Department of Health and Human Services

Office of Inspector General

Semiannual Report to Congress

October 1, 2025–March 31, 2026

Contents

A Message From the Inspector General

I am pleased to submit this *Semiannual Report to Congress* summarizing the activities of the Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) for the 6-month period ending on March 31, 2026.

During this period, OIG remained at the forefront of efforts to fight fraud, waste, and abuse in HHS programs. OIG generated a monetary impact of $5.56 billion and excluded 1,212 individuals and entities from Federal programs, safeguarding taxpayer dollars and protecting people enrolled in Federal programs from harm. Federal programs are designed to serve the people who rely on them most, including seniors, people with disabilities, low-income families, and individuals struggling with addiction. Fraudsters put these lifelines at risk by stealing taxpayer funds that are meant to support essential care.

OIG is determined to hold bad actors accountable. Notable actions include convictions of individuals running sham hospices, identification of improper payments and vulnerabilities in emerging risk areas such as Medicaid payments for autism services, and uncovering gaps in foster care systems that contributed to failures to track and find missing children. Enforcement actions spanned all aspects of the health care system, including:

- A software company CEO running a billion-dollar telemedicine and durable medical equipment scheme, sentenced to 15 years in prison and ordered to pay $452 million in restitution
- An insurance broker and marketing executive enrolling vulnerable individuals in Affordable Care Act plans without their consent, each sentenced to 20 years in prison and ordered to pay $180 million in restitution

One of the most important issues OIG is focused on is fighting fraud in Medicaid. Medicaid Fraud Control Units (MFCUs) are on the front lines of investigating and prosecuting fraud. OIG is working with MFCUs to ensure that they effectively fulfill their obligation to root out fraud. OIG's work with MFCUs last year resulted in 1,185 convictions and more than $2 billion in recoveries, demonstrating that there are high-performing MFCUs.

OIG also remains committed to ensuring the solvency of the Medicare Trust Fund through oversight of Medicare Advantage (MA). OIG's efforts resulted in two settlements totaling $674 million to resolve False Claims Act allegations. These cases involved two of the largest MA organizations and were based on whistleblower allegations that the plans received inflated payments from the Government by submitting inaccurate diagnoses that made their enrollees appear sicker than they were. Bringing bad actors to justice is only one step in safeguarding HHS's programs. OIG also works to support better program integrity—protecting HHS programs from fraud before it happens. To support program integrity across the MA industry, OIG issued the *Medicare Advantage Industry Segment-Specific Compliance Program Guidance*, a key resource

that identifies potential risk areas and offers practical pointers for effective compliance programs grounded in OIG's body of work.

OIG's innovative, multidisciplinary workforce includes law enforcement agents, auditors, evaluators, attorneys, program analysts, and data analysts. OIG is unwavering in its commitment to root out fraud, waste, and abuse, and promote the economy, efficiency, and effectiveness of HHS programs. The value of OIG's work is clear; for every dollar in funding that OIG receives, it returns $12.70 to the Federal Government. I am proud to lead this organization and am committed to using OIG's authorities to fight fraud, waste, and abuse and protect people who rely on Federal health care programs. I appreciate the continued support of Congress and HHS for OIG's critical work.

/s/
T. March Bell
Inspector General

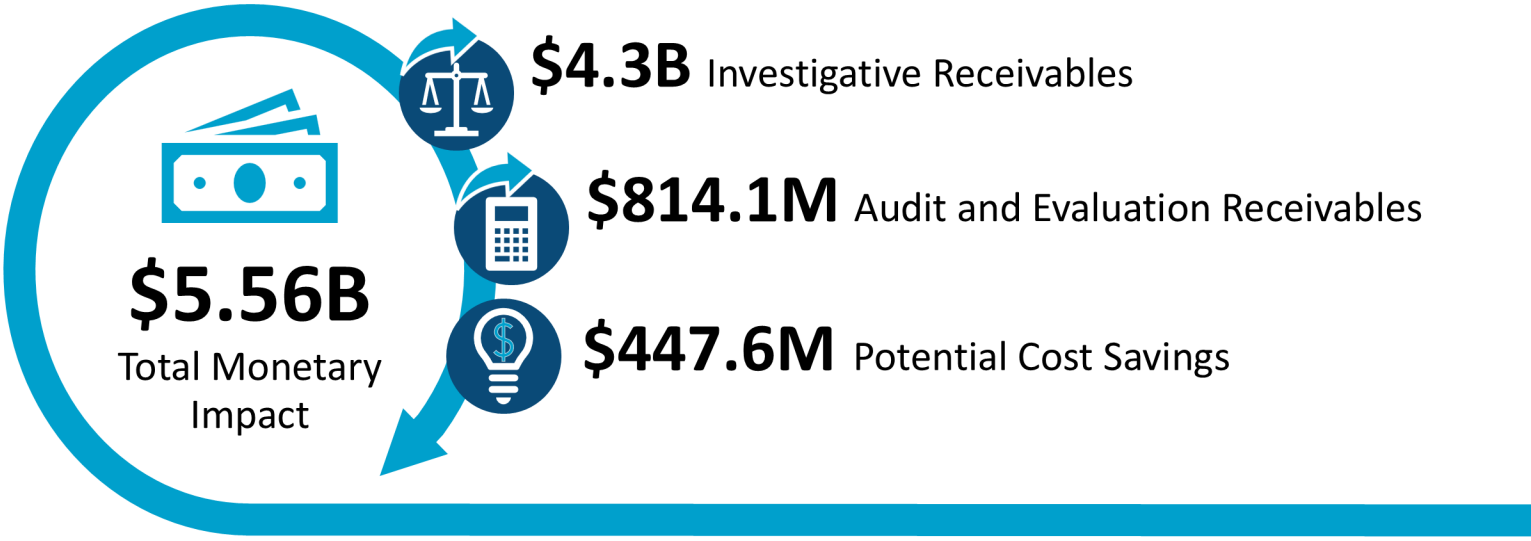
At a Glance:

OIG Accomplishments

October 1, 2025–March 31, 2026

MONETARY IMPACT*†

OIG's work returns $12.70 in expected recoveries and receivables for every $1 invested.



OVERSIGHT ACTIVITIES

- **78** Reports Issued
- **173** Recommendations Issued
- **881** Investigations Completed
- **182** Recommendations Implemented

*Totals in appendices may differ and numbers in figures may not sum due to rounding.
†See Appendix E for an explanation of terms.

ENFORCEMENT ACTIONS

- **1,212** Excluded Individuals and Entities
- **245** Criminal Informations and Indictments
- **1,168** Criminal Referrals
- **317** Criminal Actions
- **287** Civil Actions

Introduction

The Inspector General Act of 1978 (codified at 5 U.S.C. chapter 4), as amended, requires that the Inspector General report semiannually to the head of the Department of Health and Human Services (HHS or the Department) and to Congress on the activities of the Office of Inspector General (OIG). This spring 2026 semiannual report is intended to keep the Secretary and Congress fully informed of significant oversight work completed during the reporting period (October 1, 2025–March 31, 2026). To do so, this report highlights and summarizes select examples of significant oversight and enforcement actions completed during the reporting period. The report appendices also provide comprehensive data related to all of OIG's work completed in this reporting period, including a full list of OIG audits and evaluations issued to HHS.

For more information about all of OIG's work and accomplishments, please visit:

- OIG's website: Includes the full breadth of OIG's oversight and enforcement work, including all reports available by issue area and HHS agency
- OIG's Recommendations Tracker website: Includes all OIG recommendations to improve Department programs and reduce vulnerabilities, including those OIG has identified as top unimplemented recommendations
- OIG's Enforcement Actions website: Includes all criminal, civil, or administrative legal actions relating to fraud and other alleged violations of law that OIG and its law enforcement partners have initiated or investigated

1 | Combating Health Care Fraud

Millions of American seniors, individuals with disabilities, individuals in low-income households, and individuals with diseases and other complex health needs rely on Medicare and Medicaid for health care coverage. Given the importance of Medicare and Medicaid, protecting these programs from fraud, waste, and abuse is a critical priority. OIG is the leading Federal agency focused on combating health care fraud. OIG works in every State and actively coordinates with the Department of Justice (DOJ); the President's Task Force to Eliminate Fraud; and other Federal, State, Tribal, and local law enforcement agencies. OIG's ability to fight fraud is possible because of cutting-edge technology and the specialized skills of investigators, auditors, evaluators, data scientists, attorneys, and other experts. This approach resulted in a return on investment for OIG's Medicare and Medicaid work of $15.20 for every $1 for FY 2025, based on a 3-year rolling average.

Criminal and Civil Enforcement Actions

OIG uses its enforcement authorities to hold bad actors accountable and help recover stolen taxpayer dollars from fraudsters. OIG's investigations of health care fraud and abuse during this reporting period led to 317 **criminal actions,** including criminal convictions. OIG investigations of violations of the civil False Claims Act led to 287 **civil actions,** including civil settlements and judgments. Selected examples are below.

- ***Health Care Software Company CEO:*** In one of the largest telemarketing Medicare fraud verdicts, the CEO of Power Mobility Doctor Rx, LLC, a health care software company, was sentenced to 15 years in prison and ordered to pay $452 million in restitution after being convicted of conspiracy to commit health care fraud and other related crimes. He orchestrated a telemedicine and durable medical equipment fraud scheme worth more than $1 billion by targeting Medicare beneficiaries with misleading mailers, calls from offshore call centers, and sham telehealth consults to produce medically unnecessary orders.

- ***Wound Graft Company Owners:*** The owners of several wound graft companies were sentenced to prison, ordered to pay criminal restitution, and agreed to pay a settlement to resolve parallel civil False Claims Act liabilities. The couple ran a nationwide scheme that targeted Medicare beneficiaries, many in hospice care, by using untrained sales staff to generate orders for medically unnecessary, oversized bioengineered skin grafts. They also accepted hundreds of millions of dollars in illegal kickbacks and directed nurse practitioners to apply unwarranted grafts, resulting in more than $1.2 billion in fraudulent claims submitted to Federal health care programs.

CASE OUTCOMES

Wound Graft False Claims Fraud

- More than **$614.9M** in criminal restitution
- **$410.7M** in forfeitures
- **$309.9M** in civil settlements
- **29.5 total years** in prison

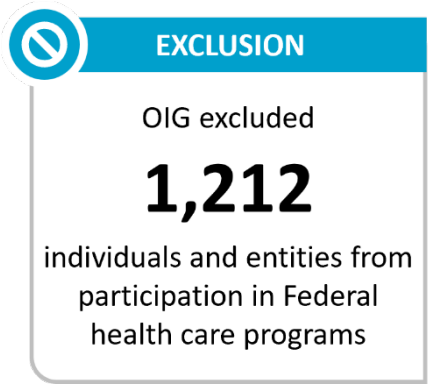
- ***Hospice Operators:*** Four California hospice operators were sentenced to prison terms ranging from 15 to 57 months and collectively ordered to pay nearly $12.5 million in restitution after being convicted of health care fraud and money laundering for operating four sham hospices. They submitted nearly $16 million in false Medicare claims for services that were medically unnecessary or never provided, used straw owners and shell

bank accounts to conceal their identities, and then laundered the proceeds through fabricated documents and offshore accounts.

- ***Insurance and Marketing Executives*:** An insurance brokerage executive and marketing firm CEO were each sentenced to 20 years in prison and ordered to pay $180.6 million in restitution after being convicted of conspiracy related to a $233 million Affordable Care Act (ACA) enrollment fraud scheme. They orchestrated a long-running operation targeting tens of thousands of vulnerable individuals, often those experiencing homelessness or mental health or substance abuse issues, by submitting false applications to enroll them in fully subsidized ACA health plans for which they were ineligible, using deceptive scripts, bogus documents, straw owners, and offshore accounts to conceal the scheme.

Program Exclusions

OIG excluded 1,212 individuals and entities from participation in Federal health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded cannot receive payment from Federal health care programs for any items or services they furnish, order, or prescribe. Selected examples are below.



- ***Chief Executive Officer:*** The CEO of two drug manufacturing companies was excluded from Federal health care programs for a minimum period of 15 years based on his conviction for distributing an unapproved drug with misleading claims about its safety and effectiveness. The CEO marketed injectable stem-cell products with false claims that the products were effective and suitable treatments for a variety of conditions such as heart and lung diseases. He also directed an employee of one of the companies to submit false information to the Food and Drug Administration (FDA) in its registration submission to the agency.

- ***Rheumatologist:*** A Texas rheumatologist was excluded from Federal health care programs for 50 years after multiple convictions related to a health care fraud scheme involving more than $118 million in false claims. The doctor falsely diagnosed patients with chronic illnesses to bill for tests and treatments that were medically unnecessary, and these false diagnoses led patients to believe that they had life-long, incurable diseases, causing them to regularly undergo unnecessary treatments, including injections, infusions, and X-rays.

OIG Hotline

OIG investigates tips received through its hotline, which accepts reports from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. During the reporting period, OIG evaluated and processed 40,815 tips leading to 21,371 referrals to entities such as OIG's investigative and legal branches, HHS Operating Divisions, and other Federal agencies. Additionally, during the reporting period, investigations previously initiated through hotline tips resulted in 27 criminal and civil actions associated with expected recoveries of more than $226.2 million. See Appendix C for additional information on OIG's hotline activity during this reporting period.

OIG Combats Medicaid Fraud

Medicaid accounts for nearly **$1** out of every **$5** spent on health care.

Fighting Medicaid fraud is a top OIG priority. OIG works closely with partners and uses every enforcement tool at its disposal to help ensure that taxpayer dollars are safeguarded and Medicaid is protected from fraud, waste, and abuse. Below we highlight the ways in which OIG has used the law enforcement tools to combat Medicaid fraud during the reporting period.

Medicaid Fraud Control Units

OIG works closely with Medicaid Fraud Control Units (MFCUs), which operate in each of the 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. In fiscal year (FY) 2025, MFCU work, including work done in conjunction with OIG, resulted in 1,185 convictions, 900 exclusions from federally funded programs, 674 civil settlements and judgments, and more than $2 billion recovered (OEI-09-26-00140).

$2B

RECOVERED

In FY 2025 MFCUs recovered **$4.64** for every **$1.00** spent.

Civil Enforcement Action

Two now-dissolved Connecticut dental practices, Dent Plus Family Dentistry and L&M Family Dentistry, and their owners agreed to pay $714,446 to resolve allegations that they submitted kickback-tainted claims to the Connecticut Medical Assistance Program for treating Medicaid patients referred by a third-party recruiting company. OIG determined the dental practices paid per-patient referral fees in violation of Federal and State False Claims Acts and the anti-kickback statute.

Administrative Enforcement Action

A professional counselor was excluded from participation in Federal health care programs for a period of 10 years based on his convictions for larceny, health insurance fraud, and identity theft. The counselor was the sole owner and principal of a behavioral health practice. He submitted false and fraudulent claims for psychotherapy services, billing the Connecticut Medicaid program for services that were either not provided or were performed by unlicensed individuals.

Criminal Enforcement Action

A mother and daughter were sentenced to pay more than $3.6 million in restitution to the Maryland Medicaid program for orchestrating a fraud scheme that used forged records, stolen identities, and fabricated patient files to bill for behavioral health services that never occurred. The mother was sentenced to 5 years in prison, and the daughter was sentenced to 5 years of supervised probation. While already on the HHS-OIG List of Excluded Individuals/Entities for a prior Medicaid fraud conviction, the mother secretly operated new behavioral health companies and submitted false claims while her daughter managed billing activities. The companies falsely billed Maryland Medicaid for services using fabricated documentation and stolen identities of both providers and beneficiaries.

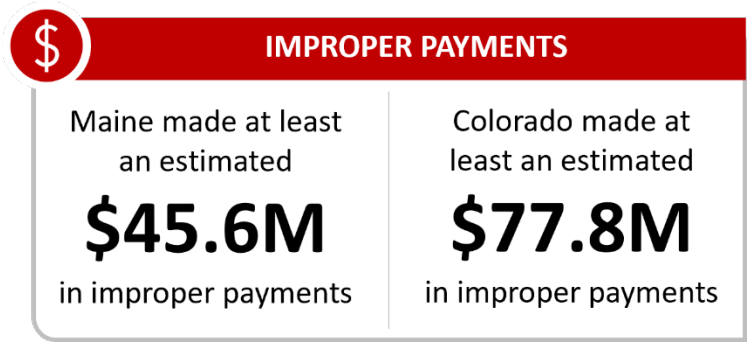
See OIG's Enforcement Actions for more information on criminal, civil, or administrative legal actions relating to fraud and other alleged violations of law, initiated or investigated by OIG and its State Enforcement Agency partners.

2 | Strengthening Financial Integrity

Preventing and Detecting Improper Payments

The Centers for Medicare & Medicaid Services (CMS) estimates a range of FY 2025 program-specific improper payment rates from 4.0 percent to 6.6 percent, resulting in more than $95 billion in payments that either failed to meet legal requirements or were issued in incorrect amounts. Improper payments duplicate other payments, fund ineligible services, enrich ineligible providers, serve ineligible recipients, or violate other program rules. OIG's oversight plays a critical role in preventing and detecting improper payments, which can jeopardize the integrity of CMS programs. Selected examples are below.

Autism Services Payments



OIG found that Maine and Colorado made improper and potentially improper fee-for-service Medicaid payments for services including applied behavior analysis, a behavioral therapy typically used to help individuals with autism. Both States saw large increases in Medicaid payments for applied behavior analysis since 2019, and, for both States, OIG identified an issue with all sampled items. In total, Maine made at least an estimated $45.6 million ($28.7 million Federal share) in improper payments and an estimated $22.4 million ($14.2 million Federal share) in potentially improper payments. Colorado made at least an estimated $77.8 million ($42.6 million Federal share) in improper payments and an estimated $207.4 million ($112.5 million Federal share) in potentially improper payments. Maine and Colorado made these improper and potentially improper payments because they did not provide effective oversight of fee-for-service Medicaid payments for autism therapy, including applied behavior analysis (A-01-24-00006, A-09-24-02004).

Durable Medical Equipment Payments

OIG found that $22.7 million in Medicare payments to suppliers for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided during inpatient stays over a 7-year period should not have been paid. Medicare generally should not pay suppliers for DMEPOS items provided during inpatient stays, but system edits to CMS's claims processing system for Medicare Parts A and B were not working properly to prevent or detect such overpayments. Of the $22.7 million, $18.2 million (about 80 percent) were made in the 2 years before CMS modified the system edits based on previous OIG recommendations; after CMS modified the edits, there was a significant reduction in improper payments, with the remaining $4.5 million in improper payments occurring over a 5-year period (OAS-24-09-005).

Fostering Cost-Effectiveness

OIG's audits and evaluations promote efficiency, effectiveness, and accountability across HHS programs, often identifying opportunities for significant savings when its recommendations are implemented. During this

reporting period, OIG identified **$447.6 million in potential savings** and issued **173 recommendations** aimed at strengthening program performance and integrity. Selected examples are below.

CMS Contract Closeout Process

OIG found that CMS did not close selected contracts totaling $11.2 billion in accordance with administrative closeout requirements, with contracts totaling $2.1 billion remaining overdue for closeout at the conclusion of the audit. By not complying with administrative closeout requirements, CMS put $11.2 billion of contract funds at risk of fraud, waste, and abuse. In addition, had CMS performed contract funds reviews as required, it could have potentially redirected $438.6 million to other project needs or returned those funds to the U.S. Treasury (A-04-24-02048).

MONETARY RISK

CMS put

$11.2B

at risk of fraud, waste, and abuse by not properly closing contracts

Opioid Use Disorder Treatment Services Payments

OIG found that 89 of 100 sampled items related to opioid use disorder treatment services had higher bundled payments than the OIG-calculated payment amounts based on the opioid use disorder services actually provided. OIG estimated that Medicare could have saved $301.5 million (53 percent of the $564.6 million in total payments) if the bundled payment rate methodology developed by CMS had reflected the types and frequency of treatment services provided to Medicare enrollees (A-09-23-03002).

POTENTIAL SAVINGS

CMS could have potentially saved an estimated

$301.5M

by implementing OIG's recommendations

Continuous Glucose Monitoring Payments

OIG found that Medicare can save at least tens of millions of dollars annually when paying for continuous glucose monitors (CGMs) and supplies. CGMs and supplies provide patients with wearable technology that can help manage diabetes by tracking glucose levels every few minutes. OIG found that payments for CGMs and supplies rose from $109 million in 2018 to $1.3 billion in 2023. OIG also found that Medicare paid an estimated $70 million more (8 percent) than suppliers' estimated total cost and $377 million more (69 percent) than suppliers' acquisition costs for CGMs. These figures indicate that there are potential cost savings for Medicare and enrollees due to the difference between Medicare payments and suppliers' costs (OEI-04-23-00430).

Noncovered Versions of Stelara Biosimilars Under Part B

OIG found that current payment policy resulted in considerably higher Medicare prescription costs for Stelara biosimilar drugs that are used to treat certain autoimmune diseases. When Medicare calculates Part B payment amounts for Stelara biosimilars, it includes self-administered versions of these drugs that Medicare Part B does not cover. OIG found that if these noncovered versions were excluded, Medicare and its enrollees would have paid 59 to 87 percent less—up to $3,765 less per vial—in the fourth quarter of 2025. Even more concerning, the resulting payment amounts for three of these Stelara biosimilars exceeded those of the brand version of Stelara (OEI-BL-25-00240).

Medicare and its enrollees would have paid between

59% and 87%

less if noncovered self-administered versions were excluded

Protecting the Fiscal Integrity of Managed Care

In 2025, Medicare Advantage, Medicare's managed care program, served nearly 35 million enrollees and accounted for $537 billion in Medicare spending. The most recent Medicaid data available shows that in 2024, more than 66 million Medicaid enrollees received care through managed care organizations (MCOs), with combined Federal and State payments totaling approximately $460 billion. Given the scale of enrollment and expenditures, OIG has prioritized oversight of managed care. This includes sharing tools and guidance with managed care organizations so they can prevent fraud through compliance programs, using enforcement tools to ensure that bad actors are held accountable, and conducting comprehensive financial reviews. Selected examples are below.

Managed Care Compliance Guidance

OIG's *Medicare Advantage Industry Segment-Specific Compliance Program Guidance* (MA ICPG) is the latest in OIG's ongoing series of updates to its longstanding voluntary compliance guidance documents. The MA ICPG is a key resource for compliance professionals and others in the Medicare Advantage industry to further the goals of reducing fraud, waste, and abuse and advancing voluntary compliance. Like OIG's other compliance program guidance documents, the MA ICPG identifies potential industry risk areas and offers practical pointers for effective compliance programs grounded in OIG work and collaboration with partners. The MA ICPG discusses potential risk areas specific to individuals and entities participating in the Medicare Advantage program, such as utilization management and prior authorization, problematic marketing and enrollment practices, and risk adjustment. The MA ICPG also offers concrete steps that stakeholders can take to help alleviate those risks.

Managed Care Enforcement Actions

- ***National Insurer Affiliates:*** Five Kaiser Permanente affiliates agreed to pay $556 million to resolve False Claims Act allegations that they systematically submitted invalid diagnosis codes for Medicare Advantage enrollees to receive inflated Government payments. From 2009 to 2018, the affiliates pressured physicians through financial incentives and internal goals to retroactively add unrelated and unsupported diagnoses via medical record addenda, in violation of CMS risk-adjustment requirements.

- ***National Insurer:*** Aetna agreed to pay $117.7 million to resolve allegations under the False Claims Act that it submitted, or failed to retract, inaccurate Medicare Advantage diagnosis codes to inflate payments from CMS. The insurer certified and maintained false and unsupported patient diagnoses, including for morbid obesity and chart review coding, resulting in overpayments.

CASE OUTCOMES

Medicare Advantage Upcoding Fraud

- **$556M** settlement with Kaiser Permanente
- **$117.7M** settlement with Aetna

Deceased Enrollee Payments

OIG found that Medicaid agencies in 35 States plus Puerto Rico and Washington, DC, made an estimated $207.5 million ($138.6 million Federal share) in unallowable capitation payments to Medicaid MCOs for deceased enrollees over a 1-year period. After the audit period, CMS began conducting audits of certain Medicaid agencies and issued guidance to Medicaid agencies about available data sources. Beginning in 2027, a provision of the One Big Beautiful Bill Act will introduce new requirements for verification to determine whether Medicaid enrollees are deceased (A-04-23-09010).

3 | Protecting People From Harm

Protecting Children

OIG works to protect vulnerable beneficiaries, such as children, in many ways, including conducting reviews to examine compliance with program requirements intended to enhance child well-being and safety. OIG also exercises its enforcement tools and authorities to ensure that individuals who cause harm to this vulnerable population are held accountable for misconduct. Selected examples are below.

American Indian and Alaska Native Children Missing From Foster Care

OIG found that in 2023 Alaska missed opportunities to protect American Indian and Alaska Native (AI/AN) children missing from foster care. Nationwide, AI/AN children go missing at an alarmingly high rate. OIG found that Alaska, as documented in its case management system, often did not notify parties who could assist with locating children and returning them to foster care and did not take additional steps (beyond notifications) to locate children and return them to foster care, as required. Alaska also missed opportunities to protect these children from the risks associated with these incidents, such as assessing children for signs of sex trafficking and determining their experiences while missing or after running away, as required (OEI-07-23-00480).

Background Investigations for Individuals Who Work With AI/AN Children

OIG found that Commissioned Corps Officers assigned to provide health care services to Tribal and Indian Health Service-operated health programs did not receive background investigations in accordance with Federal requirements. Because none of the Officers' background investigations were adjudicated based on Federal requirements, some Officers may have been favorably adjudicated despite disqualifying conduct; consequently, AI/AN children who received health care services at Indian Health Service and Tribal health programs may have been placed at an increased risk of harm (A-01-24-01500).

Enforcement Actions Related to Children

- ***Minnesota Personal Care Assistant:*** A Minnesota mother, approved to provide personal care assistant services through a Minnesota Medicaid-funded organization, was excluded from Federal health care programs for a period of 55 years based on her convictions for attempted murder, child torture, stalking, and theft by false representation. She engaged in a pattern of medical abuse toward her three children resulting in unnecessary or inappropriate medical treatment.

- ***Physician:*** A Michigan physician was excluded from Federal health care programs for a minimum period of 60 years based on his conviction for multiple counts of criminal sexual conduct. The physician sexually assaulted teen and young adult patients under the guise of performing medical care. The physician's offense involved at least 13 victims.

Ensuring Nursing Home Resident Safety

In 2025, approximately 1.2 million individuals lived in nearly 15,000 certified nursing homes. Building on decades of oversight, OIG continues to uncover systemic challenges in nursing home care. When warranted, OIG investigates misconduct that endangers residents' health and safety and pursues enforcement actions against individuals and entities responsible for abuse or neglect. Selected examples are below.

Use of Antipsychotics in Nursing Homes

OIG found instances of inappropriate use of antipsychotic drugs and vulnerabilities in care that have implications for nursing home residents. For example, nursing homes gave antipsychotic drugs to residents with dementia to manage their behavior for the benefit of staff, despite FDA's warning that these drugs may increase the risk of death (OEI-02-23-00200). OIG also found instances of nursing homes inappropriately diagnosing residents with schizophrenia to mask the nursing homes' misuse of antipsychotic drugs, to artificially inflate their star ratings, or to skirt Medicare safeguards intended to protect residents. By inappropriately diagnosing schizophrenia, nursing homes compromised residents' care (OEI-02-23-00201).

CMS's Special Focus Facility Program

The Special Focus Facility (SFF) program is CMS's flagship program to address quality problems at the Nation's poorest performing nursing homes with track records of serious noncompliance. However, OIG found the SFF program is not working because most nursing homes that graduate from the program do not keep the improvements they made over the long term. Specifically, between 2013 and 2022, nearly two-thirds of the nursing homes that were in the SFF program improved enough to graduate but soon after showed the type of quality problems (e.g., infection control) that put them in the SFF program in the first place (OEI-01-23-00050). Read more about these nursing homes in OIG's related Data Snapshot (OEI-01-23-00052).

64%

of nursing homes received a serious deficiency within 3 years of graduating from the SFF program

Nursing Home- and Nursing Facility-Related Enforcement Actions

- ***Nursing Home Owners and Related Entities:*** Ten individuals and entities were excluded from Federal health care programs for an indefinite period based on their suspension and disqualification from participation in the New Jersey Medicaid program. The New Jersey actions stemmed from an investigation into a pattern of waste and abuse of public funds that occurred at South Jersey Extended Care, a for-profit nursing facility. The individuals controlling the facility caused it to enter multiple service and supply contracts with entities owned and controlled by themselves and other co-conspirators. As a result of cost-cutting measures, residents of the facility suffered neglect, abuse, unsanitary conditions, and inadequate medical care.

- ***Skilled Nursing Facility and Owner:*** Skilled nursing facility Atrium Health and Senior Living and its CEO were sentenced after being convicted of health care fraud and tax conspiracy. The CEO was sentenced to 90 months in Federal prison, and both Atrium and the CEO were ordered to pay $146 million in restitution and $8.4 million in forfeiture. The subjects diverted millions in Medicare and Medicaid funds intended for resident care, including money earmarked for staffing, payroll taxes, insurance premiums, and resident trust accounts, to enrich themselves and the company owners. Their actions left residents in understaffed, unsafe facilities while the organization falsely certified compliance with Federal requirements.

4 | Addressing Public Health Crises

Opioids and Other Controlled Substances

The overdose crisis remains a pressing national challenge, with more than 70,000 overdose deaths in FY 2025. To combat this crisis, OIG works to ensure that those who commit fraud or engage in harmful conduct such as the unlawful distribution of controlled substances are held accountable. OIG takes civil, criminal, and administrative actions against individuals and entities that defraud HHS programs by illegally prescribing or distributing opioids and other controlled substances. Selected examples are below.

Enforcement Actions To Address Illegal Prescribing and Distribution

- ***Physician:*** A physician and owner of a Louisiana-based clinic was excluded from Federal health care programs for a period of 23 years based on his convictions for conspiracy to distribute and distributing controlled substances, conspiracy to commit health care fraud, and maintaining a drug-involved premises. The owner authorized a clinic employee to distribute pre-signed, pre-determined prescriptions for controlled substances to patients in his absence in exchange for cash and provided the prescriptions without appropriate patient examination or determination of medical necessity.

- ***Pharmacy Owner:*** A pharmacy owner was excluded from Federal health care programs for a period of 27 years based on his convictions for conspiracy to unlawfully distribute and dispense controlled substances and aiding and assisting in the preparation and presentation of false and fraudulent tax returns, statements, or other documents. The pharmacy owner purchased pharmaceutical opioids and other common prescription drugs from wholesalers and then sold them to drug traffickers, without involving physicians, patients, or prescriptions.

- ***Pharmacists and Narcotics Dealer:*** Two pharmacists and a street narcotics dealer were sentenced to prison for illegally distributing large quantities of oxycodone through their pharmacies after filling prescriptions they knew were fraudulent, medically unnecessary, or issued outside the usual course of professional practice. The subjects repeatedly dispensed high-dose oxycodone to customers with clear signs of diversion, ignored red-flag patterns, and profited from cash-based opioid sales that fueled illegal distribution networks.

CASE OUTCOMES

Illegal Distribution of Oxycodone

- **18 years** in prison for one pharmacist
- **2.5 years** in prison for the second pharmacist
- **3 years** in prison for the narcotics dealer

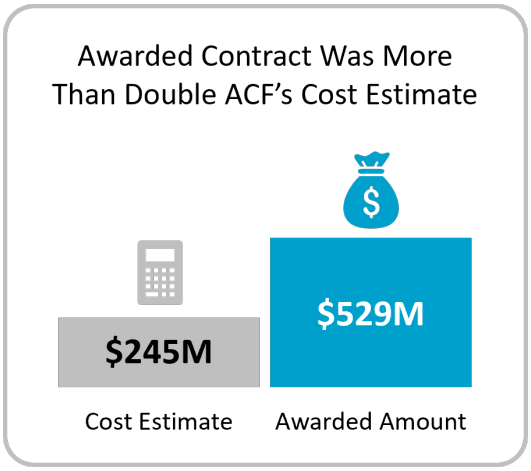
- ***Hospital and Physicians:*** Mt. San Rafael Hospital and three of its physicians agreed to pay $650,000 to resolve Controlled Substances Act and False Claims Act allegations that they issued unsafe and medically improper prescriptions for controlled substances, including high-dose opioids and dangerous drug combinations, and then sought reimbursement for those prescriptions from Federal health programs. It was alleged the physicians ignored clear red flags of misuse and diversion, such as extreme dosing, signs of substance abuse, cash payments, long-distance travel, and repeated early refill requests.

5 | Safeguarding the Integrity of Grants and Contracts

HHS operates more than 100 programs that are designed to enhance and protect the health and well-being of every American. OIG conducts oversight to help ensure that HHS programs perform well by complying with applicable laws and regulations, helping to promote better outcomes and lower costs. Selected examples are below.

Compliance With Federal Contracting Requirements

OIG found that the Administration for Children and Families (ACF) did not award a $529 million sole source contract to Family Endeavors, Inc., to operate an emergency intake site for unaccompanied alien children in accordance with Federal requirements. ACF's price analysis, completed 3 months after ACF awarded the Endeavors contract, showed that the contract ACF awarded to Endeavors cost more than double ACF's total estimated cost of $245 million. Other, more qualified contractors may have been available to perform the duties of the contract at a lower cost to the Government (A-03-22-00353).



Other Transaction Oversight

OIG found that gaps in the National Institutes of Health's (NIH's) oversight put millions in funding for Other Transactions at greater risk of fraud, waste, or abuse. NIH's use of Other Transactions—a higher risk award mechanism with fewer requirements and one that is not subject to Federal Acquisition Regulation—increased from just less than $900 million in 2020 to $1.9 billion in 2024. However, OIG found that NIH fell short in justifying its use of Other Transactions according to statutory and policy requirements and did not effectively manage the unique risks of each project. OIG also found instances in which NIH had no required internal control policies for Other Transactions; such requirements are critical for protecting against fraud, waste, and abuse (OEI-04-24-00140).

Grant-Related Enforcement Action

- ***Cancer Research Institute:*** The Dana-Farber Cancer Institute agreed to pay $15 million to settle False Claims Act allegations that it caused the submission of false claims to NIH related to scientific grants. The institute admitted that between 2014 and 2024, it used NIH funding to support cancer research publications containing misrepresented, duplicated, rotated, magnified, or stretched images, often depicting different experimental conditions or timepoints across 14 journal articles tied to 6 NIH grants.

6 | Strengthening Cybersecurity

HHS, States, and other health care systems such as hospitals face persistent cybersecurity threats that exacerbate challenges related to the use of data and technology essential to accomplishing missions. OIG provides critical oversight of the Department's, States', and other health care systems' cybersecurity, focusing on cybersecurity protections for information systems and technology that store or use sensitive and mission-critical data. Selected examples are below.

State Medicaid System Cybersecurity Controls

OIG found that 10 reviewed States implemented generally effective information technology security controls for the examined web-facing systems to prevent unsophisticated or limited cyberattacks, but they need to continue to improve these controls to prevent more sophisticated and persistent cyberattacks. OIG also found that the 10 States effectively detected and responded to some simulated cyberattacks but need to improve their detection and response to other types of cyberattacks. Overall, cyber attackers would likely need a moderate to significant level of sophistication or complexity to compromise the audited State systems (A-18-24-00002).

Hospital System Cybersecurity Controls

OIG found that a large hospital in the southeast United States implemented cybersecurity controls to protect against cyberattacks, ensure the continuity of patient care in the event of a cyberattack, and protect Medicare enrollee data. However, the Hospital could improve specific cybersecurity controls to further strengthen its defenses against cyberattacks. In particular, an account management web application lacked strong user identification and authentication controls, such as multifactor authentication, which enabled OIG to use login credentials captured from a phishing campaign to gain account management access (A-18-22-08021).

OIG Impact From Recommendations

October 1, 2025–March 31, 2026

In keeping with the mandates of the Inspector General Act and to drive positive change, OIG provides HHS with data-driven findings and actionable recommendations. OIG-issued recommendations, when implemented, result in both monetary and nonmonetary benefits. The recommendations issued during this reporting period identified $510 million in questioned costs (including $203.8 million in unsupported costs) and $447.6 million in funds put to better use.

RECOMMENDATIONS ISSUED

82	Preventing, detecting, and deterring fraud, waste, and abuse
34	Fostering sound financial stewardship and reducing improper payments
5	Holding wrongdoers accountable and recovering misspent public funds
32	Fostering quality, safety, and value of HHS-funded services
17	Promoting public health and safety
3	Supporting high-performing health and human services programs

OIG issued

173

recommendations that identified

$957.6M

in questioned costs and funds put to better use

RECOMMENDATIONS IMPLEMENTED

81	Preventing, detecting, and deterring fraud, waste, and abuse
26	Fostering sound financial stewardship and reducing improper payments
6	Holding wrongdoers accountable and recovering misspent public funds
26	Fostering quality, safety, and value of HHS-funded services
17	Promoting public health and safety
26	Supporting high-performing health and human services programs

HHS and non-HHS entities implemented

182

recommendations that saved

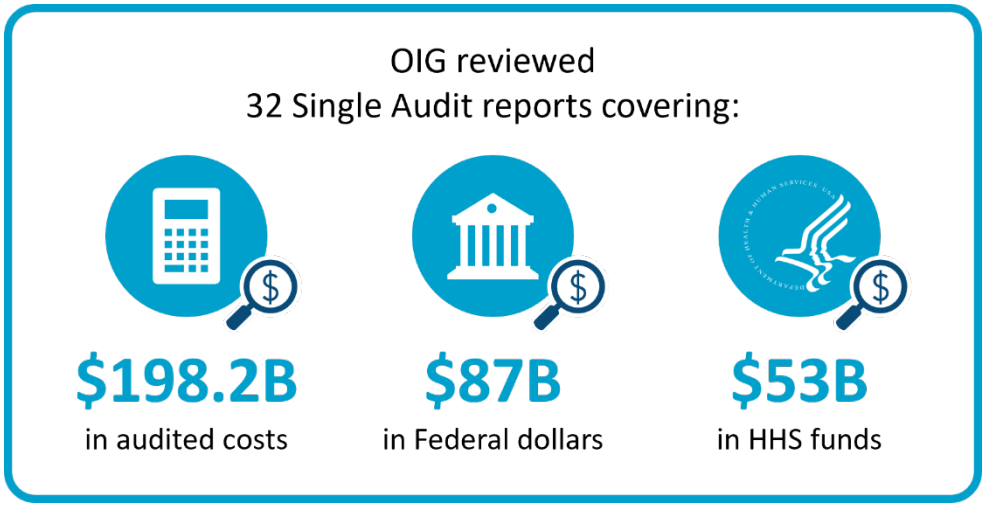
$262.8M

Additional OIG Activities

Single Audits

OIG conducts oversight of Single Audits—organizationwide audits of non-Federal entities' financial statements and expenditures of Federal awards—to monitor how recipients are using Federal funds for HHS programs. By working to improve the quality of Single Audits, OIG provides assurance to the public that taxpayer dollars are being safeguarded and spent for their intended purposes, resulting in millions of Americans receiving improved health care and human services. See below for the number of Single Audits OIG reviewed during the reporting period, as well as the amounts those Single Audits covered. Read more on OIG's Single Audits website.

Single Audits (October 1, 2025–March 31, 2026)



Whistleblower Retaliation

OIG substantiated one complaint from a whistleblower who reported wrongdoing associated with HHS-funded programs and services and was retaliated against because of it. Read more about this complaint here and more about whistleblower protection here.

Safe Harbor Proposals

OIG annually solicits proposals for developing new and modifying existing safe harbors to the Federal anti-kickback statute, section 1128B(b) of the Social Security Act, and for developing special fraud alerts. In December 2025, OIG published its annual solicitation in the *Federal Register*. OIG received 13 proposals during the reporting period, all of which are still under review as of March 31, 2026. For information about the proposals received in response to the 2024 annual solicitation and OIG's response to those proposals, see Appendix D in OIG's Fall *2025 Semiannual Report to Congress*.

Appendix A: Audits and Evaluations

The following table summarizes OIG's audit and evaluation reports issued during the reporting period, including, if applicable, the associated questioned costs, funds put to better use, unsupported costs, and whether a management decision was made during the reporting period.[1] During the reporting period, OIG identified **$510 million in questioned costs, $447.6 million in funds put to better use,** and **$203.8 million in unsupported costs.** See Appendix B for more details about reports with questioned costs and funds put to better use. Note that OIG has not yet received management decisions for most reports listed below because those decisions are not due to OIG until 6 months following the issuance of a report.

Table 1: Audit and Evaluation Reports Issued (October 1, 2025–March 31, 2026)

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Administration for Children and Families (ACF)				
ACF Can Improve Services to Homeless Youth by Strengthening Grant Recipients' Compliance With Transitional Living Program Requirements (A-06-23-07001), January 2026	-	-	-	-
ACF's $529 Million Sole Source Contract Award for Unaccompanied Alien Children Services Was Based on an Unsolicited Proposal, Double the Cost Estimate, and Noncompliant With Pre-Award Requirements (A-03-22-00353), February 2026*	-	-	-	-
New York Should Improve Its Monitoring of Low-Income Home Energy Assistance Program Subrecipients (A-02-23-02005), February 2026	$197,394,162	-	$197,394,162	-
Alaska Missed Opportunities To Protect American Indian and Alaska Native Children Missing From Foster Care (OEI-07-23-00480), February 2026	-	-	-	-
Centers for Disease Control and Prevention (CDC)				
Philadelphia Did Not Meet All of the Requirements for the COVID-19 Screening Testing Program at K-12 Schools (A-05-24-00003), February 2026	$257,620	-	-	-
Centers for Disease Control and Prevention Fiscal Year 2025 Detailed Accounting Submission and Fiscal Year 2027 Budget Formulation Compliance Report for National Drug Control Activities, and the Accompanying Required Assertions (OAS-26-03-023), February 2026	-	-	-	-

[1] OIG issued one nonpublic audit report during the reporting period.

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Centers for Medicare & Medicaid Services (CMS)				
Medicare Could Have Saved $301.5 Million if Bundled Payment Rates for Opioid Use Disorder Treatment Services Had Reflected Services Provided to Enrollees (A-09-23-03002), October 2025	-	$301,479,659	-	-
Indiana Did Not Fully Comply With Federal Waiver and State Health, Safety, and Administrative Requirements at 30 Residential Settings (A-05-24-00013), October 2025	-	-	-	-
Summary Report of Prior Office of Inspector General Penetration Tests of 10 State MMIS and E&E Systems (A-18-24-00002), October 2025	-	-	-	-
Connecticut Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (OAS-25-01-040), October 2025	-	-	-	-
Medicare Home Health Agency Provider Compliance Audit: VNA Care Network (A-05-22-00016), October 2025	$6,171	-	-	Yes
Medicare Improperly Paid Suppliers $22.7 Million Over 7 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Enrollees During Inpatient Stays (OAS-24-09-005), October 2025	$22,671,778	-	-	Yes
South Carolina Did Not Comply With Federal Waiver and State Requirements at 19 of 20 Adult Day Care Facilities (A-04-24-00137), October 2025	-	-	-	-
CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements (OEI-01-23-00050), October 2025	-	-	-	Yes
Special Focus Facility Program Nursing Homes, 2013–2022 (OEI-01-23-00052), October 2025	-	-	-	-
Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers (OEI-02-23-00540), October 2025	-	-	-	Yes
Vermont Medicaid Fraud Control Unit: 2024 Inspection (OEI-07-24-00340), October 2025	-	-	-	-
Pennsylvania Correctly Invoiced Rebates to Manufacturers for Most Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed Care Organizations (A-03-24-00206), November 2025	$284,617	-	$284,617	Yes
Texas' Ambulance Services Supplemental Payment Program Did Not Comply With Federal and State Reimbursement Requirements (A-06-23-01003), November 2025	-	-	-	-
Office of Inspector General's Partnership With the Office of the Kentucky State Auditor of Public Accounts: State Auditor's Report How Kentucky Failed to Prevent Over $800 Million of Medicaid Waste (A-09-23-02005), November 2025	-	-	-	-
Nearly All Skilled Nursing Services Provided by Pinnacle Multicare Nursing and Rehabilitation Center Did Not Meet Medicare Payment Requirements (A-02-22-01017), November 2025	$31,227,884	-	-	Yes
CMS Put $11.2 Billion at Risk of Fraud, Waste, and Abuse by Not Properly Closing Contracts (A-04-24-02048), November 2025*	-	-	-	-
Dermatology Providers Generally Met Medicare Requirements for Evaluation and Management Services Performed on Same Day as Minor Surgical Procedures (A-04-21-04083), November 2025	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Second Quarter of 2025 (OEI-03-26-00030), November 2025	-	-	-	-
Medicare Payments for Continuous Glucose Monitors and Supplies Exceeded Supplier Costs and Retail Market Prices, Indicating Medicare Can Save at Least Tens of Millions of Dollars in One Year (OEI-04-23-00430), November 2025	-	$7,354,348	-	Yes
Medicare Improperly Paid Selected Optometrists for Services Provided to Enrollees at Nursing Facilities (A-05-24-00009), December 2025	$3,059,204	-	-	-
New Jersey Did Not Ensure Providers Complied With Federal and State Requirements at All 20 Adult Day Health Services Facilities Audited (A-02-24-01009), December 2025	-	-	-	-
Florida Retina Institute Generally Met Medicare Requirements for Ophthalmology Services Provided on the Same Day as Eye Injections (A-04-22-04086), December 2025	$42,295	-	-	Yes
Podiatrists' Claims for Evaluation and Management Services Did Not Comply With Medicare Requirements (A-09-22-03012), December 2025	-	-	-	-
Podiatrists' Claims for Routine Foot Care Services Did Not Comply With Medicare Requirements (A-09-22-03011), December 2025	-	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes Humana Health Benefit of Louisiana (Contract H1951) Submitted to CMS (A-06-21-02001), December 2025	$5,470,725	-	-	Yes
Arkansas Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (OAS-25-06-029), December 2025	-	-	-	-
New Jersey Should Improve Its Oversight of Nursing Homes' Compliance With Background Check Requirements (A-02-23-01011), December 2025	-	-	-	-
Medicare Home Health Agency Provider Compliance Audit: Guardian Home Care, LLC (A-07-24-05146), December 2025	$1,690	-	-	Yes
Essence Healthcare, Inc., Did Not Comply With Federal Requirements for Reporting Direct and Indirect Remunerations for Contract Years 2017 Through 2020 (A-03-22-00002), December 2025	-	-	-	-
Illinois Made Unallowable Managed Care Capitation Payments on Behalf of Incarcerated Medicaid Enrollees (A-05-24-00019), December 2025	$8,366,521	-	-	Yes
Audit of Medicare Administrative Contractor Information Security Program Evaluations for Fiscal Year 2024 (OAS-25-18-064), December 2025	-	-	-	-
Medicaid Agencies Made Millions in Unallowable Capitation Payments to Managed Care Organizations on Behalf of Deceased Enrollees (A-04-23-09010), December 2025	-	$138,645,710	-	Yes
Oklahoma Medicaid Fraud Control Unit: 2025 Inspection (OEI-07-25-00060), December 2025	-	-	-	-
Trends in Dual-Eligible Enrollees' Access to Drugs Under Part D, 2011–2025 (OEI-05-25-00350), December 2025	-	-	-	-
Excluding Noncovered Versions Would Have Substantially Lowered Fourth-Quarter 2025 Part B Payment Amounts for Stelara Biosimilars (OEI-BL-25-00240), December 2025	-	-	-	-
Maine Made at Least $45.6 Million in Improper Fee-for-Service Medicaid Payments for Rehabilitative and Community Support Services Provided to Children Diagnosed With Autism (A-01-24-00006), January 2026	$28,796,366	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
A Large Southeastern Hospital Could Improve Certain Security Controls To Enhance Its Ability To Prevent and Detect Cyberattacks (A-18-22-08021), January 2026	-	-	-	-
Total Medicare Part B Spending on Lab Tests Rose in 2024, Driven by Increased Spending on Genetic Tests (OEI-09-25-00330), January 2026	-	-	-	-
West Virginia Did Not Obtain Rebates Associated With Millions of Dollars in Medicaid Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed Care Organizations (A-07-24-06116), February 2026	$6,078,504	-	$6,078,504	-
Missouri Did Not Obtain Millions of Dollars in Rebates for Medicaid Physician-Administered and Pharmacy Drugs (A-07-23-06113), February 2026	$12,192,968	$165,783	-	-
Medicare Home Health Agency Provider Compliance Audit: Alternate Solutions Homecare of Dayton (A-05-24-00014), February 2026	$940	-	-	-
Office of Inspector General's Partnership With the Office of the Utah Inspector General: Inspector General's Report Audit of Capitation Payments Made Concurrently With Another State (A-07-23-05136), February 2026	-	-	-	-
Sarasota Memorial Hospital Received at Least $12.1 Million in Medicare Overpayments (A-04-23-08098), February 2026	$12,199,717	-	-	-
Colorado Made at Least $77.8 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children (A-09-24-02004), February 2026	$42,649,438	-	-	-
Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Third Quarter of 2025 (OEI-03-26-00040), February 2026	-	-	-	-
Emergency Department Procedure Codes Used on Medicare Claims for Services Billed With Nonemergency Department Sites of Service Resulted in Over $15 Million in Improper and Potentially Improper Payments (A-07-23-05139), March 2026	$15,132,429	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross and Blue Shield of Alabama (Contract H0104) Submitted to CMS (A-07-22-01207), March 2026	$7,058,246	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Gateway Health Plan, Inc. (Contract H5932) Submitted to CMS (A-03-22-00004), March 2026	$4,314,513	-	-	-
Indiana Generally Ensured That Selected Nursing Homes Complied With Federal Background Check Requirements (A-05-24-00011), March 2026	-	-	-	-
Medicare Home Health Agency Provider Compliance Audit: VNS Health (A-02-22-01023), March 2026	$2,965,484	-	-	-
Selected Diabetes and Weight Loss Drugs Were Dispensed to Michigan Medicaid Managed Care Enrollees in Accordance With Federal and State Requirements (OAS-25-05-067), March 2026	-	-	-	-
Louisiana Healthcare Connections Generally Complied With Federal and State Process Requirements When Denying Prior Authorization Requests (A-06-24-02000), March 2026	-	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Priority Health (Contract H2320) Submitted to CMS (A-07-22-01208), March 2026	$4,479,698	-	-	-
Medicaid Fraud Control Units Annual Report: Fiscal Year 2025 (OEI-09-26-00140), March 2026	-	-	-	-
Psychosocial Characteristics and Their Association With Kidney Transplant Programs Waitlist Rates (OEI-01-23-00293), March 2026	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Nursing Homes' Inappropriate Use of Antipsychotic Drugs Poses a Risk to Residents (OEI-02-23-00200), March 2026	-	-	-	-
Nursing Homes Inappropriately Diagnosed Residents With Schizophrenia to Mask the Misuse of Antipsychotic Drugs (OEI-02-23-00201), March 2026	-	-	-	-
Congressional Mandate: Part B Payment Amounts for One Drug Included Noncovered Self-Administered Versions in 2024 (OEI-BL-25-00110), March 2026	-	-	-	-
Food and Drug Administration (FDA)				
Food and Drug Administration Fiscal Year 2025 Detailed Accounting Submission and Fiscal Year 2027 Budget Formulation Compliance Report for National Drug Control Activities, and the Accompanying Required Assertions (OAS-26-03-024), February 2026	-	-	-	-
Health Resources and Services Administration (HRSA)				
Four of Thirty Selected Dental Providers Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments (A-02-23-01013), November 2025	$3,381,110	-	-	Yes
Some Selected Health Centers Received Duplicate Reimbursement From HRSA For COVID-19 Testing Services (A-02-23-02009), December 2025	$313,270	-	-	-
Nine of Thirty Selected Assisted Living Facilities Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments (A-02-23-01012), December 2025	$11,292,344	-	-	Yes
Fourteen of Thirty Selected Indian Health Service and Rural Providers Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments (A-09-23-01001), February 2026	$90,299,947	-	-	-
Indian Health Service (IHS)				
The Indian Health Service Did Not Ensure That Commissioned Corps Officers' Background Investigations Complied With Federal Requirements (A-01-24-01500), December 2025	-	-	-	-
National Institutes of Health (NIH)				
Gaps in NIH's Oversight Put Millions in Funding for Other Transactions at Greater Risk of Fraud, Waste, or Abuse (OEI-04-24-00140), November 2025	-	-	-	-
The National Institutes of Health Generally Implemented the Safe Workplace Federal Reporting Requirement, but Opportunities Exist To Improve the Reporting and Monitoring Processes (A-05-24-00002), December 2025	-	-	-	-
The National Institutes of Health Administered Superfund Appropriations During Fiscal Year 2024 in Accordance With Federal Requirements (OAS-25-04-058), December 2025	-	-	-	-
National Institutes of Health Fiscal Year 2025 Detailed Accounting Submission and Fiscal Year 2027 Budget Formulation Compliance Report for National Drug Control Activities, and the Accompanying Required Assertions (OAS-26-03-025), February 2026	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Office of the Secretary (OS)				
Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2025 (OAS-25-17-070), January 2026	-	-	-	-
Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2025 (OAS-25-17-071), January 2026	-	-	-	-
Review of the Department of Health and Human Services' Compliance With the Federal Information Security Modernization Act of 2014 for Fiscal Year 2025 (OAS-25-18-041), March 2026	-	-	-	-
Total Reports: 77	**$509,937,641**	**$447,645,500**	**$203,757,283**	**14[2]**

***** Contract audit per the National Defense Authorization Act (NDAA) for Fiscal Year 2008, section 845.

[2] This table represents management decisions on reports issued during the reporting period only. OIG has not yet received management decisions for most reports listed above because those decisions are not due to OIG until 6 months following the issuance of a report. For additional information on reports for which a management decision was made during the reporting period, including reports that were issued prior to the reporting period, see Appendix B.

Appendix B: Report Details

Audit and Evaluation Reports With Questioned Costs

OIG identified **$510 million in questioned costs** during the reporting period. The table below summarizes audit and evaluation reports with questioned costs and HHS program officials' decisions to take action on these and other outstanding audit recommendations.

Table 2: Audit and Evaluation Reports With Questioned Costs (October 1, 2025–March 31, 2026)

		Number of Reports	Dollar Value Questioned	Dollar Value Unsupported*
A.	Reports for which no management decision has been made by the commencement of the reporting period	23	$861,568,000†	$93,434,000†
B.	Reports issued during the reporting period‡	26	$509,938,000	$203,757,000
	Subtotal (A + B)	**49**	**$1,371,506,000**	**$297,191,000**
Less:				
C.	Reports for which a management decision was made during the reporting period			
	i. Disallowed costs	28	**$814,075,000****	$4,701,000
	ii. Costs not disallowed	4	$107,953,000	$89,018,000
	Subtotal (i + ii)	**32**	**$922,028,000**	**$93,719,000**
D.	Reports for which no management decision has been made by the end of the reporting period [(A + B) – Subtotal C]	**17**	**$449,478,000**	**$203,472,000**
E.	Reports for which no management decision was made within 6 months of issuance††	**1**	**$22,285,000**	**-**

* Unsupported costs are a subset of questioned costs; these are costs that OIG found that, at the time of the audit or evaluation, are not supported by adequate documentation.

† The dollar value increased by the sustained excess amount because the sustained amount was greater than the original recommendation amount.

‡ One issued report containing recommendations for both questioned costs and funds put to better use is counted in both tables.

** This includes audit and evaluation receivables (expected recoveries).

†† Because of administrative delays, some of which were beyond management control, resolution of one audit was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations.

Audit and Evaluation Reports With Recommendations That Funds Be Put to Better Use

OIG identified **$447.6 million in funds put to better use** during the reporting period. The table below summarizes audit and evaluation reports with recommendations that funds be put to better use and HHS program officials' decisions to take action on these and other outstanding audit and evaluation recommendations.

Table 3: Audit and Evaluation Reports With Recommendations That Funds Be Put to Better Use (October 1, 2025–March 31, 2026)

	Number of Reports	Dollar Value
A. Reports for which no management decision has been made by the commencement of the reporting period	4	$4,267,002,000
B. Reports issued during the reporting period*	4	$447,646,000
Subtotal (A + B)	**8**	**$4,714,648,000**
Less:		
C. Reports for which a management decision was made during the reporting period		
i. Value of recommendations agreed to by management		
a. Based on proposed management action	1	$141,944,000
b. Based on proposed legislative action	0	-
ii. Value of recommendations not agreed to by management	5	$4,271,058,000
Subtotal (i + ii)	**6**	**$4,413,002,000**
D. Reports for which no management decision had been made by the end of the reporting period [(A + B) – Subtotal C]	**2**	**$301,645,000**

* One issued report containing recommendations for both questioned costs and funds put to better use is counted in both tables.

Appendix C: Investigative Actions

During the reporting period, OIG's investigative work led to **$4.3 billion in investigative receivables** and **317 criminal actions**. OIG also **took civil actions, such as assessing monetary penalties, against 287 individuals and entities**, and **excluded 1,212 individuals and entities from Federal health care programs**. The following table summarizes OIG's investigative activities and results during the reporting period.[3]

Table 4: Investigative Activity and Results (October 1, 2025–March 31, 2026)

Investigative Receivables		
Amount due to HHS		$2,907,845,320
Amount due to non-HHS entities		$1,391,932,683
	Total Investigative Receivables	**$4,299,778,003**
Investigative Results		
Criminal actions resulting from investigations		317
Civil actions		287
Judgments/settlements		196
Civil monetary penalties		91
	Total Criminal and Civil Actions	**604**
Investigations closed		881
Criminal Referrals		
Referrals to DOJ		1,066
Indictments and criminal informations resulting from referrals made prior to and during the reporting period		194
Referrals to State and local authorities		102
Indictments and criminal informations resulting from referrals made prior to and during the reporting period		51
	Total Criminal Referrals	**1,168**
Exclusions		
Individuals		1,183
Entities		29
	Total Exclusions	**1,212**
OIG Hotline Activity		
Total contacts received via hotline and web portal		95,776
Evaluated for potential investigation		40,815
Referred internally or to appropriate agency for action		21,371
Closed (e.g., no HHS violation)		19,444
Other contacts[4]		54,961

[3] OIG issued no investigative reports. See Appendix E for OIG's definition of an investigative report.

[4] Includes those contacts that are reporting fraud, waste, and abuse at other Federal or State agencies, confirming potential scams, requesting contact information for HHS programs or State and local agencies, asking questions about how to submit a complaint, and requesting Freedom of Information Act information.

Table 5: Investigations of Senior Government Employees (October 1, 2025–March 31, 2026)

OIG conducted four investigations of senior Government employees (as defined in the IG Act) during the reporting period. Of these investigations, one allegation was substantiated, and three allegations were either unsubstantiated or no determination was made (investigations were not reported publicly).

Substantiated

OIG investigated a senior Government employee (GS-15) for allegations of fraud. The fraud was alleged to be in relation to the receipt of Economic Injury Disaster Loans and the application of other loans. The matter was declined for criminal prosecution, and the employee was removed from Federal service. A report was provided to the Operating Division.

Unsubstantiated/No Determination Made and Not Reported Publicly

Description of Investigation
OIG investigated a senior Government employee for allegations of misconduct. The misconduct was alleged to be in relation to contracts. OIG closed this investigation with no findings made.
OIG investigated a senior Government employee (GS-15) for an alleged conflict of interest. The alleged conflict arose when the employee engaged in ethics violations after a deferred resignation. OIG presented the case to the United States Attorney's Office who declined to prosecute, and the investigation was closed.
OIG investigated a senior Government employee (GS-15) for an alleged conflict of interest. The alleged conflict arose when the employee took legal action to terminate their marriage (divorce) for the purpose of avoiding the application of the criminal conflict of interest statute and financial disclosure requirements. OIG presented the case to the United States Attorney's Office who declined to prosecute, and the investigation was closed.

Appendix D: Peer Reviews

Peer reviews are conducted by member organizations of the Council of the Inspectors General on Integrity and Efficiency (CIGIE). The CIGIE peer review program provides OIGs and their stakeholders with an assessment of the OIG's compliance with relevant quality standards and its quality control systems (e.g., policies and procedures).

Office of Audit Services

During the reporting period, OIG's Office of Audit Services (OAS) did not receive a peer review. The most recent peer review OAS received was conducted by the Department of Housing and Urban Development (HUD) OIG, the final report of which was issued in March 2024. In that review, OAS received a "pass" rating, and HUD-OIG issued no recommendations. OAS has no outstanding peer review recommendations. OAS did not conduct a peer review during the reporting period. The most recent peer review OAS conducted was of the Department of Defense OIG, the final report of which was issued in September 2024.

Office of Evaluation and Inspections

During the reporting period, the Small Business Administration OIG conducted a peer review of OIG's Office of Evaluation and Inspections (OEI), the final report of which has not been issued as of March 31, 2026. OEI has no outstanding peer review recommendations. OEI did not conduct a peer review during the reporting period. The most recent peer review OEI conducted was of the Special Inspector General for Afghanistan Reconstruction OIG, the final report of which was issued in March 2023.

Office of Investigations

During the reporting period, OIG's Office of Investigations (OI) did not receive a peer review. The most recent peer review OI received was conducted by the United States Postal Service (USPS), the final report of which was issued in November 2024. In that review, USPS-OIG determined that OI's system of internal safeguards and management procedures for the investigative function was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines. OI has no outstanding peer review recommendations. OI did not conduct a peer review during the reporting period. The most recent peer review OI conducted was of the Department of Agriculture OIG, the final report of which was issued in June 2025.

Appendix E: Glossary

See At a Glance: OIG Accomplishments for corresponding statistics.

Audit and Evaluation Receivables
Monies identified through OIG audits that the audited entity has sustained or formally agreed should not be charged to the Government. It does not reflect actual collections.

Civil Actions
Actions, including civil settlements and civil judgments, including actions resulting from the use of OIG's Civil Monetary Penalties Law authority.

Criminal Actions
Actions, such as convictions, that occur once an individual or entity's guilt is determined and a sentence is imposed, or when a defendant enters a pretrial diversion program before or after indictment.

Criminal Informations and Indictments
Instances in which a formal accusation of a crime is made against an individual or entity by a grand jury or prosecuting attorney.

Excluded Individuals and Entities
Untrustworthy individuals and entities OIG has excluded, pursuant to section 1128 of the Social Security Act, from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from Federal health care programs for any items or services they furnish, order, or prescribe.

Final Management Decision
A final decision by management concerning its response to the findings and recommendations included in an audit report, including actions concluded to be necessary.

Funds Put to Better Use
Funds that could be used more efficiently if management took actions to implement and complete an OIG recommendation, through reductions in outlays, deobligation of funds, and/or avoidance of unnecessary expenditures. Also referred to as "recommendations that funds be put to better use."

Investigations Completed
Completed OIG criminal, civil, and administrative investigations of fraud and abuse related to HHS programs and operations.

Investigative Receivables
Monies ordered or agreed upon to be returned or paid to HHS or other Federal and State entities or private individuals because of OIG investigative activity that led to criminal actions, civil and administrative settlements, civil judgments, or administrative actions. It does not reflect actual collections.

Investigative Report
A report that identifies or brings renewed attention to systemic weaknesses or vulnerabilities within HHS programs and recommends administrative, procedural, policy, regulatory, or legislative change to correct or minimize the problem during the reporting period.

Potential Cost Savings
Funds put to better use or funds that HHS could use more efficiently if it took action to implement OIG recommendations.

Questioned Cost
A cost that is questioned by OIG because of: (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, the cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable. Subcategories of questioned costs include:

> **Disallowed Costs**
> A subset of questioned costs; these are costs that HHS program officials have, in a management decision, sustained or agreed should not be charged to the Government.
>
> **Unsupported Costs**
> A subset of questioned costs; these are costs that OIG found that, at the time of the audit, are not supported by adequate documentation.

Recommendations Implemented
Recommendations implemented by HHS and others can result in substantial savings and can also result in improvements to HHS programs.

Recommendations Issued
Actionable recommendations, based on data-driven findings, that OIG provided to HHS and that if implemented can result in both monetary and nonmonetary benefits.

Referrals
Presentations of OIG subjects to Federal, State, or local prosecuting jurisdictions for criminal prosecutorial consideration.

Reports Issued
OIG published reports, including audit reports, evaluation reports, and reports of findings in response to Office of Special Counsel whistleblower disclosures.

Return on Investment
OIG uses a 3-year rolling average methodology of expected recoveries and receivables to calculate the annual dollars returned to taxpayers for every dollar invested in OIG oversight.

Total Monetary Impact
Total amount of potential savings from investigative receivables, audit and evaluation receivables, and recommendations that funds be put to better use.

Appendix F: Reporting Requirements

The National Defense Authorization Act (NDAA) of Fiscal Year 2023, section 5273, amended the Inspector General Act of 1978 and the Inspector General Empowerment Act of 2016 to streamline semiannual reporting requirements for offices of inspectors general, which now appear in the note of 5 U.S.C. § 405. The following table presents the new NDAA requirements and other remaining requirements, along with the location of the information in this report.

Section	Requirement	Location
U.S.C. § 405 (note)		
5(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
5(a)(2)	Recommendations for which corrective action has not been completed	OIG Impact From Recommendations and OIG's Recommendations Tracker
5(a)(3)	Significant investigations closed during the reporting period	Throughout this report
5(a)(4)	Convictions during the reporting period	Appendix C: Investigative Actions
5(a)(5)	Information regarding reports issued during the reporting period	Appendix A: Audits and Evaluations
5(a)(6)	Information regarding any management decision made during the reporting period with respect to any report issued during a previous reporting period	At a Glance: OIG Accomplishments, OIG Impact From Recommendations, and OIG's Recommendations Tracker
5(a)(7)	Information required by the Federal Financial Management Improvement Act of 1996	None this reporting period
5(a)(8)	Results of peer reviews of HHS-OIG conducted by other OIGs	Appendix D: Peer Reviews
5(a)(9)	Outstanding recommendations from peer reviews of HHS-OIG conducted by other OIGs	Appendix D: Peer Reviews
5(a)(10)	Peer reviews of other OIGs conducted by HHS-OIG	Appendix D: Peer Reviews
5(a)(11)	Investigative statistical tables	Appendix C: Investigative Actions
5(a)(12)	Metrics description for investigative statistical tables	Appendix C: Investigative Actions
5(a)(13)	Investigations of senior Government employees	Appendix C: Investigative Actions
5(a)(14)	Description of whistleblower retaliation instances	Additional OIG Activities
5(a)(15)	Description of attempts to interfere with OIG independence	None this reporting period
5(a)(16)	Descriptions of investigations of senior Government employees	Appendix C: Investigative Actions
5(a)(16)	Descriptions of nonpublic reports	Appendix A: Audits and Evaluations
Other Requirements		
NDAA 2008, § 845	Significant contract audits	Appendix A: Audits and Evaluations
Social Security Act § 1128D Health Insurance Portability and Accountability Act	Public proposals for new and modified safe harbors	Additional OIG Activities

Stay in Touch

HHS Office of Inspector General

OIGatHHS

Sign up for our newsletter

OIG.HHS.GOV

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

Scan to Report at

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.