conspired to defraud the DOL's Office of Workers' Compensation Program (OWCP) by submitting claims for medically unnecessary prescription drugs. The clinic owner allegedly sent prescriptions for high-reimbursing drugs to the pharmacy in exchange for illegal kickbacks. It is further alleged that the pharmacy then filled medically unnecessary prescriptions for injured federal workers who had benefits through OWCP. The total loss to OWCP is over $5.6 million. Of this amount, the loss to VA is approximately $526,000. This investigation was conducted by VA OIG, FBI, DOL OIG, and US Postal Service OIG.

- A current Florida VA employee and a VA community care provider were charged by information in the Middle District of Florida for conspiracy to pay and receive healthcare kickbacks. A VA OIG and FBI investigation revealed that, between 2019 and 2023, the VA employee steered approximately 2,915 veterans to the community care provider's clinics in exchange for approximately $175,172 in kickbacks. VA paid the community care provider approximately $12 million.

- A defendant was indicted in the District of Arizona as part of the 2026 National Health Care Fraud Takedown following over $1.2 billion of false and fraudulent claims submitted to Medicare, CHAMPVA, and other health insurance programs for expensive, medically unnecessary wound grafts derived from illegal kickbacks that were applied to elderly and terminally ill patients. Approximately $1.15 million was attributed to fraudulent claims against CHAMPVA. Two additional defendants were charged by information on this same date with conspiracy to commit healthcare fraud.

- AVA-contracted cardiologist was arrested after being indicted in the Southern District of Florida for healthcare fraud. A VA OIG, Department of Health and Human Services (HHS) OIG, and FBI investigation resulted in charges alleging that a mobile cardiac company fraudulently billed Medicare, Medicaid, private insurance companies, and CHAMPVA for medically unnecessary cardiovascular testing services. The investigation further showed that the defendant evaluated numerous patient heart echocardiograms and

requested diagnostic testing with minimal clinical review of the patient record without an existing patient-doctor relationship. The loss to Medicare and Medicaid is approximately $95 million. The loss to VA is approximately $3.9 million.

- A home health company and its owner were indicted in the Northern District of Iowa on charges of healthcare fraud. A VA OIG and FBI investigation resulted in charges alleging that the defendant and his company submitted false and fictitious claims for payment to VA's third-party administrator for home health services that were not actually provided. It is further alleged that the defendant and his company submitted false claims for a greater number of care hours than those actually provided to infirm veterans. The defendant allegedly used the fraudulently obtained VA funds to pay for sports gambling and other personal expenses. The loss to VA is approximately $371,981.

- A defendant was indicted in the Eastern District of Louisiana for conspiracy to commit healthcare fraud. A multiagency investigation resulted in charges alleging the defendant, who was a sales representative for a diagnostic laboratory, conspired with others to solicit providers to issue orders for excessive and unnecessary respiratory panel tests to be bundled with COVID-19 tests to maximize reimbursement from healthcare benefit programs. The defendant and others allegedly capitalized on COVID-19 testing shortages across the state of Louisiana by offering providers short turnarounds on COVID-19 tests but only if they were ordered in combination with medically unnecessary, and far more expensive, respiratory panel tests. To conceal the fraud, they allegedly instructed providers to often add false diagnostic codes when testing asymptomatic patients and concealed the billing codes from the medical providers to hide the bundling of the expensive and medically unnecessary respiratory panel testing when they knew providers intended to order only a COVID-19 test. The defendant allegedly caused the submission of over $51.7 million in claims to healthcare benefit programs of which the programs reimbursed over $28.4 million. The total estimated billed amount to all healthcare benefits programs was $120 million, of which approximately $60 million was paid. The loss to VA is approximately $200,000. This investigation was conducted by VA OIG, Louisiana Medicare Fraud Control Unit, DCIS, DOL OIG, HHS OIG, and FBI.

Fiduciary Fraud

VA's Fiduciary Program was established to protect veterans and other beneficiaries who are unable to manage their financial affairs due to injury, disease, or age-related issues. Fiduciary fraud involves the theft of benefits by a VA-appointed fiduciary who is supposed to manage VA

beneficiaries' finances in their best interests.

- A VA OIG investigation resulted in charges alleging the son of a veteran's widow who previously served as her VA-appointed fiduciary spent more than $59,000 of her VA benefits for his own personal debts and living expenses. The defendant was indicted in the Eastern District of Kentucky on charges of misappropriation of funds by a fiduciary.

Pension Benefits Fraud

VA pension benefits are available to wartime veterans or their survivors who meet certain age or disability requirements and have limited income and net worth. VA pension beneficiaries who need help with daily activities or are housebound may be eligible for an additional monetary payment. Veterans are targets of wide-ranging "pension poaching" schemes that attempt to steal their assets.

- A VA OIG investigation revealed that the daughter of a deceased VA beneficiary continued to receive VA pension benefits intended for her mother following her death in November 2016. The defendant was sentenced in the District of Delaware to three months' home confinement, 24 months' supervised release, and ordered to pay restitution of $152,927 and a fine of $20,000 after previously pleading guilty to making a materially false statement in connection with theft of government funds.

Service-Disabled Veteran-Owned Small Business (SDVOSB) Fraud

SDVOSB fraud is committed by ineligible individuals or entities seeking to improperly obtain, perform, or profit from VA contracts set aside for small businesses owned and controlled by veterans with military service–connected disabilities. In some fraud schemes, an SDVOSB is set up, or a service-disabled veteran is named as owner, to "pass through" contract performance to another business not owned by a veteran with a disability.

- A multiagency investigation resolved allegations that two government contractors and two of their executives improperly obtained federal set-aside contracts for which they were not eligible by using purported SDVOSBs and other small businesses as pass-through entities. The defendants entered into a settlement agreement in the Northern District of New York under which they agreed to pay $21.3 million to the government to resolve these allegations. Of this amount, VA will receive over $18 million. This investigation was conducted by VA OIG, DCIS, Department of the Army Criminal Investigation Division, General Services Administration OIG, SBA OIG, SBA Office of General Counsel, and US Postal Inspection Service.

- A VA OIG and SBA OIG investigation resolved allegations that a government contractor was awarded seven SDVOSB set-aside contracts to which they were not entitled because the management and daily business operations were not controlled by a service-disabled veteran. A subcontractor also allegedly violated the Contract Disputes Act by causing breaches of the seven contracts due to their representations this contractor met the requirements of a service-disabled veteran-owned small business. The defendants entered into a settlement agreement in the Middle District of Florida under which they agreed to pay $3.6 million to the government to resolve these allegations.

- A defendant pleaded guilty in the Middle District of Pennsylvania to an indictment charging conspiracy to commit major fraud against the United States. A VA OIG, DCIS, SBA OIG, and Army Criminal Investigation Division investigation resulted in charges alleging that the defendant, plus three coconspirators, colluded to fraudulently obtain construction contracts at a DOD facility that were reserved for companies in the SBA's 8(a) Business Development Program. With the assistance of a recently convicted former DOD employee, the defendant's 8(a) company allegedly obtained contracts on which their employees did little or no work. It is further alleged that the defendant's three coconspirators also collaborated to obtain a service-disabled veteran-owned small business set-aside contract valued at approximately $5.3 million at the Salem (Virginia) VAMC, by allegedly moving an electrical subcontractor's employees onto the SDVOSB's payroll to make it appear as if the company was complying with a contract requirement to perform at least 15 percent of the labor with their own employees.

Compensation Benefits Fraud

Compensation benefits fraud involves individuals' submission of fraudulent claims for payment of VA disability benefits.

- A defendant contracted by VA to be a caregiver pleaded guilty in the Western District of Virginia to forgery of government checks. A VA OIG and Franklin County Sherrif's Office investigation resulted in charges alleging that between August 2023 and April 2024, two defendants deceived an elderly disabled veteran into moving into their home under the pretense that they were going to provide care. The codefendant previously met the veteran while employed as a personal care attendant for a VA-contracted home health service company. It is alleged that the defendants failed to provide any care for the veteran, which resulted in him being hospitalized for four months in the intensive care unit at a non-VA medical facility. While the veteran was hospitalized, the defendants allegedly gained access to the veteran's bank account, stole

over $70,000, and attempted to steal an additional $100,000. The veteran's monthly VA compensation benefits were the primary source of funds in the bank account. The other codefendant is pending trial.

- A VA OIG investigation resulted in charges alleging that the widow of a veteran provided false information to VA in order to continue receipt of VA Dependency and Indemnity Compensation (DIC) benefits. The defendant allegedly remarried in 1988, which would have ended her eligibility for DIC benefits. It is further alleged that the defendant later continued to submit forms to VA in which she claimed that she had not remarried. The loss to VA is over $466,000. The defendant was indicted in the District of Colorado on charges of mail fraud.

- A VA OIG, Department of Education OIG, and Federal Bureau of Investigation (FBI) investigation revealed that a veteran submitted fraudulent documents to VA to support her claims for VA monthly compensation benefits. The defendant then submitted an application to discharge her federal student loan debt due to a finding of total and permanent disability by VA, which was obtained in part through the fraudulent documents that were submitted to VA. The defendant was sentenced in the Northern District of West Virginia to 12 months' and one day of imprisonment, 36 months' supervised release, and ordered to pay restitution of approximately $355,000 after previously pleading guilty to theft of government money. Of this amount, VA will receive more than $112,000.

COVID-19 Program Fraud

COVID-19 fraud involves the submission of fraudulent applications for payments under the Small Business Administration's (SBA) small business pandemic relief programs including the Payroll Protection Program (PPP) and Economic Impact Disaster Loan Program. These programs were created through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was signed into law in March 2020 in response to the economic fallout from the COVID-19 pandemic.

- A civil judgment was ordered in the Eastern District of Louisiana through which a defendant was to pay $23,332 to the SBA. A VA OIG and Department of Labor (DOL) OIG investigation revealed the defendant obtained a fraudulent SBA-backed PPP loan through the main defendant in this investigation. The total loss to the government is over $1 million.

- A former Bay Pines, Florida, VA medical center (VAMC) employee was sentenced in the Middle District of Florida to 36 months' supervised release and ordered to pay restitution of $40,090 to the SBA and $15,096 to the US Department of Agriculture (USDA). A VA OIG proactive investigation revealed that while employed by VA, the defendant fraudulently obtained two SBA-backed PPP loans totaling $40,090 for a business that was never in operation. The investigation also revealed that the defendant filed materially false and fraudulent applications to qualify for the USDA Supplemental Nutrition Assistance Program by failing to report his true income and that of his VA-employed spouse.

- A former Columbia, Missouri, VA employee pleaded guilty in the Western District of Missouri to charges of wire fraud. A VA OIG proactive investigation resulted in charges alleging that while employed by VA, the defendant obtained fraudulent PPP loans totaling approximately $20,000 for businesses that never had any earnings nor were in operation as claimed by the defendant.

Current number of ongoing investigations: 1,010

Audits – Recently Issued Reports and Ongoing Projects

Audit of VISN 8 Supply Chain Management (Published June 18, 2026)

The VA OIG conducted an audit of supply chain management at VA medical facilities in Miami, Orlando, and Gainesville, Florida. The review assessed whether facility and network leaders effectively oversaw supply chain activities and followed VHA policies. The audit focused on four areas that had recurring weaknesses identified in prior audits: expendable supplies, nonexpendable equipment, supply chain leadership, and warehouse and distribution controls.

Overall, all three facilities did not consistently meet requirements for managing expendable supplies and nonexpendable equipment. These shortcomings were tied to gaps in oversight and monitoring. As a result, facilities risked using expired products as well as losing supplies or equipment.

For expendable supplies, the audit identified $3.1 million in funds that could be put to better use due to inaccurate inventories. Facility staff did not always record supply use in real time, and some storage areas at the Miami and Gainesville facilities were not properly secured. Inaccurate supply records increase the risk of expired items, unnecessary purchases, and delays in patient care when supplies cannot be located.

For nonexpendable equipment, the team estimated that 48 percent of items were not in the locations recorded in VA systems. An estimated 1,100 items—worth about $12.7 million—were missing. Missing or incorrectly tracked equipment can delay equipment maintenance and patient care.

The facilities also did not consistently tag, record, or track new equipment as required. Reports needed to investigate missing equipment were not routinely completed. Although the network chief logistics officer conducted required oversight reviews, the network does not have direct authority to enforce corrective actions at facilities or ensure sustained improvements.

The OIG made seven recommendations to improve supply chain management across the network; VA concurred with six recommendations and concurred in principle with one.

Audit of VISN 22 Supply Chain Management (Published June 18, 2026)

The VA OIG audited supply chain management at medical facilities in West Los Angeles and San Diego, California, and Phoenix, Arizona—all in Veterans Integrated Service Network (VISN) 22. The OIG team focused on expendable supplies, nonexpendable equipment, supply chain leadership, and storage practices—areas with recurring weaknesses in past audits. The

audit covered expendable supply operations in the third quarter of fiscal year (FY) 2025 and equipment purchased from October 2019 through May 2025.

The OIG found that all three facilities struggled to meet VHA requirements for managing expendable and nonexpendable inventory. Two facilities stored supplies insecurely, increasing risk of theft, loss, and misuse. Overall, inadequate inventory controls put VHA at risk for higher costs and potential fraud, waste, and abuse.

The team estimated that at least 15 percent of items in the expendable inventory, valued at about $1.4 million, reflected fewer actual on-hand quantities than reported across the three VISN 22 facilities. At least 10 percent of items, valued at about $369,000, had more on-hand quantities than reported in the system. About half of expendable supplies were above VHA's required normal stock levels, and 4 percent were below reorder points. Inventory issues were partly attributed to supply chiefs not consistently enforcing monitoring and reconciliation procedures.

For nonexpendable equipment, about 41 percent of items were in different places than recorded, and at least 5 percent—with a value of at least $8.7 million—were missing. Facilities often did not update equipment locations or complete required reports of survey, weakening accountability.

Finally, VISN quality control reviews for FYs 2024 and 2025 showed repeat findings because corrective actions were not implemented or sustained. Despite VISN engagement, recurring deficiencies indicate the need for stronger internal processes and oversight.

VHA concurred with the OIG's seven recommendations to improve VISN 22 supply chain management.

Review of Physical Security of Information Technology Equipment at the Columbia, South Carolina, VA Regional Office (Published June 23, 2026)

The VA OIG assessed a hotline complaint alleging that hundreds of IT devices at the VBA regional office in Columbia, South Carolina, were stored in unsecured areas. Storing IT equipment in a location that is not secure is contrary to VA policy.

The OIG substantiated the allegation. Additionally, the Columbia Office of Information and Technology (OIT) did not effectively manage IT equipment in storage, resulting in unused equipment that was nearing or beyond the end of its useful life expectancy. Specifically, Columbia OIT staff should have distributed 241 unused IT devices, worth $178,223, before new equipment was purchased. Also, another 82 devices in storage, worth $127,384, had not been used and were past their life expectancy.

The team found that the OIT manager did not use the most complete IT inventory data when making decisions about using equipment. This occurred because the OIT manager did not integrate federal and VA requirements for physical security and IT equipment management into local inventory procedures. As a result, Columbia OIT staff did not implement sufficient physical security controls to protect IT devices in a temporary staging area. For the OIG, these findings led to concerns about waste and abuse of taxpayer dollars as well as potential tampering, loss, and theft of equipment.

The OIG made two recommendations to further improve the effectiveness of IT storage and equipment management in the Columbia VA Health Care System. The healthcare system's acting executive director concurred with both recommendations. The OIG will close the recommendations when officials provide sufficient evidence that they have addressed the risks identified in the report.

Current number of ongoing audits and reviews: 51

Fraud Awareness Training

DATE	TOPIC AND LOCATION
6/2/2026	Fraud Awareness Brief – all Compliance Officers in VISN 19
6/2/2026	Fraud Awareness Brief – West LA VAMC's Executive Leadership Team
6/4/2026	Fraud Awareness Brief – Iowa Medicaid Fraud Unit, Iowa Department of Inspection and Appeals, and the Iowa Economic Fraud Unit
6/9/2026	Fraud Awareness Brief – Phoenix VA Regional Office
6/10/2026	Fraud Awareness Brief – West LA VAMC leadership
6/15/2026	Fraud Awareness Brief – VISN 23 VA Compliance Officer Team
6/15/2026	Fraud Awareness Brief – Bronx VAMC
6/22/2026	Fraud Awareness Brief – Hines VAMC Executive Leadership
6/23/2026	Fraud Awareness Brief – Hines VAMC Employees
6/25/2026	Fraud Awareness Brief – Northern California Health Care System