

SEMIANNUAL REPORT to Congress

Issue 96 | April 1–September 30, 2026

US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

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

MISSION VISION VALUES

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

A MESSAGE FROM THE INSPECTOR GENERAL



I am honored to provide this semiannual report to Congress on behalf of the Department of Veterans Affairs (VA) Office of Inspector General (OIG), reflecting our work during the reporting period of April 1 through September 30, 2026. As we approach Veterans Day and continue to observe America's 250th anniversary, the OIG remains firmly devoted to the mission established under the Inspector General Act of 1978—independent oversight that combats fraud, waste, and abuse and ensures veterans receive the care, benefits, and services earned through their service to the Nation.

Since assuming leadership in August 2025, I have emphasized oversight that is fact-based and uncompromising in protecting veterans and the integrity of the programs serving them. Independence and accountability are not aspirations at the OIG; they are the standard we hold ourselves and VA to every day.

This period, we advanced the fight against fraud and other crimes, securing 143 arrests, 86 convictions, and more than $612 million in monetary benefits from investigations. These results reflect coordinated work across the OIG to stop schemes involving health care, benefits, education, procurement, mortgage assistance, and fiduciary misuse of vulnerable veterans' funds. Our investigative success is strengthened by the technical expertise of our auditors, inspectors, and analysts, who identify weaknesses and risks that create openings for criminal activity or improper payments. The hotline, which received 22,021 contacts this period and 43,386 across the full fiscal year, remains a critical source of tips that drive investigative and oversight activity.

We work closely with partners across the federal government and law enforcement—including the Department of Justice, its US Attorneys' Offices, and other interagency fraud-fighting efforts—to investigate complex schemes and support high-impact prosecutions. These relationships reinforce accountability across agencies and reflect the seriousness of the oversight mission shared across the IG and federal law enforcement communities. As I meet with VA OIG staff and other government leaders,

I continue to emphasize the importance of strong, independent oversight nationwide to ensure federal programs function as intended and serve the American people with integrity.

Fraud is far from the only front where OIG staff are making an impact. This report highlights the OIG's work across the VA enterprise that improved timely and coordinated care; strengthened safeguards for all veterans, including at-risk populations; enhanced clinical safety and infrastructure; reinforced the accuracy and consistency of benefits delivery; advanced VA's information security posture; and increased the reliability of programs that steward taxpayer resources. Over these six months, we published 152 reports and other products with 392 recommendations, and our follow-up work confirmed VA's implementation of 391 recommendations. The OIG's monetary impact totaled nearly $4.8 billion, resulting in a return on investment of approximately $38 for every dollar spent on oversight. Across the full fiscal year, our oversight contributed to 270 arrests, 186 convictions, 254 reports and other products, 725 recommendations issued and 872 closed, and more than $7 billion in monetary impact, a return on investment of approximately $28 for every dollar spent.

The OIG is honored to work alongside dedicated VA professionals, Congress, veterans service organizations, and countless other partners to confront these challenges and improve the lives of the millions of veterans and families who depend on VA.



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, including participating in memorial cleanup efforts in Washington, DC. These photos show staff members cleaning the Vietnam Veterans Memorial.









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:

- Benjamin Ahmadi
- Mark Bartuska, Jr.
- Felix Beltran
- Amber Clark
- Craig Cruz
- Silas Darden
- Conner Davis
- Andrew Eichner
- Cesar Garcia
- Steven Hodge, Jr.
- Jacob Karn
- Kinh-Luan Nguyen
- Abraham Raymond
- Lachey Ross
- Tasha Felton Williams

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 managed a $441 billion budget for fiscal year (FY) 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) provides independent oversight of VA's programs and operations to promote accountability, integrity, and improved outcomes for the veterans and families VA serves. Established under the Inspector General Act of 1978, as amended, and further directed by the Veterans Benefits and Services Act of 1988, the OIG is authorized to

conduct audits, investigations, inspections, and evaluations to advance the efficiency, effectiveness, and integrity of VA operations.[1]

STATUTORY AUTHORITY AND RESPONSIBILITIES

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

The objectives guiding OIG oversight—outlined in the Inspector General Act—include:

- Helping to ensure veterans receive prompt access to exemplary, patient-centered care by qualified providers in VA facilities and in the community.
- Making actionable recommendations to facilitate the swift delivery of benefits and services to eligible veterans, their families, and caregivers.

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

- Identifying procedures and strategies for making the most responsible use of VA's appropriated funds and assets, including reducing fraud, waste, and misuse of resources.
- Addressing accountability in governance and leadership, including noncompliance with laws and other requirements and lack of accountability.
- Encouraging innovation and recommending enhancements to VA's infrastructure and systems.

STAFFING, FUNDING, AND LOCATIONS

The VA OIG employs more than 900 staff across four specialized directorates: Investigations, Audits and Evaluations, Healthcare Inspections, and Management and Administration (including the OIG hotline). Additional offices focus on congressional relations, legal counsel, data and analytics, executive support, and public affairs.

The OIG receives a dedicated appropriation through the Military Construction, Veterans Affairs, and Related Agencies funding bill. For FY 2026, Congress provided $296 million to support OIG operations.

Along with its headquarters in Washington, DC, the OIG maintains field offices nationwide—many strategically located near or within VA facilities—to enhance accessibility, responsiveness, and local insight. 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**.



VA OIG Staffing and Funding Levels from FY 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 and risk.
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, fiduciary, mortgage, and benefits fraud; contracting schemes; cybercrime; bribery; and violent offenses. Using analytics and covert strategies, the office protects veterans and VA resources while deterring fraud and crime and promoting accountability through prosecutions.
THE OFFICE OF AUDITS AND EVALUATIONS	This office conducts audits and reviews to strengthen VA program integrity and compliance, and to identify vulnerabilities to fraud, waste, and abuse from weak controls or oversight. Staff examine such areas as healthcare delivery, benefits administration, financial management, acquisitions, and information technology security. They also review contracts before and after award to ensure fair pricing and recover overcharges.
THE OFFICE OF HEALTHCARE INSPECTIONS	This office evaluates the quality and timeliness of VA medical care through targeted inspections and proactive cyclical reviews, identifying weaknesses in clinical oversight and accountability that can enable fraud, waste, abuse, or patient harm. 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 delivers mission-essential business operations that drive the overall effectiveness and efficiency of the organization, including operations, human resources, budgeting and finance, information technology and security, space and facilities management, and training. It also oversees the OIG hotline, which screens allegations of wrongdoing and prioritizes cases that pose the greatest risk to veterans and the 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. To provide this level of accurate, timely, and actionable information, the OIG must actively engage a wide network of stakeholders—VA leaders, Congress, veteran service organizations (VSOs), other federal agencies, and law enforcement partners—to gather insights, verify facts, understand emerging risks, and coordinate on issues that cross organizational lines. These relationships ensure the OIG has the comprehensive, current perspective necessary to support 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;
- consulting regularly with VSOs and other groups for their perspectives;
- providing testimony before Congress and routinely briefing committee members and staff;
- working with law enforcement partners to investigate and report criminal and civil violations to the Department of Justice to drive deterrence and for potential prosecution and litigation;
- coordinating with other inspectors general and oversight entities;
- operating a hotline that triages allegations with internal and external subject-matter experts; and
- delivering accessible, credible, clear reports to the public and media.

Inspector General and Deputy Engagements

The inspector general (IG) and deputy inspector general (DIG) 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:

- **VA leaders.** IG Mason regularly participated in weekly VA senior leader meetings, addressing OIG fraud-related work in health care, benefits, and trade while providing updates on major oversight issues. Additionally, she met several times individually with the Under Secretary for Health, the Acting Under Secretary for Health, the Acting Under Secretary for Benefits, and VA's Chief Financial Officer to review recent OIG reports and discuss ongoing VA transformation efforts.

  IG Mason and Counselor to the IG Chris Wilber met monthly with the Acting Assistant Secretary for the Office of Accountability and Whistleblower Protection to discuss related activities and other matters of mutual interest.

  IG Mason also conducted extensive field engagement with VA facilities, including visits to VA medical centers in Dallas and Houston, Texas; Salisbury, Fayetteville, and Durham, North Carolina; Atlanta, Georgia; Orlando and West Palm Beach, Florida; Seattle, Washington; Los Angeles, Sacramento, San Diego, and San Francisco, California; Columbus, Ohio; Kansas City, Missouri; and Nashville, Tennessee. At each location, she met with executive leadership teams to discuss local challenges, recent oversight findings, and emerging operational priorities. In Nashville and Houston, she met with VBA regional office leadership. While in North Carolina, she also met with the Salisbury National Cemetery director.

- **Congress.** IG Mason briefed staff from the House and Senate Veterans' Affairs Committees (HVAC and SVAC) on OIG reports addressing VBA recurring benefits for beneficiaries aged 100 or older and automated decisions in service-connected death claims. She also participated in staff-level discussions on Payment Integrity



Information Act compliance.

She and OIG healthcare inspections personnel also briefed HVAC and SVAC committee staff on the OIG's report covering community care consult management at the VA Fayetteville Coastal Healthcare Systems in North Carolina. The team also briefed staff for Senator Thom Tillis and Representative David Rouzer, highlighting the OIG's oversight of VHA's coordination and scheduling of community care for patients with serious health conditions.

IG Mason and OIG personnel discussed the OIG's FY 2027 President's Budget with both HVAC and SVAC staff, covering priorities such as community care quality, homelessness programs, and IT modernization.

Finally, IG Mason and DIG David Case joined HVAC and SVAC staff calls focused on the OIG's fraud prevention efforts and related legislative topics.

- **Other Federal Agencies.** IG Mason continued close engagement with federal oversight partners. She participated in the Department of Justice's National Health Care Fraud Takedown press conference and met multiple times with Colin McDonald, Assistant Attorney General for the National Fraud Enforcement Division, to discuss emerging national fraud prevention initiatives. She also had a briefing with the Department of the Treasury regarding **fraud.gov** as part of this work.

  During her travels, IG Mason met with several US Attorneys' Offices to address local fraud matters relevant to OIG oversight, including Adam McMichael, West Palm Beach Managing Assistant US Attorney; Andrew Boutros, US Attorney for the Northern District of Illinois; Dan Bishop, US Attorney for the Middle District of North Carolina; R. Matthew Price, US Attorney for the Western District of Missouri, and staff from the Western District of Washington and Northern District of Georgia.

  She met with Office of Management and Budget Director Russell Vought regarding OIG budget priorities and separately engaged Government Accountability Office leadership to support coordination on upcoming reviews of OIG operations.

  In addition, IG Mason met with the Domestic Policy Council, which coordinates White House domestic policymaking and ensures federal programs align with presidential priorities. She also met independently with the White House Fraud Task Force to discuss protecting veterans' benefits and services through ongoing OIG fraud prevention efforts, including surge response coordination.

Finally, IG Mason and DIG Case participated in 2026 Eagle Horizon, an annual exercise for federal executive branch agencies to test continuity of operations plans and demonstrate capabilities for ensuring preservation of the government during an emergency.

- **VSOs and Nonprofit Organizations.** IG Mason met with major VSOs to discuss oversight concerns and shared priorities. These engagements included meetings with the American Legion on veterans' employment, national security, and government affairs; discussions with Disabled American Veterans and Paralyzed Veterans of America on issues affecting disabled veterans; and outreach to Veterans of Foreign Wars focused on healthcare, benefits, and broader oversight challenges. These meetings strengthened relationships between OIG and key veteran advocacy groups.

  In addition to VSOs, IG Mason and DIG Case met with representatives from Warrior Canine Connection to discuss PAWS for Veterans Therapy Act compliance.

- **Military/Inter-IG Community.** IG Mason participated in the 2026 Army IG Worldwide Conference in Shepherdstown, West Virginia, where she addressed transformation, technology, and fraud prevention initiatives underway at VA OIG and across the civilian oversight community. She met individually with Lieutenant Generals Gregory Brady (Army IG) and David Lyons (Air Force IG), Vice Admiral Michael Baze (Navy IG), and Carl Adams (Acting Marine Corps IG) to discuss evolving oversight expectations and opportunities for deeper collaboration. Additionally, she and DIG Case met with Department of War IG Platte Moring to discuss coordination and shared oversight objectives.

  In April, IG Mason assumed the role of Chairperson of the Council of the Inspectors General on Integrity and Efficiency (CIGIE) following her unopposed election in March. She and other IGs have expanded collaboration on fraud prevention and investigation. IG Mason also attended the IG Community Forum on Combating Fraud, where she highlighted how VA OIG works to deter and prevent fraud and collaborates across OIGs through joint initiatives and task forces aligned with the President's commitment to stop fraud and save taxpayer dollars.

- **Public Speaking and Ceremonies.** IG Mason delivered remarks at the Memorial Day ceremony at Salisbury National Cemetery (North Carolina). She addressed the National Organization of Veterans' Advocates spring conference (San Diego, California), spoke at the National Coalition for Homeless Veterans annual conference (Washington, DC), and presented at the National Association of State Directors of Veterans Affairs annual training conference (Savannah, Georgia).

DIG Case participated in a FedInsider/George Washington University panel on legal AI in federal agencies and attended the Spring 2026 VBA Senior Leaders Training meeting in Baltimore, Maryland, where he presented on reporting issues, possible fraud referral pathways, and ways to strengthen integrity across the enterprise.

Additional Engagements by OIG Staff

OIG staff continued to interact extensively with Congress, oversight partners, and other key stakeholders to support transparency and informed decision-making.

- **Briefings.** OIG staff conducted 63 briefings for House and Senate committees and members' personal staff, covering a wide portfolio of oversight topics. These included many of the healthcare inspection publications, and there was increased interest in reports focused on VHA's supply chain management program.
- **Inquiries.** OIG congressional relations personnel managed an increased volume of congressional inquiries—131 this reporting period. These inquiries addressed a wide range of issues involving VA programs and services, including individual healthcare concerns and the VA Home Loan Guaranty program.
- **GAO coordination.** OIG staff collaborated closely with the Government Accountability Office (GAO) throughout the period, participating in 33 engagements. GAO interviews involved their ongoing review of the status of federal IGs. Continuing from prior reporting periods, regular coordination calls focused on IT and cybersecurity, contracting, mental health care, community care, benefits delivery, and the Federal Electronic Health Record to help ensure that OIG and GAO oversight work remained aligned, complementary, and non-duplicative.

Reviews of Proposed Legislation and Regulations

As required by the Inspector General Act, the OIG reviews existing and proposed legislation and regulations affecting VA programs and operations and provides recommendations regarding their impact on economy, efficiency, and the prevention and detection of fraud and abuse.[2]

During this reporting period, the OIG reviewed six bills addressing VA governance, consumer fraud prevention, home loan processing, and veterans' access to mental health care. For two of the bills, the OIG provided background information only. The remaining four bills were:

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

- H.R. 7950, which would establish the Office of Congressional and Legislative Affairs in the Department of Veterans Affairs. The OIG provided feedback about oversight obligations the bill would have assigned to the OIG.
- S.2683, the Veterans Scam and Fraud Evasion Act of 2025, which would establish a consumer scam program office in VA and improve communications with veterans about such scams. The OIG provided information on its statutorily mandated anti-fraud work.
- A draft bill that would codify processing timelines for VA home loan assumption applications and require OIG oversight. The OIG provided information to the bill's authors about the types of data the legislation would have required it to report.
- Another draft bill that would modify access standards for mental health care under VHA's community care program. The OIG provided feedback based on findings and recommendations from prior OIG work related to the issues addressed in the bill.

The OIG also reviewed 11 internal VA directives and handbooks that guide VA employee operations and provided comments on three of them.

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 and VA,
- stewardship of taxpayer dollars,
- the pervasiveness of the issue, and
- the availability of other remedies.

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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. Over the past three fiscal years (2024–2026), the hotline has received nearly 40,000 contacts annually on average, with contact volume increasing each year. All contacts 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

- screened 22,021 contacts from complainants and referred higher-risk matters to OIG offices and directorates for case evaluation.
- referred 443 cases to VA offices or officials and required written responses for OIG experts to review.
- made 1,138 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 421 cases—substantiating 48 percent of allegations—contributing to 404 nonmonetary benefits through administrative sanctions and corrective actions and more than $1.5 million in monetary benefits.

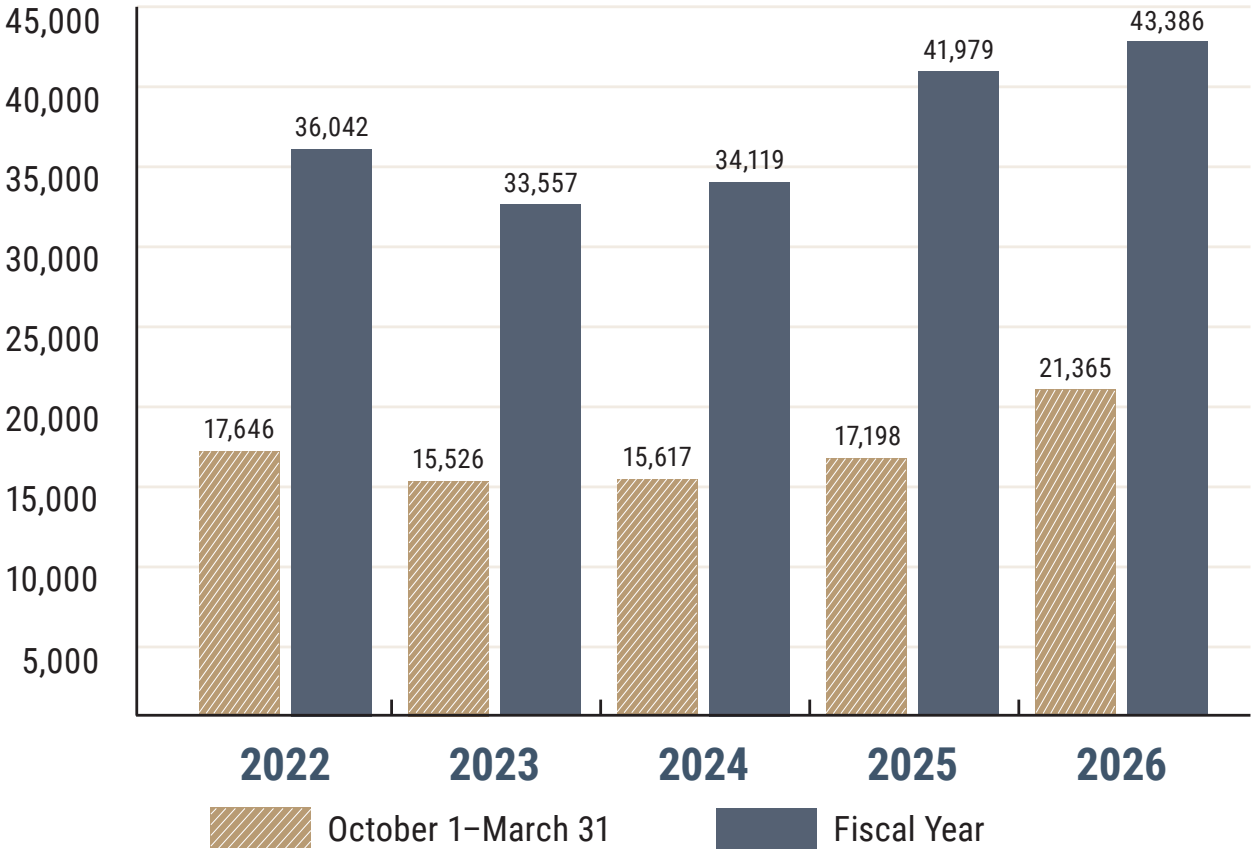


VA OIG Hotline Results for the Six-Month Period

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 one allegation related to human trafficking that is under review. The OIG did not close any investigations pertaining to human trafficking allegations received during a previous reporting period. The OIG made no recommendations to improve VA programs and operations pursuant to this information.

Hotline Contact Volume by Fiscal Year





FINDINGS AND IMPACT



VA is the second-largest federal department 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 and to recommend data- and evidence-driven improvements.

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 challenges and vulnerabilities that require corrective action and form the basis for practical recommendations to reduce risks related to VA patient care, resources, personnel, and systems. Each recommendation reflects a shared commitment to continuous improvement by the OIG and VA 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 investigations and publications featured here highlight a broad range of OIG oversight that significantly influences VA programs and processes, ultimately supporting stronger, more accountable, and more effective delivery of care and benefits to the veteran community.

The Office of Investigations

The Office of Investigations (OI) serves as the OIG's fraud command center, working closely with other OIG components and collaborating with VA, multiple fraud task forces, and external law enforcement partners—including the Department of Justice—to prevent, detect, and address fraud and other crimes targeting veterans and VA programs. Through this coordinated approach, OI plays a critical role in the "War on Fraud," protecting VA health care, benefits, and operations by identifying schemes, supporting high-impact prosecutions, and safeguarding veterans, VA employees, and agency assets.

Impacts from OI's work included

- investigations of criminal activity—including drug offenses, crimes of violence, and cyberthreats, as well as civil violations of law—that resulted 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 that helped prevent losses to the department, increase veteran safety, and stop the use of counterfeit or substandard goods and services by VA

National Health Care Fraud Takedown. In June 2026, OI participated in the **National Health Care Fraud Takedown**, a coordinated, two-week law enforcement initiative led by the Department of Justice. This effort resulted in criminal charges against 455 defendants accused of participating in various healthcare fraud and opioid diversion schemes that, if not thwarted, were expected to result in more than $6.5 billion in losses to federal- and state-administered healthcare programs and private insurers.

As part of this initiative, OI conducted 13 investigations that led to charges against 18 individual defendants and one corporation. The schemes involved kickbacks and fraudulent billing for services and equipment that were not provided or were not medically necessary, including home health care, durable medical equipment,

cardiovascular testing, diagnostic laboratory testing, wound care products, transcranial magnetic stimulation treatments, and sleep studies. These schemes caused approximately $21.4 million in losses to VA's Community Care and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) programs.

In one example, federal prosecutors **charged a VA employee and the CEO of a Florida company** with conspiracy to pay and receive kickbacks. The CEO allegedly paid about $175,000 to the VA employee in exchange for steering community care patients to his company, resulting in roughly $14 million in claims submitted to VA, of which the department paid about $11.9 million.

Service-Disabled Veteran-Owned Small Business (SDVOSB) Fraud. A **$21.3 million settlement** resolved allegations that two businesses and their executives violated the False Claims Act by improperly obtaining federal contracts reserved for SDVOSBs and other eligible small businesses. The settlement resolved allegations that, from April 2017 through May 2025, the defendants used purported SDVOSBs and other small businesses as pass-through entities to obtain set-aside contracts for which they were not eligible.

OI Quantitative Metrics at a Glance



In a separate matter, **two companies agreed to pay more than $3.6 million** to settle allegations under the False Claims Act and Contract Disputes Act. According to the agreement, one company allegedly submitted false claims and false SDVOSB certifications for seven set-aside contracts awarded between May 2017 and June 2018,

Fraud-Related Investigative Results for the Six-Month Period

87	68	$611M
of the 143 total **arrests** were fraud-related (61%).	of the 86 total **convictions** were fraud-related (79%).	in potential **investigative monetary impact** was tied to fraud (99.7%).

despite not meeting ownership and control requirements. The second company also allegedly made inaccurate SDVOSB representations.

Fraud Committed Against Vulnerable Beneficiaries. Among the most egregious matters OI investigates are crimes committed by VA-appointed fiduciaries, caregivers, and other trusted individuals who exploit vulnerable beneficiaries. In one case, **a New Hampshire man who pleaded guilty to bank fraud was sentenced to 21 months in prison** for stealing $225,200 from an elderly, disabled veteran living in a nursing home. He spent the stolen funds on personal purchases—including a snowmobile, jewelry, and travel—and deposited about $85,000 into accounts he controlled.

In a separate case, **a personal care attendant contracted by VA pleaded guilty to stealing from a Vietnam War veteran in her care**. Between August 2023 and April 2024, she and a codefendant allegedly persuaded the elderly, disabled veteran to move into their home under the pretense of providing care. The codefendant had previously met the veteran while working for a VA-contracted home health service. Once he moved in, they allegedly provided no care, resulting in the veteran being hospitalized for four months in a non-VA intensive care unit. While he was hospitalized, the defendants gained access to his bank account, stole more than $70,000, and attempted to steal another $100,000. The veteran's monthly VA compensation was the primary source of the funds. The codefendant remains pending trial.

In another case, **a woman was sentenced to 37 months in prison for misusing VA funds entrusted to her as a fiduciary for her adult son**, a permanently disabled Army veteran who used a wheelchair. Instead of managing his finances for his benefit, she diverted the money for her own use—transferring VA funds into her personal bank account, buying a vehicle the beneficiary never used, paying her bills, and taking trips unrelated to his care. The total loss to taxpayers exceeded $275,000.

Identity Theft and Fraud. **A defendant was sentenced to 30 months in prison and ordered to pay over $1 million in restitution** for a fraudulent scheme that spanned more than 25 years. Evidence showed that he assumed the identity of a US Marine Corps

veteran who had served in Vietnam and used that stolen identity to obtain VA disability compensation benefits and healthcare services. He also opened financial accounts in the victim's name and submitted false statements and documents to maintain or reinstate benefits. Even after the veteran died in 2018, the defendant continued the scheme by persuading agencies to resume payments in the victim's name.

Healthcare Fraud. Investigators aggressively pursue healthcare fraud that harms VA and the veterans it serves. In one multiagency investigation, OI helped secure the conviction of **a former NFL player who received a 196-month prison sentence for orchestrating a yearslong scheme that defrauded Medicare and CHAMPVA of nearly $200 million**. Trial evidence showed he obtained and sold patient information and sham doctors' orders for medically unnecessary orthotic braces—often targeting patients who were amputees or living with dementia or Alzheimer's disease. He then billed the federal programs for the braces through companies he owned and managed, using fake owners and false documents to conceal his involvement.

Threats Against VA Employees. OI also advances cases involving threats of violence against VA and other federal employees. In one example, **a veteran was sentenced to 12 months of imprisonment after pleading guilty to transmitting a threat in interstate commerce**. The veteran had been receiving VA treatment in Michigan and then moved to Raleigh, North Carolina, without coordinating the transfer with VA. After being unable to immediately receive desired treatment in Raleigh, the veteran sent several emails and texts threatening mass homicide.

Fraud Awareness and Prevention. In addition to investigative work, OI staff routinely conduct fraud awareness briefings for VA personnel across the country to complement the OIG's **online fraud toolkit**. These briefings and related resources help employees identify warning signs of fraud. During this reporting period, OI conducted 85 fraud awareness briefings attended by approximately 6,500 VA employees. In August, the OIG restructured this effort to integrate auditors and inspectors into the fraud awareness program, strengthening both its content and reach. VA OIG is collaborating with the department to roll out the enhanced program nationwide across all VA facilities in early FY 2027. **Crime alerts** are also widely disseminated to the veteran community to encourage reporting to the OIG hotline and prevent victimization.

See **appendix A** for list of investigative press releases issued this reporting period.

Read more criminal investigative updates on the OIG website.

The Office of Audits and Evaluations

The Office of Audits and Evaluations (OAE) promotes accountability, efficiency, and effectiveness across VA through independent oversight of programs, services, and operations affecting veterans, their families, beneficiaries, caregivers, and survivors. Its reports identify control and accountability weaknesses that expose VA to fraud or improper use of taxpayer funds and help ensure the department follows laws, regulations, and contract requirements.

OAE recommended significant improvements related to

- 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

During the six-month reporting period, OAE conducted audits, reviews, and information security inspections that recommended significant improvements to veterans' access to health care, benefits administration, stewardship of taxpayer dollars, governance, and the protection of sensitive systems and information. OAE also collaborated with OI, leveraging its expertise in benefits, contracting, and systems to flag potential fraud and related risks.

OAE's work prompted corrective actions across VA. In response to OAE findings, VA is revising policies, clarifying procedures, strengthening oversight structures, and implementing system changes. These actions address deficiencies, enhance accountability, improve service delivery, and reinforce safeguards to deter fraud.

Veterans' Access to Health Care. OAE's oversight strengthened administration of the community care program. Two mandated reports found that **VHA did not consistently meet timeliness standards** for processing consults for direct (VA-provided) and community care, **nor did it consistently inform eligible veterans about their care options**.[3] In response, VHA took corrective actions to improve consult timeliness by establishing procedures to track consults that had not been acted on and to provide

[3] Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act; Pub. L. No. 118-210, § 110, 138 Stat. 2706; VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023).

oversight through regular meetings, data reviews, and targeted field support. VHA also expanded its External Provider Scheduling System, enabling VA to book appointments directly with participating community providers.

OAE Quantitative Metrics at a Glance



Administration of Veterans' Benefits. OAE improved benefits administration by identifying risks of improper disability claims payments and weaknesses in protections for vulnerable beneficiaries. For example, **a review of automated decisions for veterans' service-connected death claims** found improper payments, prompting VBA to update procedures to remove outdated long-form narrative requirements and begin transitioning to the new Smart Pension Automation platform, which is intended to improve accuracy and transparency in automated death-benefit decisions. Separately, OAE's ***Review of the Fiduciary Program's Misuse Allegation Process*** led VBA to strengthen national procedures intended to protect vulnerable beneficiaries from financial abuse. VBA now requires staff to evaluate every credible misuse allegation and ensure allegations advance to investigation unless they are clearly unfounded. VBA also approved a national misuse quality assurance program to strengthen oversight through reviews of all stages of the misuse allegation process.

Stewardship of Taxpayer Funds. To improve VA's financial stewardship, OAE verified whether funds were used effectively and in accordance with law. **One review found weaknesses in VBA's oversight of open obligations**, including undelivered orders and accruals, that delayed the release of funds no longer needed. Another found that **VHA's**

reimbursement processes for non-VA emergency care costs filed by third parties conflicted with statutory requirements, which may have led to improper claim denials.

Governance and Operational Controls. OAE's work also advanced reforms in additional high-risk areas. For instance, **an audit of VA's police staffing decision tool** identified opportunities to strengthen staffing processes that support VA's broader police modernization effort, building on prior OAE findings on performance and staffing challenges within VA's police program.[4] In June 2026, **VA announced it was reforming its police force** by creating a centralized law-enforcement chain of command—an overhaul the department said was necessary following years of OIG and GAO reporting.

In addition, OAE's **audit of security and access controls for the Patient Advocate Tracking System-Replacement** prompted VA's Office of Information Technology to increase the system's risk categorization (from low to moderate impact), strengthen privacy controls, restrict unauthorized access to medical records, and improve account deactivation processes. Several other OAE reports identified ways to strengthen access controls and monitoring to protect VA systems from cyber threats and insider misuse.[5]

Information Security Risks. OAE assessed department-wide information-security risks through the FY 2025 **Federal Information Security Modernization Act audit**. Although VA continues to face significant challenges meeting information security requirements, the audit noted progress in closing six prior-year recommendations related to improved monitoring of controls for contractor systems and VA's detection of unauthorized vulnerability scans. The audit further described progress in areas such as increased visibility into infrastructure platforms; maturation of assessment and authorization processes within the governance, risk, and compliance tool; and improved remediation of new vulnerabilities on network devices and components, though additional work remains to ensure controls are consistently implemented across VA's environment.

Collectively, OAE's work advanced improvements across VA, strengthening policies, training, scheduling and eligibility processes, financial oversight, and governance—all to improve operations, support veterans, and safeguard public funds.

See **appendix A** for list of all OAE oversight products issued this reporting period.

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[4] VA OIG, *Inadequate Governance of the VA Police Program at Medical Facilities and Security,* Report No. 17-01007-01, December 13, 2018; VA OIG, *Security and Incident Preparedness at VA Medical Facilities*, Report No. 22-03770-49, February 22, 2023.

[5] VA OIG, *Federal Information Security Modernization Act Audit for Fiscal Year 2025*, Report No. 25-01698-70, July 27, 2026; VA OIG, *Follow-Up Inspection of Information Security at the VA Southern Oregon Healthcare System*, Report No. 25-02402-83, June 25, 2026; VA OIG, *Inspection of Information Security at the VA Saginaw Healthcare System in Michigan*, Report No. 25-02113-77, May 28, 2026; VA OIG, *Audit of Program Management for the Benefits Enterprise Platform Modernization*, Report No 25-01098-103, August 11, 2026.

The Office of Healthcare Inspections

As the OIG's healthcare oversight arm, the Office of Healthcare Inspections (OHI) conducts evaluations of VHA programs and operations to improve patient safety, clinical quality, and the effectiveness of care delivery. Using multidisciplinary teams with clinical and administrative expertise, OHI completed cyclical reviews, national assessments, and targeted inspections in response to emerging concerns or allegations of wrongdoing. These efforts identified risks affecting timely, coordinated care and exposed vulnerabilities in patient safety processes, clinical documentation, and governance of new technologies. OHI's recommendations guided VA in correcting deficiencies, strengthening safeguards, and improving the reliability of care delivery across VHA.

Impacts from OHI's work included

- changes to policies, governance structures, and how leaders fulfill their roles and responsibilities
- enhancements to mental health, 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

Care Coordination. OHI inspections consistently highlighted challenges in care coordination, especially for veterans relying on community providers or requiring complex diagnostic pathways. Several reviews identified delays in scheduling, inadequate oversight of consult backlogs, and insufficient mechanisms for identifying high risk clinical needs—factors that contributed to postponed diagnoses and fragmented care. For example, a review of community care consult management at the **VA Fayetteville Coastal Healthcare System** found that staff did not appropriately triage or follow up on consults, including an urgent pulmonary consult, reducing opportunities for earlier diagnosis and treatment of a lung mass. An inspection at the **VA Portland Health Care System** found that workload pressures and limited resources resulted in missed monthly case management contacts and discharge gaps within the Health Care for Homeless Veterans program. OHI's **national review of traumatic brain injury (TBI) screening and evaluation for post-9/11 veterans** found that although most eligible veterans were screened, many who accepted comprehensive evaluations did not receive them or were evaluated late due to referral gaps, scheduling barriers, limited use of polytrauma telehealth, and restrictions that limited the comprehensive TBI evaluation template to

OHI Quantitative Metrics at a Glance



a single use. These shortcomings underscored the importance of structured triage processes, reliable tracking of referrals, and strengthened clinical communication. VHA leaders have already started implementing reforms in these areas.

Women Veterans' Care. OHI also identified coordination and follow-up failures that disproportionately affected women veterans. Inspections of breast imaging processes **revealed delays in receiving and uploading community-provided images, gaps in tracking abnormal results, and inconsistent identification of patients due for routine screenings**. Because timely access to complete imaging is essential to breast cancer detection, these gaps pose substantial risks to women veterans—a population whose healthcare needs continue to grow across VHA. Veterans Integrated Service Network and facility leaders have initiated corrective actions, including improved imaging workflows, modernized tracking mechanisms, and clearer screening processes, reflecting steady progress in addressing these concerns.

Clinical Infrastructure and Patient Safety. A review of sterile processing services and their impact on ear, nose, and throat surgery at the Michael E. DeBakey VA Medical Center in Houston **revealed conditions that jeopardized surgical readiness, including inconsistent management of reusable medical devices and equipment shortages that led to canceled procedures**. These findings reflect broader risks stemming from staffing instability, prolonged leadership vacancies, and gaps in facility oversight. In response, VHA leaders committed to strengthening inventory controls, recruiting for a critical

position, and enhancing review processes so surgical teams can better rely on sterile processing as a foundational safety function.

Adverse Event Response and Suicide Prevention Processes. In a review of care provided to a patient who died by suicide and the subsequent root cause analysis at the Robley Rex VA Medical Center in Louisville, Kentucky, **OHI identified deficiencies in safety planning, documentation accuracy, and root cause analysis practices**—including inadequate oversight of interim patient safety personnel and inconsistent adherence to suicide prevention protocols. Facility leaders have since taken steps to reinforce training, reconcile inconsistent guidance, and strengthen internal processes to improve suicide prevention and clinical documentation quality. These actions demonstrate renewed attention to the systems that support vulnerable veterans.

Oversight of New Technology Risks. Reflecting its role in emerging oversight domains, OHI completed **a national review of VA's use of generative artificial intelligence in clinical settings**. The review found widespread clinical use of general purpose AI tools, such as VA GPT and Microsoft 365 Copilot Chat—although VA did not categorize these tools as high impact technologies or implement required safeguards. OHI found limited coordination with national patient safety entities and no mechanisms to track AI-related safety events, leaving VHA without a clear understanding of potential risks posed by these tools. VHA leaders agreed to define permissible clinical use, establish oversight responsibilities, implement safeguards comparable to those for other high-impact AI tools, and integrate AI-related risk monitoring into patient safety programs. This inspection represents foundational work in an area poised to shape future care delivery across VA.

Across these efforts, OHI advanced the Inspector General's ACER principles—Accountability, Collaboration, Efficiency, and Resolution—by promoting accountability for timely clinical oversight, strengthening collaboration between facilities and national program offices, improving efficiency in consult and documentation processes, and driving resolution of systemic vulnerabilities affecting veterans' care. Taken together, the directorate's work underscores its central role in safeguarding veterans from preventable harm, supporting timely access to coordinated care, and ensuring VA remains prepared to address both longstanding and emerging risks. OHI will continue to monitor programmatic changes resulting from these inspections and assess their effectiveness in strengthening the quality, consistency, and safety of healthcare services across the VA system.

See **appendix A** for list of all OHI oversight products issued this reporting period.

Investigations of Senior Government Employees

SUBSTANTIATED MISCONDUCT BY SENIOR GOVERNMENT EMPLOYEES

The Inspector General Act requires OIGs to report on criminal or administrative investigations in which allegations of misconduct by a senior government employee were substantiated.[6] Required reporting includes the employee's name, if previously disclosed; a description of the facts and circumstances; and the status and disposition of the matter, including the dates of any referral to and declination by the Department of Justice.

During this reporting period, the OIG closed an investigation involving allegations that a podiatrist at the Overton Brooks VA Medical Center in Shreveport, Louisiana, violated federal controlled substance laws by obtaining diazepam, a controlled substance, through fraud and possessing it with intent to dispense. The OIG referred the matter to the Department of Justice on July 7, 2023, and it was declined for prosecution on October 18, 2024. In May 2025, local authorities arrested the doctor on related state charges. In 2026, he entered into a diversion agreement and surrendered his Drug Enforcement Administration registration and state prescribing license in exchange for dismissal of the felony charge. Administrative actions resulting from the investigation included retirement in lieu of adverse action and documented cost savings of $124,809, representing six months of salary.

NONPUBLICLY DISCLOSED INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEE

The Inspector General Act also requires OIGs to report on any criminal or administrative investigation involving a senior government employee that was closed during the reporting period but not otherwise made public, regardless of whether the allegations were substantiated.[7] Such matters may not be publicly disclosed by the VA OIG when allegations are unsubstantiated or when they are referred to another entity for action.

During this reporting period, the VA OIG closed one matter involving unsubstantiated allegations against a senior government employee. An anonymous complainant alleged that, since at least 2023, the employee had improperly claimed a duty station in an eastern US city while actually residing in a Midwestern city, resulting in approximately

[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).

$18,000 annually in improper locality pay. Following a preliminary evaluation, the OIG found insufficient evidence to warrant further review.

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 work concludes due to legislative changes, VA reforms, or other superseding 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

OAE 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 preaward and postaward audits completed during the reporting period in **appendix A** and annually publishes summary reports with high-level findings. During this reporting period, the OIG issued the latest FY 2025 summary reports for Federal Supply Schedule **pharmaceutical** and **nonpharmaceutical** proposals, which are also included in appendix A. The recommendations from these FY 2025 reviews helped VA contracting officers attain about $24.7 million in savings on pharmaceutical proposals and about $11.7 million on nonpharmaceutical proposals. Because these amounts stem from work performed in FY 2025, they represent sustained savings from the prior year and are not included in the potential monetary impact reported for this period or for FY 2026.

As part of the overall potential monetary impact identified by OAE during this reporting period, preaward audits accounted for $240 million in funds that could be put to

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

better use; for all of FY 2026, the total was $289.2 million. Postaward audits identified $3.9 million in questioned costs in this reporting period; for all of FY 2026, that total was $5.2 million.

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 13 new allegations of whistleblower reprisal and closed four 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

22,021
Hotline Contacts

63
Congressional Engagements*

138
Oversight Reports

14
Other Work Products

392
Recommendations Made to VA

391
Recommendations Implemented by VA

143
Arrests

94
Convictions, Pretrial Diversions, and Deferred Prosecutions

565
Administrative Sanctions and Corrective Actions‡

$4.8B
Total Potential Monetary Impact

$38:1
Return on Investment

* Figure Includes any testimony and briefings.

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

Table 1. Potential Monetary Impact and Return on Investment

Type	This Period	Last Period	Fiscal Year
Better Use of Funds	$1,139,068,729	$66,448,979	$1,205,517,708
Dollar Recoveries	$2,083,046	$5,596,593	$7,679,639
Fines, Penalties, Restitution, and Civil Judgments[12]	$476,596,243	$2,125,076,178	$2,601,672,421
Fugitive Felon Program	$68,682,809	$16,790,586	$85,473,395
Savings and Cost Avoidance	$66,423,608	$26,969,464	$93,393,072
Questioned Costs	$3,018,358,692	$23,745,762	$3,042,104,454
Total Dollar Impact	**$4,771,213,127**	**$2,264,627,562**	**$7,035,840,689**
Cost of OIG Operations[13]	$125,991,734	$126,508,378	$252,500,112
Return on Investment[14]	**$38:1**	**$18:1**	**$28:1**

Table 2. Recommendations Inventory

	This Period	Last Period
Beginning Balance of Open Recommendations	572	720
Issued	392	333
Closed	(391)	(481)
Ending Balance*	**573**	**572**

* As of September 30, 2026, the total number of open OIG recommendations was 573. This included 163 carryover recommendations that had been open for more than one year, of which 17 had been open for more than five years. The OIG continues to work with VA officials to implement corrective actions and close these longstanding recommendations.

[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 and fiscal year, the monetary impact to VA is $119,147,186 and $459,264,255, respectively. This amount includes forfeited funds for which VA could submit a petition for remission.

[13] The six-month and fiscal year operating costs for OHI ($22,008,266 and $43,499,888, respectively), 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	Last Period	Fiscal Year
Audits	13	6	19
Care in the Community Inspections	0	1	1
Healthcare Facility Inspections	37	24	61
Healthcare Inspections	16	11	27
Information Security Inspections	3	2	5
Mental Health Inspections	6	4	10
National Healthcare Reviews	8	5	13
Postaward Contract Audits*	5	8	13
Preaward Contract Audits*	28	19	47
Reviews	21	3	24
Vet Center Inspections	1	5	6
Subtotal	**138**	**88**	**226**
OTHER WORK PRODUCTS	**This Period**	**Last Period**	**Fiscal Year**
Budget Request	0	1	1
Congressional Testimonies	0	3	3
Fraud Watch Publications	6	0	6
Major Management Challenges	0	1	1
Management Advisory Memoranda	3	1	4
Monthly Highlights	0	2	2
Peer Reviews (Completed of other OIGs)	1	0	1
Preliminary Result Advisory Memoranda	0	5	5
Press Releases	3	0	3
Whistleblower Reprisal Investigation Memoranda*	1	1	2
Subtotal	**14**	**14**	**28**
Total	**152**	**102**	**254**

* Indicates products restricted from public release under federal law.

Table 4. Selected Office of Investigations Activities

Type[15]	This Period	Last Period	Fiscal Year
Arrests[16]	143	127	270
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	5	7	12
Indictments	95	95	190
Indictments and Informations Resulting from Prior Referrals to Authorities	57	75	132
Criminal Complaints	34	47	81
Convictions	86	100	186
Pretrial Diversions and Deferred Prosecutions	8	11	19
Case Referrals to the Department of Justice for Criminal Prosecution[17]	171	166	337
Case Referrals to State and Local Authorities for Criminal Prosecution[18]	38	45	83
Administrative Sanctions and Corrective Actions	161	151	312
Cases Opened	225	232	457
Cases Closed	258	283	541

[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 13 arrests of fugitive felons made by VA OIG agents during the reporting period, bringing the fiscal year total to 22. This 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	Last Period	Fiscal Year
Clinical Consultations to Other VA OIG Offices	2	0	2
Clinical Consultations to Other Federal Entities	0	3	3
Hotline Referrals Reviewed	2,405	2,155	4,560

Table 6. Selected Hotline Division Activities

Type	This Period	Last Period	Fiscal Year
Contacts	22,021	21,365	43,386
Cases Opened	443	351	794
Cases Closed	421	374	795
Administrative Sanctions and Corrective Actions	404	359	763
Allegation Substantiation Rate	48%	42%	45%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	73	37	110
Individuals Provided Office of Special Counsel Contact Information	16	37	53
Individuals Provided Merit Systems Protection Board Contact Information	0	9	9
Individuals Provided Office of Resolution Management Contact Information	30	59	89

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.vaoig.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 diligently 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 for the Fiscal Year

720
Beginning Balance as of October 1, 2025

725
Recommendations Issued This Fiscal Year

872
Recommendations Closed This Fiscal Year

573
Ending Balance as of September 30, 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.

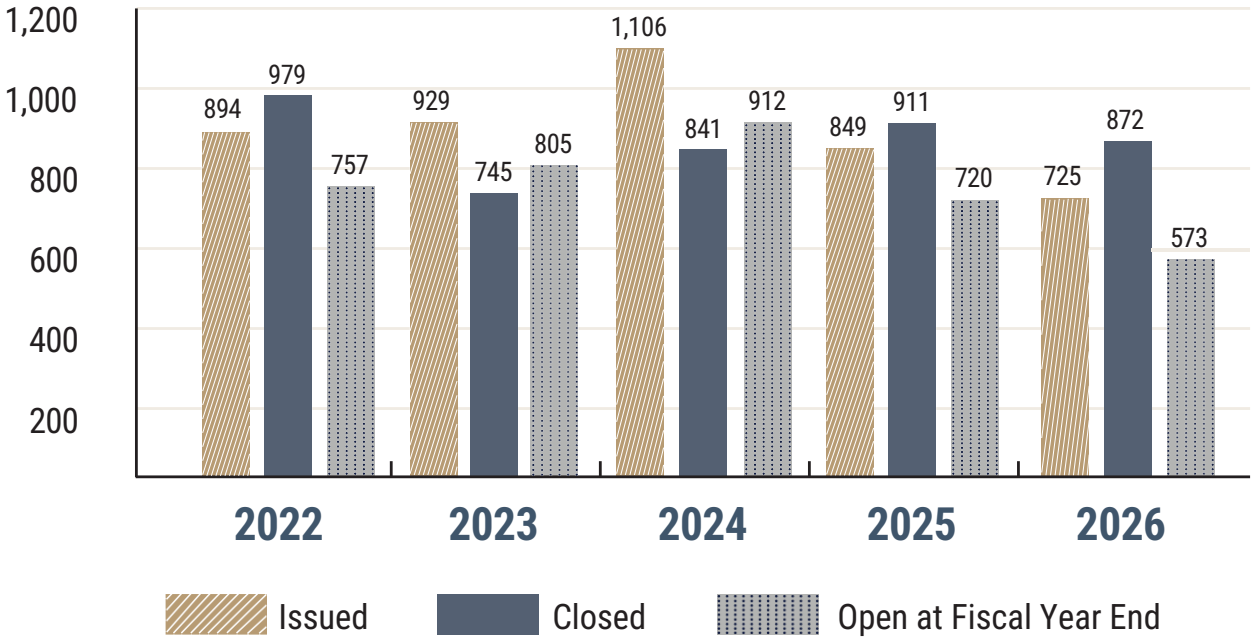
Unimplemented (Open) Recommendations

The figures below highlight key trends in the recommendation inventory, and **appendix B** lists all recommendations from prior reporting periods for which corrective actions remain in progress. The **OIG website** also provides real-time, filterable data on all open recommendations.

Distribution of Open Recommendations by Age as of September 30, 2026

410	146	17
Open Less Than One Year	Open Between One and Five Years	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 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.

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[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, with results also published to the **OIG website**.

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	4/9/2026	Housing and Urban Development	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
4/7/2026	*Woman Sentenced to a Year in Jail for Threats*
4/9/2026	*Former VA Employee Charged with Fraudulently Obtaining Multiple COVID-19 Benefits*
4/14/2026	*Former Jacksonville Church Pastor Indicted for Wire Fraud Involving SBA Paycheck Protection Program Loans*
5/1/2026	*VA Employee Charged with Fraudulently Obtaining Multiple COVID-19 Benefits*
5/7/2026	*Defendant Sentenced to Thirty Months in Federal Prison for Decades-Long Identity Theft and Fraud Scheme*
5/7/2026	*Former NFL Player Sentenced to Over 16 Years in Prison for $197 Million Medicare Fraud*
5/11/2026	*Bath Man Sentenced to Federal Prison for Stealing $225,200 from an Elderly Disabled Veteran*

[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)

Date	Title
5/13/2026	*Rankin County Woman Sentenced to 37 Months for Misappropriating Disabled Veteran Benefits Funds*
5/13/2026	*Owner of Healthcare Software Company Convicted of Fraud Conspiracy*
5/26/2026	*North Carolina Woman Charged with Conspiracy to Commit Immigration Fraud, VA Disability Fraud*
6/18/2026	*Harrison County Woman Sentenced for Falsifying VA Medical Records to Steal Disability Benefits and Erase $242,000 in Student Loans*
6/18/2026	*National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with More Than $6.5 Billion in Alleged Fraud (Iowa)*
6/22/2026	*Two Charged in the District of Oregon as Part of the National Health Care Fraud Takedown*
6/22/2026	*National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with More Than $6.5 Billion in Alleged Fraud (Louisiana)*
6/24/2026	*U.S. Attorney's Office for the Middle District of Florida Charges Defendants as Part of National Health Care Fraud Takedown*
7/11/2026	*Scammer Pharmacist Guilty in $20 Million Healthcare Kickback Scheme*
8/7/2026	*Jury Convicts Army Veteran of Embellishing Health Issues to Defraud VA*
8/21/2026	*VA Nurse Indicted for Stealing Opioids*
9/2/2026	*Inmate Serving Life Sentence for Murder Pleads Guilty to Stealing $354,813 in Veterans Benefits*
9/15/2026	*Conscientious Objector Who Faked Vietnam Combat and Medals Pleads Guilty to Defrauding VA*
9/16/2026	*Former VA Field Examiner Indicted on Federal Fraud Charge Related to COVID-19 Relief Programs*
9/16/2026	*Grand Jury Indicts Four in Sweeping $7.3 Million Mortgage Fraud Scheme Targeting FHA and VA Programs*
9/24/2026	*Two Defendants Plead Guilty to Conspiring to Obtain Over $80 Million In Government Contracts Through Fraud*

Reports and Other Products Issued This Reporting Period

Table A.2 lists all VA OIG reports and memoranda issued during the reporting period, whether public or nonpublic. For each report, as applicable, the table identifies questioned costs, including any unsupported costs, and recommendations that funds be put to better use.[28]

Questioned costs represent VA actions or inactions—such as spending or failing to fully compensate eligible beneficiaries—that violate a law, regulation, or agreement; lack adequate documentation; or are unnecessary or unreasonable under governing authorities. Unsupported costs, which must be disclosed separately under statute, are a subset of questioned costs and refer to amounts lacking sufficient documentation at the time of audit. Funds put to better use reflect amounts that could be used more efficiently if VA management implements the recommended actions.

Some OIG reports cannot be publicly released under federal law and are marked with an asterisk (*).[29] Those marked with a double dagger (‡) indicate instances for which the VA OIG did not request or receive a VA management decision during the reporting period.[30] Finally, while there are no such investigations to report during this period, any future reports involving substantiated allegations of misconduct by senior government officials will be identified with a section symbol (§).[31]

The VA OIG publishes all reports to its **website** unless law or regulation prohibits disclosure, offers **real-time data on open recommendations**, and allows users to filter recommendations by status, date range, topic area, responsible action office, and other criteria. Notifications are also posted on the **OIG website** when a final report is not completed, such as when work concludes due to legislative changes, VA reforms, or other superseding events.

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

[29] Preaward and postaward contract audits 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 whistleblower reprisal investigations concerning VA contractors and grantees (§ 4712 investigation reports) from public release.

[30] 5 U.S.C. § 405(b)(5)(B)

[31] 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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations				
Audits and Reviews				
4/30/2026	*Review of Automated Decisions for Veterans' Service-Connected Death Claims*	25-00153-47	–	$2,727,764
4/30/2026	*Review of VBA's Recurring Benefits for Beneficiaries Aged 100 Years or Older*	25-02364-84	–	$612,000
5/14/2026	*Independent Review of VA's Special Disabilities Capacity Report for Fiscal Year 2024*	26-00720-100	–	–
5/27/2026	*Review of VBA's Process for System Overrides*	25-00630-89	–	$67,155
6/10/2026	*Audit of VA's Police Staffing Decision Tool*	25-00523-82	–	–
6/17/2026	*Audit of Consult Timeliness for VA and Community Care*	25-01015-138	–	–
6/17/2026	*Audit of Veterans' Community Care Eligibility Determinations*	25-01014-139	–	$1,744,845,232
6/18/2026	*Audit of VISN 22 Supply Chain Management*	25-02834-142	$369,000	–
6/18/2026	*Audit of VISN 8 Supply Chain Management*	25-00885-144	$3,077,369	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Audits and Reviews (Continued)				
6/23/2026	*Review of Physical Security of Information Technology Equipment at the Columbia, South Carolina, VA Regional Office*	25-04347-110	$305,607	–
6/25/2026	*Audit of Pharmaceutical Purchases Made Outside the Prime Vendor Contract*	25-02487-143	–	–
7/7/2026	*Audit of Security and Access Controls for the Patient Advocate Tracking System-Replacement*	25-01781-71	–	–
7/16/2026	*Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2025*	25-04241-151	–	–
7/23/2026	*Review of Open Obligations in VBA's General Operating Expenses Account*	25-02887-107	$895,257,953	–
7/23/2026	*Review of Medical Facilities' Management of Specialty Care Calls*	25-03621-145	–	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Audits and Reviews (Continued)				
7/24/2026	*Review of the Fiduciary Program's Misuse Allegation Process*	25-02440-122	–	–
7/24/2026	*Audit of the Education Service's Compliance Surveys*	25-01584-123	–	$19,386,671
7/27/2026	*Federal Information Security Modernization Act Audit for Fiscal Year 2025*	25-01698-70	–	–
8/6/2026	*Review of Assignment of Noncompensable Musculoskeletal Joint Disabilities*	25-02645-131	–	$44,979,787
8/10/2026	*Review of Timeliness of Mental Health Community Care Appointments*	25-03623-147	–	–
8/11/2026	*Audit of Program Management for the Benefits Enterprise Platform Modernization*	25-01098-103	–	–
8/12/2026	*Review of VBA's Unidentifiable Mail Certification Process*	25-02228-172	–	$822,468
8/20/2026	*Audit of VHA and VBA Controls Over the Toxic Exposures Fund*	25-03218-133	–	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Audits and Reviews (Continued)				
8/21/2026	*Audit of the Healthcare Enrollment Program at VA Medical Facilities*	24-03691-175	—	—
8/28/2026	*A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2025 on VA Federal Supply Schedule Pharmaceutical Proposals*	26-00127-169	—	—
8/31/2026	*Review of VBA's Processing of Adverse Actions for Service-Connected Disability Compensation*	25-01011-154	—	$16,895,038
9/1/2026	*Review of Contracted Backup Services for the Veterans Crisis Line*	23-03464-146	—	$11,200,000
9/2/2026	*Review of Supply Chain Management at the VA Augusta Health Care System in Georgia*	26-02023-176	—	—
9/9/2026	*Review of Minor Construction and Nonrecurring Maintenance Projects at the Fayetteville VA Medical Center in Arkansas*	24-03185-148	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Audits and Reviews (Continued)				
9/22/2026	*Review of Contracts Terminated for Convenience*	25-03033-230	–	–
9/22/2026	*A Summary of OIG Preaward Contract Reports Issued in Fiscal Year 2025 on VA Federal Supply Schedule Nonpharmaceutical Proposals*	26-00128-191	–	–
9/24/2026	*Review of the Major Construction Project for the New VA Medical Center in Louisville, Kentucky*	25-01782-158	–	$1,172,892,283 *($1,172,892,283 unsupported costs)*
9/24/2026	*Audit of Processing of Community Care Requests for Services*	25-03946-211	–	–
9/29/2026	*Fiscal Year 2026 Risk Assessment of VA's Charge Card Programs*	25-03760-282	–	–
Information Security Inspections				
5/28/2026	*Inspection of Information Security at the VA Saginaw Healthcare System in Michigan*	25-02113-77	–	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Information Security Inspections (Continued)				
6/25/2026	*Follow-Up Inspection of Information Security at the VA Southern Oregon Healthcare System*	25-02402-83	—	—
9/10/2026	*Inspection of Information Security at the Lovell Federal Healthcare System in Illinois*	25-04267-174	—	—
Management Advisory Memoranda				
7/17/2026	*Denials of Emergency Care Claims*	26-01111-117	—	—
8/7/2026	*Desk Review of the U.S. VETS Single Audit Reporting Package for the Year Ended June 30, 2025*	26-02642-227	—	—
9/9/2026	*VA Federal Supply Schedule Contracts*	26-01466-189	—	—
Postaward Contract Audits*‡				
5/14/2026	*Independent Audit Report of Compliance with Public Law Under a Contract*	25-00765-120	—	$5,852
7/6/2026	*Independent Audit Report of Compliance with Public Law Under a Contract*	22-03433-159	—	$98,987

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Postaward Contract Audits (Continued)*‡				
7/20/2026	*Independent Audit Report of Compliance with Public Law Under a Contract*	26-00632-157	–	–
8/10/2026	*Independent Audit Report of Compliance with Public Law Under a Contract*	25-02375-229	–	–
9/4/2026	*Independent Audit Report of Compliance with Public Law Under a Contract*	26-00230-254	–	$3,825,455
Preaward Contract Audits*‡				
4/1/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03400-87	–	–
4/1/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-04315-104	$13,276,624	–
4/2/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01291-92	$1,488,905	–
4/10/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03399-90	$4,410,922	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Preaward Contract Audits (Continued)*‡				
4/16/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03994-106	$25,370,310	—
4/28/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03327-91	—	—
5/11/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-00655-116	$3,193,005	—
5/14/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01148-119	$34,964,799	—
5/15/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-00291-109	—	—
5/21/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-00601-108	$183,585	—
5/26/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01760-111	$1,078,897	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Preaward Contract Audits (Continued)*‡				
5/29/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03985-121	—	—
6/4/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03478-132	—	—
7/7/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	25-03398-150	—	—
7/20/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01089-152	—	—
7/21/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-00292-161	—	—
7/22/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-00639-153	—	—
7/28/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01151-192	$2,528,536	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Preaward Contract Audits (Continued)*‡				
8/6/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-02347-228	$49,678,752	–
8/13/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01146-246	–	–
8/14/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-02426-197	–	–
8/19/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-00126-201	$102,985,722	–
8/20/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01632-249	–	–
9/2/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01150-264	–	–
9/4/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-02286-268	$13,186	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Audits and Evaluations (Continued)				
Preaward Contract Audits (Continued)*‡				
9/9/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-03223-261	$269,569	–
9/24/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-01878-283	–	–
9/28/2026	*Independent Audit Report of a Proposal Submitted Under a Solicitation Number*	26-02929-265	$615,988	–
Office of Healthcare Inspections				
Healthcare Facility Inspections				
4/16/2026	*Tomah VA Health Care System in Wisconsin*	25-00216-101	–	–
5/28/2026	*Ralph H. Johnson VA Health Care System in Charleston, South Carolina*	25-00237-112	–	–
6/16/2026	*VA Illiana Healthcare System in Danville, Illinois*	25-00240-125	–	–
6/18/2026	*VA Dayton Healthcare System in Ohio*	25-00251-124	–	–
6/22/2026	*VA Wilmington Healthcare System in Delaware*	25-00257-149	–	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Facility Inspections (Continued)				
7/16/2026	*VA El Paso Healthcare System in Texas*	25-00193-155	–	–
7/16/2026	*VA San Diego Healthcare System in California*	25-00253-156	–	–
8/5/2026	*Alaska VA Healthcare System in Anchorage*	25-00248-162	–	–
8/5/2026	*Bay Pines VA Healthcare System in Florida*	26-00033-168	–	–
8/7/2026	*St. Cloud VA Health Care System in Minnesota*	25-00252-204	–	–
8/7/2026	*VA Wichita Healthcare System in Kansas*	25-00250-210	–	–
8/11/2026	*VA Syracuse Healthcare System in New York*	25-00246-220	–	–
8/11/2026	*VA Asheville Health Care System in North Carolina*	25-04052-222	–	–
8/13/2026	*VA Kansas City Healthcare System in Missouri*	25-00204-215	–	–
8/13/2026	*Montana VA Healthcare System in Fort Harrison*	25-00258-217	–	–
8/13/2026	*VA Houston Healthcare System in Texas*	26-00029-236	–	–
8/14/2026	*VA Pacific Islands Health Care System in Honolulu, Hawaii*	25-04253-243	–	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Facility Inspections (Continued)				
8/26/2026	*VA New Mexico Healthcare System in Albuquerque*	26-00043-232	—	—
8/26/2026	*San Francisco VA Health Care System in California*	26-00032-248	—	—
8/26/2026	*VA Lebanon Healthcare System in Pennsylvania*	25-00259-250	—	—
8/26/2026	*Northern Arizona VA Health Care System in Prescott*	26-00052-251	—	—
8/28/2026	*VA Mountain Home Healthcare System in Tennessee*	25-04252-256	—	—
9/4/2026	*VA Philadelphia Healthcare System in Pennsylvania*	25-00255-206	—	—
9/4/2026	*Salisbury VA Health Care System in North Carolina*	26-00030-213	—	—
9/4/2026	*VA Tuscaloosa Healthcare System in Alabama*	26-00038-262	—	—
9/4/2026	*Southern Arizona VA Health Care System in Tucson*	26-00045-263	—	—
9/23/2026	*VA NY Harbor Healthcare System in New York*	26-00053-273	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Facility Inspections (Continued)				
9/23/2026	*VA White River Junction Healthcare System in Vermont*	26-00084-274	—	—
9/25/2026	*VA New Jersey Healthcare System in East Orange*	25-00242-195	—	—
9/25/2026	*VA Milwaukee Healthcare System in Wisconsin*	25-00249-275	—	—
9/25/2026	*VA Albany Healthcare System in New York*	25-00256-276	—	—
9/28/2026	*VA Bedford Healthcare System in Massachusetts*	25-00247-234	—	—
9/28/2026	*VA Amarillo Healthcare System in Texas*	26-00042-279	—	—
9/28/2026	*VA Wilkes-Barre Healthcare System in Pennsylvania*	26-00056-280	—	—
9/30/2026	*Central Arkansas Veterans Healthcare System in Little Rock*	25-00203-180	—	—
9/30/2026	*Central Virginia VA Health Care System in Richmond*	25-00213-242	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Inspections				
9/30/2026	*William S. Middleton Memorial Veterans Hospital and Clinics in Madison, Wisconsin*	25-00254-277	—	—
4/8/2026	*Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina*	24-03186-99	—	—
4/24/2026	*Review of Responsiveness to Patient Care Concerns, and Credentialing and Supervision of a Nurse Practitioner and Physician Assistant at the VA Loma Linda Healthcare System in California*	25-02464-105	—	—
5/21/2026	*Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora*	25-02420-118	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Inspections (Continued)				
6/2/2026	*Review of VA's Oversight of a State Veterans Home at the Western North Carolina VA Health Care System in Asheville*	26-00509-126	—	—
6/4/2026	*Review of the Peer Review Process at the VA Caribbean Healthcare System in San Juan, Puerto Rico*	25-04138-129	—	—
6/4/2026	*Review of Inpatient Mental Health Unit Processes at the West Palm Beach VA Healthcare System in Florida*	25-02766-130	—	—
6/9/2026	*Review of Care Provided to a Patient Who Died by Suicide and the Subsequent Root Cause Analysis at the Robley Rex VA Medical Center in Louisville, Kentucky*	25-00734-134	—	—
6/11/2026	*Review of Clinical Care and Behavior Concerns about Two Surgeons at the Martinsburg VA Medical Center in West Virginia*	25-01013-135	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Inspections (Continued)				
6/16/2026	*Review of Ear, Nose, and Throat Surgery-Related Sterile Processing Services Concerns at the Michael E. DeBakey VA Medical Center in Houston, Texas*	25-02152-136	–	–
6/18/2026	*Review of the Management of the Homemaker/Home Health Aide Services at the Eastern Oklahoma VA Health Care System in Muskogee and the Oklahoma City VA Healthcare System*	25-03512-141	–	–
6/23/2026	*Review of Primary Care Providers' Completion of Electronic Health Record Documentation at the VA Augusta Health Care System in Georgia*	25-00333-137	–	–
8/5/2026	*Review of VHA's Screening and Evaluation of Traumatic Brain Injury in Post-9/11 Veterans*	24-03541-173	–	–
8/5/2026	*Review of Radiology Staffing and Services at the VA Washington DC Healthcare System*	25-03881-160	–	–

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Inspections (Continued)				
8/6/2026	*Review of Facility Leaders' Oversight of Care Coordination Services Within Homeless Programs at the VA Portland Health Care System in Oregon*	25-04102-182	—	—
8/10/2026	*Review of VHA Maternity Care Coordination and Women Veterans' Experience*	24-00818-208	—	—
8/14/2026	*Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond*	25-04450-218	—	—
8/20/2026	*Review of VHA's Management of Heart Failure with Reduced Ejection Fraction in Women Veterans*	24-03176-247	—	—
8/26/2026	*Review of Individual Psychotherapy at the Northport VA Medical Center in New York*	26-01069-255	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
Healthcare Inspections (Continued)				
8/31/2026	*Review of a Patient's Care in the Intensive Care Unit at the Wm. Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina*	25-03401-257	—	—
Mental Health Inspections				
5/19/2026	*VA Ann Arbor Healthcare System in Michigan*	25-00732-113	—	—
5/19/2026	*VA Milwaukee Healthcare System in Wisconsin*	25-00731-115	—	—
9/2/2026	*VA Boston Healthcare System in Brockton, MA*	25-03934-258	—	—
9/2/2026	*VA Kansas City Healthcare System in Missouri*	25-03939-259	—	—
9/2/2026	*VA Jackson Healthcare System in Mississippi*	25-03937-260	—	—
9/14/2026	*South Texas Veterans Health Care System in San Antonio*	25-03943-269	—	—
National Healthcare Reviews				
5/20/2026	*National Review of VHA's Adherence to Alcohol Use Screening Requirements and Provision of Interventions*	24-02757-114	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of Healthcare Inspections (Continued)				
National Healthcare Reviews (Continued)				
6/2/2026	*Overview of Veterans' Experience, Environment of Care, and Staff Perspectives for Women Veterans in VHA Mental Health Residential Rehabilitation Treatment Programs*	24-00817-127	—	—
6/3/2026	*Review of Emergency Dispatch and Facility Transport Processes at the Veterans Health Administration's Veterans Crisis Line*	25-02786-128	—	—
6/11/2026	*Review of Generative Artificial Intelligence Chat Tools for Clinical Use*	26-00182-140	—	—
9/11/2026	*OIG Report of Veterans Health Administration's Responses on Severe Occupational Staffing Shortages Fiscal Year 2026*	26-01046-271	—	—
Vet Center Inspection				
8/21/2026	*North Atlantic District 1 Vet Center Operations*	24-02172-253	—	—

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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

Date	Title	Report Number	Better Use of Funds	Questioned Costs
Office of the Counselor to the Inspector General				
Whistleblower Reprisal Investigation (Contractors and Grantees)*‡				
6/24/2026	*Report of Investigation of Whistleblower Retaliation Claim Under 41 U.S.C. § 4712*	2025-01072-SR-0001	—	—
Total			**$1,139,068,729**	**$3,018,358,692**

* Prohibited from public release pursuant to federal law.

‡ No VA management decision requested or received during the reporting period.

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.[32] Table B.1 identifies recommendations made prior to this reporting period that were open (unimplemented) as of September 30, 2026. The **OIG website** also provides real-time, filterable data on all open recommendations.

Table B.1. Open Recommendations from Prior Reporting Periods

Date	Title	Report Number	Open Recommendations	Potential Cost Savings
12/13/2018	*Inadequate Governance of the VA Police Program at Medical Facilities*	17-01007-01	1	—
2/25/2021	*Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement*	19-07053-51	6	—
5/25/2021	*Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program*	20-03178-116	5	—

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

[32] 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 Recommenda-tions	Potential Cost Savings
6/10/2021	*Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency*	20-00541-133	1–4	–
6/15/2021	*Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs*	20-01487-142	2	$129,700,000
7/7/2021	*Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program*	20-03185-151	2–6	–
8/19/2021	*Review of Veterans Health Administration Staffing Models*	20-01508-214	1	–
9/9/2021	*Failure to Locate Missing Veteran Found Dead at a Facility on the Bedford VA Hospital Campus*	20-03465-243	1, 3–4	–
12/8/2021	*VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services*	20-01099-249	3	$285,500,000

* 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 Recommendations	Potential Cost Savings
12/8/2021	*VHA Risks Overpaying Community Care Providers for Evaluation and Management Services*	21-01807-251	1	$59,600,000
1/20/2022	*Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020*	21-01507-61	1–2	–
4/7/2022	*Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities*	20-00827-126	2	–
4/25/2022	*The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule*	21-02889-134	1–4	–
5/24/2022	*VHA Continues to Face Challenges with Billing Private Insurers for Community Care*	21-00846-104	2–3	–

* 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 Recommenda-tions	Potential Cost Savings
6/22/2022	*Mission Accountability Support Tracker Lacked Sufficient Security Controls*	21-03080-142	3	—
7/21/2022	*Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure*	21-02704-135	2–3	—
7/28/2022	*VBA Improperly Created Debts When Reducing Veterans' Disability Levels*	21-01351-151	2, 4	—
8/3/2022	*The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring*	21-02401-190	3	—
12/8/2022	*VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments*	21-03063-04	2	—
1/18/2023	*Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama*	22-01854-13	7	—
5/25/2023	*Vet Center Inspection of North Atlantic District 1 Zone 4 and Selected Vet Centers*	21-03269-123	1–2, 8–9	—

* 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 Recommenda-tions	Potential Cost Savings
6/7/2023	*Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania*	22-02960-70	4	—
9/7/2023	*VHA Faces Challenges Implementing the Appeals Modernization Act*	22-02064-155	1–4, 6–14	—
9/27/2023	*VA Should Strengthen Enterprise Cloud Security and Privacy Controls*	22-03525-195	3	—
9/27/2023	*Inspection of Information Security at the VA El Paso Healthcare System in Texas*	23-01179-204	5, 7	—
9/28/2023	*Inspection of Information Security at the VA Dublin Healthcare System in Georgia*	23-01138-203	5	—
12/14/2023	*VA Needs to Conduct Seismic Evaluations on Critical and Essential Buildings to Effectively Prioritize Program Funds*	22-00410-197	1	—

* 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 Recommenda-tions	Potential Cost Savings
1/17/2024	*VA Should Enhance Its Oversight to Improve the Accessibility of Websites and Information Technology Systems for Individuals with Disabilities*	22-03909-19	1, 3, 5	–
2/8/2024	*Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk*	21-03255-02	5	–
2/21/2024	*Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*	23-00153-41	1	$3,300,000
4/4/2024	*Deficiencies in Attention Deficit Hyperactivity Disorder Diagnostic Assessment, Evaluation of Stimulant Medication Risks, and Policy Guidance*	22-03013-129	5	–
6/5/2024	*Inspection of Information Security at the VA Bedford Healthcare System in Massachusetts*	23-02330-127	9	–
6/27/2024	*VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits*	23-01266-78	1	$1,008,400,000

* 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 Recommendations	Potential Cost Savings
7/17/2024	*VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability*	23-01772-162	1	$100,000,000
7/23/2024	*Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*	23-00995-211	3, 6	–
9/12/2024	*Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management*	23-02123-202	2, 4–6	–
9/18/2024	*Additional Controls Are Needed to Improve the Reliability of Grant and Per Diem Program Data*	23-02610-226	1–3	–
9/23/2024	*VA Needs to Strengthen Controls to Address Electronic Health Record System Major Performance Incidents*	22-03591-231	1, 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 Recommenda-tions	Potential Cost Savings
9/25/2024	*Alleged Mismanagement of Contracts for Wheelchair-Accessible Transportation Services by the Health Administration Service at the Dallas VA Medical Center in Texas*	23-03128-213	2	$3,739,068
9/25/2024	*VHA Needs to Establish Controls for Its Ambulatory Care Budget Estimate*	23-01624-243	1–2	–
10/24/2024	*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*	23-03526-07	2–3	–
11/14/2024	*VBA Did Not Ensure Employees Sent Some Letters Using Its Package Manager Application*	23-00547-187	1	–
1/8/2025	*Inspection of Pacific District 5 Vet Center Operations*	24-00390-41	4–5	–

* 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 Recommendations	Potential Cost Savings
2/4/2025	*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*	24-00234-53	8	–
2/20/2025	*Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services*	23-00748-28	3, 5	$910,700,000
3/5/2025	*Ensuring Grantee Compliance with Veteran Care and Safety Requirements in Transitional Housing: Lessons Learned from San Diego*	22-03076-65	1–3	–
3/19/2025	*Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight*	24-01143-44	3, 5–8	–

* 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 Recommenda-tions	Potential Cost Savings
3/27/2025	*The Causes and Conditions That Led to a $12 Billion Supplemental Funding Request*	24-03127-66	1, 3	–
3/31/2025	*Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*	23-02350-95	1–2, 4	–
4/3/2025	*VHA Should Improve Monitoring of Underground Storage Tanks to Minimize Environmental and Health Risks at VA Medical Facilities*	24-00295-49	3, 7	–
4/8/2025	*Independent Audit Report on a Transportation Company's Billing Practices Under a VA Healthcare System Contract*	22-02369-48	1	$1,811,694
4/10/2025	*Healthcare Facility Inspection of the VA Western Colorado Healthcare System in Grand Junction*	24-00595-93	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 Recommenda-tions	Potential Cost Savings
4/24/2025	*Integrated Financial and Acquisition Management System Interface Development Process Needs Improvement*	24-00645-84	1–2	–
5/22/2025	*Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia*	24-00617-118	3–5	–
5/29/2025	*VBA's Special Monthly Compensation Calculator in the Veterans Benefits Management System for Rating Did Not Always Produce Accurate Results*	24-01083-112	1	–
6/12/2025	*Recruitment, Relocation, and Retention Incentives for VHA Positions Need Improved Oversight*	23-01695-94	1–3, 6, 8	$345,532,795
6/12/2025	*Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia*	24-00606-137	2–4, 6–7	–
6/26/2025	*Mental Health Inspection of the VA Salem Healthcare System in Virginia*	24-01861-144	2	–

* 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 Recommenda-tions	Potential Cost Savings
6/26/2025	*Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*	24-01862-151	1, 3–4	—
7/1/2025	*VA Needs to Prioritize Accessibility for Individuals with Disabilities When Procuring Information Technology Systems*	24-02142-105	1–4	—
7/10/2025	*Healthcare Facility Inspection of the Sheridan VA Health Care System in Wyoming*	24-00615-163	2–3	—
7/17/2025	*Deficiencies in Crisis Management of a Client, Crisis Reporting, and Documentation Practices at the Everett Vet Center in Washington*	24-02690-167	4–6	—
7/29/2025	*Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan*	24-00824-174	8, 11–13	—

* 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 Recommendations	Potential Cost Savings
7/30/2025	*Implementation of a Military Sexual Trauma Operations Center Resulted in Minimal Change Despite Planned Intent to Improve Claims-Processing Accuracy*	24-01429-145	3	—
8/7/2025	*Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records*	24-02154-154	10	—
8/13/2025	*VA Can Strengthen Appeals Processing and Tracking by Improving Caseflow Program Management*	24-01457-114	2	—
8/21/2025	*Former Acquisition Academy Executive Violated Ethical Standards and VA Policy*	23-03768-204	1–2	—
9/4/2025	*Improved Oversight of VHA's Nonexpendable Equipment Is Needed*	24-01676-153	3–4, 6	$210,900,000

* 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 Recommendations	Potential Cost Savings
9/4/2025	*Facilities Need to Fully Implement VHA's Strategic Planning and Request Process for Nonexpendable Medical Equipment*	24-02295-155	1	–
9/10/2025	*Weak Governance Threatens the Viability of a Major Construction Project at the Palo Alto VA Medical Center in California*	23-03189-148	1–3	$1,624,411,962
9/10/2025	*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*	24-00982-147	1–2, 4	–
9/11/2025	*Deficiencies in VA Homeless Program Intake Documentation, Suicide Risk Assessment, and Care Coordination Processes*	23-02507-210	2, 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 Recommendations	Potential Cost Savings
9/24/2025	*Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians*	24-03319-213	2	—
9/25/2025	*Loma Linda Healthcare System's Oversight of Community-Based Outpatient Clinic Contracts Needs Strengthening*	23-00324-170	5, 7	—
9/26/2025	*VHA Did Not Effectively Oversee the Use of Manual Journal Vouchers*	25-00451-200	1–2, 4	—
9/30/2025	*Better Controls Needed to Accurately Determine Decisions for Veterans' Nonpresumptive Conditions Involving Toxic Exposure Under the PACT Act*	23-03357-156	3	—
9/30/2025	*The Accuracy of Veteran Readiness and Employment Claims Cannot Be Assessed Because of Insufficient Documentation*	23-03328-197	1–2, 4–5	$309,500,000

* 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 Recommenda-tions	Potential Cost Savings
9/30/2025	*Widespread Failures in Response to Suspected Community Living Center Resident Abuse at the VA New York Harbor Healthcare System in Queens*	24-01092-228	5–6	–
10/8/2025	*Review of Clinical Contact Centers to Assess Leadership and Oversight*	25-00228-214	1–3, 5–7	$17,273,700
10/10/2025	*Healthcare Facility Inspection of the Eastern Oklahoma VA Health Care System in Muskogee*	25-00194-239	2–3	–
10/14/2025	*Inspection of Midwest District 3 Vet Center Operations*	24-00392-240	3	–
11/19/2025	*Healthcare Facility Inspection of the Miami VA Healthcare System in Florida*	25-00196-05	1, 3–5	–
11/19/2025	*Healthcare Facility Inspection of the Minneapolis VA Health Care System in Minnesota*	24-03416-237	2	–

* 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 Recommendations	Potential Cost Savings
11/20/2025	*Review of Quality of Care for Patients Seeking Acute Mental Health Care at the Lexington VA Healthcare System in Kentucky*	25-00349-10	1	—
12/2/2025	*Audit of Funding Fee Refunds for Veterans Using Dual Entitlement on VA Joint Home Loans*	25-00824-227	2	—
12/2/2025	*Review of VISN 21 Clinical Resource Hub Sleep Medicine Physician Privileging*	25-00302-243	4	—
12/4/2025	*Review of Veterans Health Administration's National Teleradiology Program*	25-01255-242	3–5	—
12/9/2025	*Audit of Homeless Screening Clinical Reminder Process*	25-00077-215	1–4	—
12/10/2025	*Healthcare Facility Inspection of the VA Sioux Falls Health Care System in South Dakota*	24-03420-18	5	—
12/17/2025	*Healthcare Facility Inspection of the VA Gulf Coast Healthcare System in Biloxi, Mississippi*	25-00205-26	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 Recommendations	Potential Cost Savings
12/18/2025	*Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia*	24-03520-20	5, 7–13, 16	–
12/18/2025	*Mental Health Inspection of the VA NY Harbor Healthcare System in New York*	25-00729-23	3, 5–9, 11–12, 17	–
1/8/2026	*Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois*	24-02987-27	3	–
1/13/2026	*National Review of Mental Health Integration and Suicide Risk Identification in Audiology Clinic Settings*	24-00560-29	2–3, 5	–
1/13/2026	*Supplemental Review of VHA Recruitment, Relocation, and Retention Incentive Service Obligations*	25-00631-211	1, 3	$17,511,510
1/15/2026	*Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York*	25-02192-39	8	–

* 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 Recommendations	Potential Cost Savings
1/22/2026	*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*	25-00421-37	6, 8–9	—
1/28/2026	*Healthcare Facility Inspection of the VA Central Alabama Health Care System in Montgomery*	24-03419-34	2–11, 13–14	—
2/17/2026	*Audit of Integrated Financial and Acquisition Management System Access Controls*	25-00529-219	1–3	—
2/18/2026	*Inspection of Information Security at the VA Spokane Healthcare System in Washington*	25-00975-234	2–6	—
2/24/2026	*Healthcare Facility Inspection of the VA Eastern Colorado Health Care System in Aurora*	25-00200-48	1–6, 8–9	—
3/6/2026	*Audit of Community-Based Outpatient Clinic Contracts*	24-00900-230	1–11	—

* 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 Recommendations	Potential Cost Savings
3/11/2026	*Mental Health Inspection of the Lexington VA Healthcare System in Kentucky*	24-03543-78	3, 8	–
3/12/2026	*Healthcare Facility Inspection of the VA Loma Linda Healthcare System in California*	25-00208-64	4–8	–
3/31/2026	*Inspection of Select Vet Centers in North Atlantic District 1 Zone 4*	25-00373-95	1, 4	–
3/31/2026	*Inspection of Select Vet Centers in North Atlantic District 1 Zone 2*	25-00371-97	10	–
3/31/2026	*Inspection of Select Vet Centers in North Atlantic District 1 Zone 1*	25-00369-98	1–2	–
Total				**$5,027,880,729**

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

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 405(b), 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 (Report No. 25-01268-16, January 27, 2026). This report is also included in the Semiannual Report to Congress for the period ending March 31, 2026.

(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)[33];

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

[33] 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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