Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
October 1, 2008-March 31, 2009

Message from the Inspector General

This Semiannual Report to Congress focuses on the accomplishments of the VA Office of Inspector General (OIG) for the reporting period from October 1, 2008, through March 31, 2009. Issued in accordance with the *Inspector General Act of 1978*, as amended, it presents results based on OIG strategic goals, which cover the areas of health care delivery, benefits processing, financial management, procurement practices, and information management.

During this reporting period, OIG issued 102 reports on VA programs and operations. We recommended systemic improvements and efficiencies in quality of care, accuracy of benefits, financial management, economy in procurement, and information security. OIG audits, investigations, and other reviews identified over $614.4 million in monetary benefits, for a return of $16 for every dollar expended on OIG oversight. Our criminal investigators have closed 492 investigations and made 253 arrests for a variety of crimes including fraud, bribery, embezzlement, identity theft, drug diversion and illegal distribution, computer crimes, and personal and property crimes. OIG investigative work also resulted in 298 administrative sanctions. A criminal information was filed against the former associate director of the Hines, IL, Consolidated Mail Outpatient Pharmacy, his wife, and her staffing company charging them with conspiracy to commit wire fraud. Between 2000 and 2007, the defendants and other unindicted co-conspirators used the company to bill VA for more than $8 million in services.

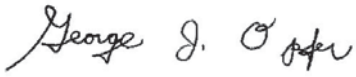
An OIG audit determined the Veterans Health Administration (VHA) lacks an effective method to track and report unused appointments, particularly those canceled in advance and those never filled by a scheduler. VHA also needs to implement effective processes to reduce patient "no-shows," which cost VHA about $564 million annually. Minimizing the number of unused outpatient appointments by two-thirds could enable Veterans to receive more timely patient care, and allow VHA to make better use of resources valued at about $76 million annually and $380 million over a 5-year period. OIG also audited the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review (STAR) process, a quality assurance program that is a key mechanism for evaluating VA Regional Office performance in processing accurate benefit claims for Veterans and beneficiaries. OIG determined that VBA's STAR process did not effectively identify and report errors in compensation claim rating decisions, and that VBA has not fully implemented plans to ensure Veterans receive consistent ratings. OIG determined that VBA needs to increase accuracy and strengthen controls to ensure Veterans receive their entitled benefits.

As part of OIG's oversight of VA health care, the Office of Healthcare Inspections analyzed the access to VA-provided and VA-purchased mental health care by Veterans in Montana and the impact of peer-to-peer counseling programs. This report pioneered the use of Veterans' travel times, whether or not they were users of VA, from their home addresses to providers' physical service locations. OIG found that 95 percent of this Veteran population had access to care offering at least medication management or therapy services within 30 minutes of travel, and over 88 percent of the population had access within 1 hour of travel to a provider with both services.

The Office of Contract Review (OCR) conducted preaward and postaward reviews specifically designed to improve VA's procurement process by protecting the interest of the Government and identifying and resolving contractor overcharges. OCR issued 46 reports that resulted in savings and dollar recoveries of $96.4 million.

The *American Recovery and Reinvestment Act of 2009,* signed into law on February 17, 2009, provided VA over $1.4 billion for programs, grants, and projects with a twofold mission: to help rejuvenate the U.S. economy, and to improve the care and services VA provides to America's deserving heroes, our Veterans. OIG has developed a proactive oversight strategy to help VA spend tax dollars on economic recovery in the most effective, economic, and efficient manner.

OIG appreciates the ongoing support we receive from the Secretary, the Deputy Secretary, and senior management. We look forward to working with VA and Congress to make VA as effective as possible in meeting the needs of Veterans for quality and timely health care and benefits.



GEORGE J. OPFER
Inspector General

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Statistical Highlights

DOLLAR IMPACT ($$$ in Millions)

Better Use of Funds	$380.0
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Savings and Cost Avoidance	$15.7
OIG Dollar Recoveries	$3.5
Contract Review Savings and Dollar Recoveries (including $31.0 million in questioned costs)	$96.4

RETURN ON INVESTMENT

Dollar Impact ($614.4)/Cost of OIG Operations ($38.9)*	16:1

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Investigative Cases

Opened	512
Closed	492

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Cases Opened	474
Cases Closed	448

* Because inspection work performed by the Office of Healthcare Inspections results in saving lives and not dollars, their operating costs ($7.3 million) are not included in calculating return on investment.

** Includes the apprehension of 38 fugitive felons by OIG for this period.

VA and OIG Mission, Organization, and Resources

The Department of Veterans Affairs

The Department's mission is to serve America's Veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to the Nation. The VA motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2009, VA has a $93.4 billion budget and over 278,000 employees serving an estimated 23.4 million living Veterans. To serve the Nation's Veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Republic of the Philippines.

VA has three administrations that serve Veterans:

- Veterans Health Administration (VHA) provides health care.
- Veterans Benefits Administration (VBA) provides income and readjustment benefits.
- National Cemetery Administration provides interment and memorial benefits.

For more information, please visit the VA Internet home page at www.va.gov.

VA Office of Inspector General

The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the *Inspector General Act*, Public Law (P.L.) 95-452, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 522 employees, is organized into three line elements: the Offices of Investigations, Audit, and Healthcare Inspections, plus a contract review office and a support element. FY 2009 funding for OIG operations provides $87.8 million from appropriations. The Office of Contract Review, with 25 employees, receives $3.6 million through a reimbursable agreement with VA for contract review services including preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule contracts. The *American Recovery and Reinvestment Act of 2009* provided OIG an additional $1 million for oversight of the $1.4 billion the Recovery Act provided to VA. In addition to the Washington, DC, headquarters, OIG has field offices located throughout the country.

OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strives to be leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity. For more information, please visit the OIG Internet home page at www.va.gov/oig.

Health Care Delivery

The health care that VHA provides Veterans is consistently ranked among the best in the Nation, whether those Veterans are recently returned from Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) or are Veterans of other periods of service with different patterns of health care needs. OIG oversight helps VHA maintain a fully functional program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events.

OFFICE OF HEALTHCARE INSPECTIONS

The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses VHA services. During this reporting period, OHI published 25 cyclical Combined Assessment Program (CAP) reviews along with 18 hotline reports and national reviews to evaluate quality of care issues in several VHA medical facilities.

New Study Approach Finds High Percentage of Montana Veterans with Timely Access to Mental Health Care

At the request of U.S. Senators Jon Tester and Max Baucus, OIG reviewed the quality and availability of mental health services within the VA Montana Healthcare System (VAMHS). OIG analyzed the access to VA-provided and VA-purchased mental health care by Veterans in Montana and the impact of peer-to-peer counseling programs. This report pioneered the use of Veterans' travel times from their home addresses, whether or not they were users of VA, to providers' physical service locations. Particular access to care challenges facing VAMHS includes the availability of mental health providers and coping with a geographically large area with high population dispersion. Despite these challenges, OIG found that 95 percent of this Veteran population had access to care offering at least medication management or therapy services within 30 minutes of travel, and over 88 percent of the population had access within 1 hour of travel to a provider with both services. OIG made recommendations to increase the availability of both evidence-based post-traumatic stress disorder (PTSD) treatment and specialty substance use treatment for Montana Veterans.

Improvements Needed in Abdominal Aortic Aneurysm Management

OIG completed a national review to determine whether VHA medical facilities had implemented abdominal aortic aneurysm (AAA) screening policies and protocols. OIG recommended that clinicians consider patients' risk factors for AAA when ordering abdominal imaging studies and image the aorta, when appropriate. This action could address and mitigate the concerns expressed by VHA and facility-level managers regarding the need for additional imaging resources. VHA should also develop a plan for screening male smokers 65–75 years old.

Review Finds VHA Research Funding Relevant to Veterans' Needs

The Subcommittee for Military Construction, VA, and Related Agencies, House Appropriations Committee, requested that OIG complete a review of VHA research to determine whether efforts are appropriate to the needs of Veterans. OIG determined that in particular, mental illness, substance abuse, and the common disorders of aging were the most frequent reasons Veterans utilized VA health care facilities. These conditions correspond closely to the top three areas of VA research funding: mental health, aging, and health systems. OIG concluded that appropriated funds for VA research address the broad spectrum of medical issues facing Veterans, but also noted that VHA's reporting on appropriated funds for research could be more transparent and detailed.

No Changes Found in Mental Health Diagnoses at Central Texas Healthcare System

At the request of James B. Peake, M.D., Secretary of Veterans Affairs, and Members of Congress, OIG reviewed allegations relating to the diagnosis, treatment, and compensation of Veterans with PTSD within the Central Texas VA Healthcare System (HCS) in Temple, TX. The review stemmed from the public release of an interoffice e-mail, which raised questions whether the author was advocating the use of the diagnosis "adjustment disorder" over other diagnoses, particularly PTSD. OIG's interviews with recipients of the e-mail revealed no consistent perception that the e-mail suggested rendering

inappropriate diagnoses. The e-mail was written on the author's initiative, without instruction from local, regional, or national VA leadership. OIG also found no change in the appropriateness of clinical diagnoses, Compensation & Pension (C&P) examination diagnoses, and service connection determinations occurring before and after the e-mail.

Review Finds Failure To Provide Continuity of Care at Salt Lake City VAMC

OIG reviewed allegations surrounding the care of a patient hospitalized at the VA Medical Center (VAMC) in Salt Lake City, UT. OIG found that insufficient and fragmented discharge planning and the failure of a pharmacist to follow written orders caused the patient to experience a disruption in continuity of care. OIG also found that staff failed to disclose to the patient's family the details of a rare complication that ultimately resulted in the patient's death. OIG made recommendations to include staff education on the particulars of rural health care needs and adverse event disclosure, possible administrative action against the pharmacist, and that the VAMC confer with Regional Counsel regarding informing the patient's family about their right to file tort and benefit claims.

Delays in Mammography, Cardiology, and Colonoscopy Noted at Muskogee, Oklahoma, VAMC

At the request of Senator James M. Inhofe, OIG conducted an inspection to determine the validity of allegations surrounding the Jack C. Montgomery VAMC in Muskogee, OK. OIG concluded that there were issues regarding delays in mammography services, cardiology consults, and scheduling colonoscopy procedures. Prior to the inspection, management had already implemented initiatives to correct the issues, and OIG confirmed that the number of delays to schedule consultations and procedures for these services decreased. OIG recommended that Regional Counsel review a colonoscopy patient's case to determine whether this case meets disclosure requirements; Regional Counsel concluded that it did not meet disclosure requirements.

Allegations of Quality of Care Issues at a VA HCS Inspected

OIG performed an inspection to determine the validity of an anonymous allegation that "a number of patients" died while under the care of a board certified surgeon. OIG concluded that the system took appropriate actions to ensure patient safety and to review the provider's quality of care prior to and during OIG's review of the allegations. OIG also recommended that Regional Counsel review all pertinent documentation an actions taken by the system and determine whether the system had a legal obligation to report the provider to the National Practitioner's Database and/or the appropriate state licensing boards.

Homeless Women Veterans Program Deficiencies Found at Atlanta VAMC

A complainant alleged that a female patient committed suicide because of inadequate care provided by the Homeless Women Veterans Program at the Atlanta, GA, VAMC. OIG found that the patient received appropriate services and care, and noted that the medical examiner ruled the cause of death as accidental. While not an allegation, OIG did identify deficiencies specific to the halfway house contract, inspections, and services, and recommended revisions to the contract. The VAMC director relocated the Veterans to another facility that met the requirements of OIG's recommendations.

Equipment, Communication Problems at Puget Sound, Washington, HCS

OIG reviewed allegations that a patient's death at the VA Puget Sound, WA, HCS was caused by equipment failure and not by aspiration pneumonia. While OIG concluded that a suction machine failed as the patient experienced aspiration shortly before his death, OIG could not confirm whether the delay in clearing the patient's airway was a contributing factor in his death. Although aspiration pneumonia was accurately listed as the cause of death, staff did not ensure the patient's family understood the nature of the condition completely. OIG recommended that suction machine procedures, staff competencies, and equipment checks be clarified and that staff should comply with VA policy related to incident reporting and disclosure.

Patient Care Equipment Problems Noted at Las Vegas HCS

At the request of Congressman Bob Filner, Chairman of the House Committee on Veterans' Affairs, OIG conducted a review of gastroenterology (GI) services at the VA

Southern Nevada HCS in Las Vegas, NV. Generally, GI providers performed their duties appropriately while they were contractors of the system; however, OIG substantiated that refurbished scopes were purchased and that a scope broke during a GI procedure. OIG recommended improvements pertaining to the handling of patient care equipment. OIG also recommended that employees promptly report Government property loss or damage, and that regulations pertaining to services provided by non-VA entities are followed.

Hospice Training Lacking for Staff at Maryland HCS

OIG reviewed allegations regarding care received by a terminally ill patient at the VA Maryland HCS in Baltimore, MD. OIG recommended improved documentation of pain assessments, along with a recommendation that patients admitted for hospice care receive that care from a dedicated, trained, interdisciplinary hospice team.

Greater Oversight Needed at Oklahoma City Community Nursing Home

An OIG inspection determined that the Community Nursing Home (CNH) Program at the Oklahoma City, OK, VAMC failed to comply with policy regarding VHA staff visits to patients. In addition, the CNH Program needed to perform follow-up visits every 30 days and implement ongoing monitoring of exclusion criteria for nursing facilities. OIG determined there was a need to establish both a CNH Oversight Committee and a CNH Review Team.

Credentialing and Privileging Allegations Unfounded at Western New York HCS

OIG did not substantiate allegations that a surgeon at the VA Western New York HCS in Buffalo, NY, performed lung surgeries without appropriate credentials and privileges or that the surgeon's infection control practices were inadequate. The surgeon had appropriate credentials and privileges for the surgeries performed, and when surgical procedures involving the lungs were necessary, a second surgeon who was appropriately credentialed and privileged either assisted with or performed those procedures. The surgeon followed established pre-operative prophylactic antibiotic protocols, appropriately consulted Infectious Disease clinicians, and had an excellent clean wound infection rate.

Allegations of Delayed Access to Care Not Substantiated at Bay Pines, Florida, VA HCS

OIG conducted a review to evaluate allegations regarding a patient's experience with schedulers in the Primary Care Call Center and the Cardiology Clinic at the Bay Pines, FL, VA HCS. OIG did not substantiate the allegation of delayed access to cardiology care. While documentation could have been improved, management had already taken action to resolve the issue. Nevertheless, OIG determined that the complainant should have been scheduled for a primary care appointment within 30 days of his request. OIG also found that the schedulers acted in accordance with system policy regarding the patient's request for a cardiology appointment.

Summary of OHI CAP Reviews

CAP reviews are part of OIG's efforts to ensure that quality health care services are provided to Veterans. CAP reviews provide cyclical oversight of VHA health care facilities; their purpose is to review selected clinical and administrative operations and to conduct a fraud and integrity awareness program. During this reporting period, OIG issued 25 CAP reports, which are listed in Appendix A. Topics reviewed in a facility CAP may vary with the facility mission, hotline activity, and VHA Office of Medical Inspector reports. Topics generally run for 6-12 months; the CAP topics in current use since January 2009 are:

- Suicide prevention.
- Contracted/agency registered nurses.
- Quality management.
- Environment of care.
- Coordination of care.
- Medication management.
- Emergency/urgent care operations.
- Survey of healthcare experiences of patients.
- Physician privileges.

When findings warrant more global attention, summary or "roll up" reports are prepared at the conclusion of a topic's use.

OFFICE OF AUDIT

OIG audits of VA programs focus on the effectiveness of health care delivery for Veterans. These audits identify opportunities for enhancing management of program operations and provide VA with constructive recommendations to improve health care delivery.

VHA Needs To Reduce Unused Appointments

An OIG audit requested by Senator Daniel Akaka, Chairman, Senate Committee on Veterans' Affairs, determined that VHA needs to make improvements to minimize the number of unused outpatient appointments. VHA lacks an effective method to track and report unused appointments, particularly those canceled in advance and those never filled by a scheduler. VHA also needs to implement effective processes to reduce patient "no-shows," which cost VHA about $564 million annually. Also, VHA needs to establish procedures to ensure that staff contact patients on wait lists when a canceled appointment becomes available. Minimizing the number of unused outpatient appointments by two-thirds could enable Veterans to receive more timely patient care, and allow VHA to make better use of resources valued at about $76 million annually and $380 million over a 5-year period.

Use of "Non Count" Clinics Results in Inaccurate Waiting Times

Chairman Akaka also requested that OIG review allegations that the leadership of the North Florida/South Georgia Veterans HCS was manipulating their patient waiting list. Although OIG did not find evidence of willful manipulation, OIG determined that the practice of using "non count" clinics (i.e., clinics where patients are not counted) impairs the ability of VHA to assess waiting times accurately by understating new patients' actual waiting time.

Audit Reveals Safety, Security, Privacy Problems in Domiciliary Program

An OIG audit found that VHA needs to establish national procedures for the inspection of Veterans' rooms to prevent substance abuse and the misuse of controlled substances. Further initiatives need to be taken to ensure the safety, security, and privacy of all Veteran residents, but particularly female Veterans. Lastly, improvements are needed in the annual reporting and follow-up processes. OIG determined that implementation of the draft VHA Mental Health Residential Rehabilitation Treatment Programs Handbook, as well as planned assessments at all domiciliaries in FY 2009 would result in improved safety, security, and privacy for residents.

OFFICE OF INVESTIGATIONS

The OIG Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of Veterans. In the area of health care delivery, OIG opened 196 cases, made 115 arrests, and obtained over $2 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Former Albany, New York, Oncology Chief Sentenced

The former Chief of Oncology at the Albany, NY, VAMC was sentenced to 5 years' probation and ordered to make restitution of $502,925 jointly with another individual who was previously sentenced in this case. An OIG investigation revealed that the former chief wrongfully and unlawfully failed to establish and maintain adequate and accurate case histories in connection with clinical trials and studies being conducted at the VAMC. His failures allowed Veterans to be placed into studies he was supervising for which they would otherwise be ineligible to participate and, because of his supervisory failures, his research coordinator was able to alter medical records of 62 VA patients to make it appear, in some cases, as though they were qualified to participate in cancer research. At least one Veteran patient died as a result of the altered records being used, as the Veteran was subjected to treatment with chemotherapy agents he ultimately could not have tolerated had his true laboratory results been reviewed. The research coordinator was previously sentenced to serve 71 months' incarceration.

Drug Diversion

During this reporting period, OIG opened 54 investigations regarding diversion of controlled substances. Subjects of these investigations included VA employees, Veterans, and private citizens. Thirty defendants were charged with various crimes relating to drug diversion. Among them were the following:

- A former Salt Lake City, UT, VAMC contract nurse was arrested for theft and possession of a controlled substance with intent to distribute. An OIG and local law enforcement investigation revealed that the defendant obtained morphine by falsely claiming to have administered it to Veterans.
- A San Antonio, TX, VAMC physician's assistant was indicted for receiving controlled substances through prescription fraud. An OIG investigation revealed that the defendant used the name and Drug Enforcement Agency (DEA) registration number of a VAMC physician to set up a fraudulent physician's profile in the database of a local retail pharmacy. The defendant, purporting to be the physician, then used the profile to phone in multiple prescriptions and refills for controlled substances, each time listing himself as the patient. The employee resigned from the VAMC as a result of this investigation.

Veteran Sentenced for Overdose Death of Sailor

A Veteran was sentenced to 30 months' incarceration and 3 years' probation after pleading guilty to distributing Percocet, Codeine, Xanax, and Fentanyl, which were provided to the defendant by a VAMC. An OIG, Naval Criminal Investigative Service, and local police investigation revealed that a 25-year-old sailor bought some of the drugs from the defendant while on leave in Michigan during the 2005 Labor Day holiday. When the sailor returned to duty in Florida, he ingested the substances and died of a drug overdose.

Defendant Pleads Guilty to Pharmaceuticals Theft at Hines, Illinois, VAMC

A co-conspirator involved in a scheme to steal VA pharmaceuticals pled guilty to misbranding of drugs. An OIG investigation determined that the defendant was involved with two other subjects in a conspiracy to steal drugs estimated at $250,000 from the Hines, IL, VAMC pharmacy and resell them at a retail pharmacy. The primary conspirator, a former VA pharmacist, was previously sentenced in this case.

Veterans Arrested for Drug Distribution in Mathews County, Virginia

Eight Veterans and their associates were indicted and subsequently arrested for distributing prescribed narcotics obtained from the Richmond, VA, VAMC to include Oxycontin, Oxycodone, Percocet, and Xanax. An OIG and state police task force investigation revealed that the Veterans were selling their VA prescribed narcotics and having their associates distribute the narcotics throughout the Mathews County, VA, community.

Big Spring, Texas, VAMC Pharmacy Technician Indicted for Drug Theft

A Big Spring, TX, VAMC pharmacy technician was indicted for acquiring a controlled substance by fraud and using the U.S. Mail to unlawfully distribute controlled substances. An OIG and VA Police investigation determined that the defendant, who worked as a prescription refill telephone operator, used the pharmacy profiles of unsuspecting Veterans to steal prescription narcotics by mailing the prescriptions to himself or family members' residences.

San Antonio VAMC Employee Indicted for Narcotics Fraud

A San Antonio, TX, VAMC administrative employee was arrested after being indicted for obtaining prescription narcotics by fraud. A joint OIG and VA Police investigation revealed that between April 2007 and July 2008 the employee fraudulently used the names and DEA numbers of various VA doctors and physician assistants to forge written prescriptions for controlled substances, which he then obtained or attempted to obtain from a local pharmacy.

Physician Impersonator Sentenced

A defendant was sentenced to 12 months and 1 day of incarceration, 3 years' probation, and ordered to pay restitution of $42,758 to two female victims after pleading guilty to making a false statement and wire fraud. An OIG investigation determined that the defendant, a known con artist, applied for a position as a surgeon at the Fort Wayne, IN,

VAMC and represented himself in a resume and a personal interview as a military officer and surgeon with extensive educational and professional experience. Attempts by VA to verify his credentials proved them false. After his arrest, the defendant admitted to providing false statements and engaging in an online scheme to gain the confidence of female victims and then attempt to defraud them.

False Claims for Health Benefits

During this reporting period, OIG initiated 14 investigations regarding fraudulent receipt of health benefits. Among the 10 defendants charged with this type of crime were the following:

- A Veteran who was not eligible for VA health care benefits was indicted for identity theft and theft after a joint OIG and VA Police investigation revealed that the defendant used the identity of another Veteran to fraudulently receive VA health care. The investigation determined that on five occasions at two different Chicago, IL, VAMCs, the defendant fraudulently received medical treatment, counseling, and medication. The loss to VA is $50,923.
- A non-Veteran defendant was sentenced to 27 months' incarceration, 36 months' probation, and ordered to pay restitution of $75,597. An OIG investigation determined that the defendant fraudulently received VA pension and health care benefits after falsely claiming that he was a former Marine with combat service in Vietnam. The defendant was able to collect VA benefits because his military service was erroneously confirmed by the National Archives and Records Administration.

Former Bedford VAMC Employees Charged with Theft from Veterans

Two former Bedford, MA, VAMC employees and another subject were indicted for conspiracy, identity fraud, and access device fraud. An OIG, U.S. Secret Service, and VA Police investigation revealed that the two former employees stole checks, credit card numbers, and bank account numbers from several disabled Veterans who resided at the VAMC. The three defendants then used these items and information to purchase goods and services over the telephone and Internet.

Former West Los Angeles VAMC Employee Sentenced for Theft

A former West Los Angeles, CA, VAMC employee was sentenced to 3 years' probation, 45 days' community service, and ordered to pay restitution of $7,465 after pleading no-contest to elder abuse. A joint OIG and VA Police investigation determined that the defendant stole funds from five elderly and disabled Veterans who were patients at the VA nursing home.

Former Martinsburg, West Virginia, VAMC Nursing Assistant Arrested for Theft

A former Martinsburg, WV, VAMC nursing assistant was indicted and subsequently arrested for identity theft and unauthorized use of an access device. An OIG and VA Police investigation revealed that the defendant used debit cards belonging to two inpatients to obtain money, goods, and services totaling approximately $50,000.

Former VAMC Nurse Sentenced for Workers' Compensation Fraud

A former Columbia, SC, VAMC nurse was sentenced to 5 years' probation and was ordered to pay restitution of $68,763 after pleading guilty to having committed fraud to obtain Federal workers' compensation. A joint OIG and Department of Labor (DOL) OIG investigation determined that, after leaving the VAMC on a work-related injury, the employee failed to notify DOL that she had obtained employment as a nurse in another state while continuing to receive workers' compensation benefits.

Former Atlanta VAMC Employee Convicted of Fraud and Conflict of Interest

A former Atlanta, GA, VAMC employee was convicted at trial of mail fraud, criminal conflict of interest, and obstruction of justice. A co-defendant was sentenced to 13 months' incarceration, 3 years' probation and ordered to pay restitution of $20,200 after pleading guilty to mail fraud. An OIG investigation revealed that the defendants profited from a scheme to receive payments from fiduciaries by providing housing to Veterans suffering from mental illness and substance abuse disorders. The VAMC employee resigned her position during the investigation.

Abuse of Authority and Preferential Treatment at a VAMC in Augusta, Georgia

OIG determined that a VAMC director improperly applied a Title 38 hiring authority, violating Federal law and VA policy in order to make a non-competitive appointment. OIG determined that the director chose this course of action against the advice of the medical center's Human Resources personnel, and in doing so displayed a preference for one favored person while denying others the opportunity to apply and compete for the position. OIG recommended that appropriate administrative action be taken against the director and that the improper appointment be redressed.

Atlanta VAMC Employee Sentenced for Assaulting VA Police Officer

An Atlanta, GA, VAMC employee was sentenced to 3 years' incarceration and 7 years' probation after being convicted at trial of obstruction, fleeing or attempting to elude a police officer, and other charges. An OIG and VA Police investigation determined that the employee struck and injured a VA police officer with her vehicle when she was stopped for expired tags. The employee also hit a vehicle and the officer's bicycle while evading VA Police and fleeing the VAMC property.

Benefits Processing

Many Veterans, especially returning OEF/OIF Veterans, need a variety of benefits and services in order to transition to civilian life. OIG works to improve the delivery of these benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing. In addition, OIG reduces criminal activity in the delivery of benefits through proactive and targeted audit and investigative efforts.

OFFICE OF AUDIT

OIG performs audits of Veterans' benefits programs focusing on the effectiveness of benefits delivery to Veterans, dependents, and survivors. These audits identify opportunities for enhancing the management of program operations and provide VA with constructive recommendations to improve the delivery of benefits.

Audit Finds Deficiencies with Benefits Quality Assurance Program

OIG audited the VBA Systematic Technical Accuracy Review (STAR) process, a quality assurance program that is a key mechanism for evaluating VA Regional Office (VARO) performance in processing accurate benefit claims for Veterans and beneficiaries. OIG determined that VBA's STAR process did not effectively identify and report errors in compensation claim rating decisions. Also, VBA has not fully implemented plans to conduct consistency reviews to ensure that Veterans claiming similar conditions receive the same rating decision and benefits, regardless of which VARO completed the review. Without an effective quality assurance program, VBA cannot adequately monitor performance to make necessary program improvements and ensure Veterans receive accurate and consistent ratings.

Inaccurate Benefit Claim Receipt Dates Did Not Impact Veterans' Benefits

OIG conducted a review to evaluate the accuracy of VARO C&P benefit claim receipt dates after a VBA investigation concluded that VARO New York had intentionally reported inaccurate claim receipt dates. OIG found that the four VAROs reviewed in Albuquerque, Boston, San Diego, and Winston-Salem did not have high rates of inaccurate dates. Further, except for one intentional inaccuracy, inaccurate dates were most likely unintentional. The inaccurate dates did not cause any Veterans to receive incorrect or delayed benefits, nor did they significantly affect most of the reported FY 2008 average claim-processing times. OIG determined that establishing goals for receipt date accuracy and strengthening controls would improve accuracy and documentation and provide greater assurance of reliable claim-processing times.

OFFICE OF INVESTIGATIONS

VA administers a number of financial benefits programs for eligible Veterans and certain family members. Among the benefits are VA guaranteed home loans, education, insurance, and monetary benefits provided by the C&P Service. With respect to VA guaranteed loans, OI conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties.

C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. An ongoing proactive income verification match identifies possible fraud in the pension program. OI also conducts an ongoing death match project that identifies deceased beneficiaries of the VA C&P program whose benefits continue because VA was not notified of the death. In this reporting period, the death match project recovered $3.4 million, with another $1.3 million in anticipated recoveries. Generally, family members of the deceased are responsible for this type of fraud. In the area of benefits processing, OIG opened 258 cases, made 98 arrests, and had almost $20 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Louisville VARO Employee and Thirteen Others Indicted for Conspiracy

Fourteen defendants, including a former Louisville, KY, VA senior Veteran's service representative and a former Disabled American Veterans (DAV) national service officer, were indicted for conspiring to defraud VA, bribery of a public official, and additional charges. The DAV employee was also charged with stealing over $47,000 in contributions made payable to the DAV. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the former VA employee and former DAV employee recruited friends, family members, and other acquaintances to submit fraudulent VA disability claims, supported with counterfeit or altered medical documentation. The former VA employee and the former DAV employee received kickbacks from the Veterans' monthly retroactive checks, most of which were in excess of $2,700 each. The loss to VA is approximately $1.9 million.

VA Monetary Benefits Fraud

During this reporting period, the OIG opened 173 monetary benefits fraud investigations. Among the 51 defendants charged with these offenses were the following:

- The daughter-in-law of a deceased VA widow beneficiary pled guilty to a criminal information charging her with theft of Government funds. An OIG investigation determined that between May 1996 and September 2007 the defendant received, forged, and negotiated VA benefit checks that were issued after her mother-in-law's death. The loss to VA is $185,720.
- The son of a deceased VA beneficiary was sentenced to 1 year home confinement, 5 years' probation, and ordered to pay restitution of $105,964 to VA and $43,847 to the Social Security Administration (SSA) after pleading guilty to theft of Government funds. An OIG and SSA OIG investigation determined that between November 1994 and February 2005 the defendant stole $135,004 in VA benefits and $96,228 in Social Security benefits that were deposited by VA and SSA in his deceased mother's bank account.
- The daughter of a deceased Dependency and Indemnity Compensation (DIC) beneficiary was sentenced to 5 years' probation and ordered to pay VA $156,736 in restitution after an OIG investigation determined that for over 10 years she stole VA funds that were issued after her mother's death.
- The sister of a disabled Veteran, who was also his appointed fiduciary, pled guilty to conversion of money of the United States and income tax violations. She was sentenced to 2 years' probation and ordered to pay restitution of $54,319 to the Veteran and $23,495 to the Internal Revenue Service (IRS) after a joint OIG, Social Security OIG, and IRS Criminal Investigations Division investigation determined that the defendant misappropriated VA funds intended for her brother.
- A Veteran was convicted of submitting false documents and submitting false claims to VA as the result of an OIG investigation that revealed that he fraudulently obtained VA benefits. To support his VA claim the defendant obtained medical records from a hospital in Hawaii and altered them to make it appear that he had been treated for a heart attack in 1974. The loss to VA is $265,963.
- A Veteran was sentenced to 6 months' home detention, 5 years' probation, and ordered to pay $187,130 in restitution after pleading guilty to making false statements. An OIG and SSA OIG investigation revealed that the defendant fraudulently received VA unemployability and Social Security disability benefits and filed a fraudulent application for a VA specially adapted housing grant. The investigation discovered various contractors who had employed the Veteran and financial documents showing his frequent business activity. Also, evidence was obtained showing the Veteran walking with a severe limp and using a cane only for his VA medical appointments.
- A non-Veteran defendant was sentenced to 3 years' probation and ordered to pay restitution of $136,902 after pleading guilty to making false statements. An OIG investigation determined that the defendant obtained the DD-214 of a Veteran with an identical name and used it to obtain compensation benefits for PTSD and medical benefits, while also claiming prisoner of war status.

- A Veteran was sentenced to 6 months' incarceration and ordered to pay VA $198,048 in restitution after being convicted of making false statements to a Federal officer. The Veteran, whose first wife died while they were both on active duty, was previously convicted of DIC fraud in 1989 when he failed to notify VA that he had remarried 1 year after his first wife's death. In that case, the Veteran paid VA $41,320 in court-ordered restitution. A second and more recent OIG investigation revealed that although the Veteran divorced his second wife in 1989, they continued to live together as husband and wife, which made the defendant ineligible for further DIC benefits. During this time period and while on active duty, the defendant also reported to the U.S. Navy that he was still married in order to receive military dependency benefits for his second wife.
- A Veteran pled guilty to theft of Government funds after an OIG investigation determined that he fraudulently received VA pension benefits as a result of failing to report his marriage and self employment income to VA. The loss to VA is $94,176.
- A Veteran was sentenced to 366 days' incarceration and 3 years' probation for making false statements, theft, and wearing unauthorized military medals after an OIG investigation determined that the Veteran testified in a murder for hire case, as the hired hit man, and used his altered military history to bolster his credibility. The Veteran fraudulently received VA benefits by altering and forging various military records, to include his DD-214. The Veteran claimed to have been wounded in combat and to having earned several medals of valor, to include the Purple Heart and Silver Star. The loss to VA is $95,088.

Financial Management

VA needs to provide all its components with accurate, reliable, and timely information for sound oversight and decision making. Since 1999, VA has achieved unqualified ("clean") audit opinions on its consolidated financial statements (CFS). OIG audits and reviews identify areas in which VA can improve financial management controls, data validity, and debt management.

OFFICE OF AUDIT

OIG performs audits of financial management operations, focusing on adequacy of VA financial management systems in providing managers information needed to efficiently and effectively manage and safeguard VA assets and resources. OIG oversight work satisfies the *Chief Financial Officer Act of 1990*, P.L. 101-576, audit requirements for Federal financial statements and provides timely, independent, and constructive reviews of financial information, programs, and activities. OIG reports provide VA with constructive recommendations needed to improve financial management and reporting throughout VA.

VA Receives Unqualified Opinion on CFS

OIG contracted with the independent public accounting firm, Deloitte & Touche LLP (Deloitte), to perform the audit of VA's FY 2008 and 2007 CFS. Deloitte provided an unqualified opinion on those statements and reported three material weaknesses, all of which are repeat conditions from the prior year's audit. They are (1) financial management system functionality, (2) information technology security controls, and (3) financial management oversight. VA corrected a fourth material weakness, retention of computer generated detail records in the Benefits Delivery Network system that Deloitte reported last year. Deloitte reported that VA is not in substantial compliance with the *Federal Financial Management Improvement Act (FFMIA) of 1996* because VA did not substantially comply with Federal financial management systems requirements. Management identified, and Deloitte included in their report, an Antideficiency Act violation. The violation was reported by the Secretary to the President of the United States and Director of the Office of Management and Budget in 2008 related to activity in FY 2007.

OFFICE OF INVESTIGATIONS

OIG conducts criminal and administrative investigations related to allegations of serious misconduct with regard to VA financial management. These investigations often indicate weaknesses and flaws in VA financial management.

Providence VAMC Employee Indicted for Embezzlement

An agent cashier at the Providence, RI, VAMC was indicted for embezzling money of the U.S. A joint OIG, FBI, and VA Police investigation revealed that the cashier initially reported that an armed individual robbed the agent cashier's office. While being interviewed the cashier recanted his story and admitted that he had stolen the cash, checks, and other items. A search of the cashier's vehicle and residence resulted in the recovery of the stolen funds and documents.

Former Philadelphia VAMC Union Officials Sentenced for Embezzlement

A joint OIG and DOL Office of Labor Management Standards investigation revealed that the former president and the former treasurer of an American Federation of Government Employees local union embezzled union money from the Philadelphia VAMC local. The former president was sentenced to 18 months' incarceration, 36 months' probation, and fined $3,000. The former treasurer was sentenced to 12 months and 1 day of incarceration and 24 months' probation. Both defendants were also sentenced to pay total restitution of $184,130.

Former Albuquerque VAMC Employee Indicted for Fraud

A former Albuquerque, NM, VAMC employee, who was the local union president, was indicted for wire fraud. A joint OIG and DOL investigation disclosed that the defendant utilized union debit and credit cards intended for official business to pay for personal expenses. The loss to the union is $84,627.

Former Chicago VAMC Employee Arrested for Theft

A former Chicago, IL, VAMC employee was arrested for felony theft after an OIG investigation revealed that the former employee used her Government-issued purchase card to pay for repairs to her personal automobile, while disguising the purchases to appear as if they were for a Government vehicle. Additionally, the defendant admitted to using the Government purchase card to pay her personal cell phone and residential phone service bills. The loss to VA is $23,768.

Procurement Practices

VA spends over $15 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology (IT), construction, and services. OIG contract audits focus on compliance with Federal and VA acquisition regulations and cost efficiencies, which result in recommendations for improvement. Preaward and postaward contract reviews have resulted in $96.4 million in monetary benefits during this reporting period.

OFFICE OF INVESTIGATIONS

OIG investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. In the area of procurement practices, OIG opened four cases and had $5.2 million in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Criminal Information Filed Against Former CMOP Associate Director, Wife

A criminal information was filed against the former associate director of the Hines, IL, Consolidated Mail Outpatient Pharmacy (CMOP), his wife, and her staffing company charging them with conspiracy to commit wire fraud. The director of the facility previously pled guilty to conspiracy and the acceptance of illegal gratuities. An OIG investigation determined that the director, associate director, and his wife conspired to provide temporary pharmacists to the CMOP at a higher pay rate than employees were previously paid. The staffing company was created by the associate director in 2000 to provide pharmacists to the Hines Outpatient Pharmacy. The company later sought Small Business Administration certification as a woman-owned, minority-owned small disadvantaged business and 8(a) Program participant. The associate director was also charged with wire fraud for making materially false misrepresentations to VA and other Government officials. The defendant falsely claimed that the company was solely managed by his wife in order to avoid conflict of interest laws governing Federal employees. Between 2000 and 2007, the defendants and other unindicted co-conspirators used the company to bill VA for more than $8 million in services.

Former Pharmaceuticals Sales Representative Found Guilty Of Conspiracy

A former pharmaceutical company sales representative was found guilty of conspiracy to introduce or deliver for introduction into interstate commerce a drug that was misbranded after promoting the off-label use of Xyrem. The drug is intended to treat a muscular symptom found in narcoleptic patients; however, in 2002, the company went on an aggressive off-label marketing project to promote its use for other conditions and symptoms. Additionally, the company pled guilty to felony misbranding and introduction of a misbranded drug into interstate commerce with the intent to defraud or mislead, in connection with its illegal promotion of the drug. The company was ordered to pay $20 million in civil and criminal penalties. VA will receive $187,460 of the total settlement. The conviction was a result of a 4-year OIG, FBI, and Food and Drug Administration investigation.

Transcription Service Settles Civil Suit with Government

The largest medical transcription service provider in the U.S. agreed to pay $6.6 million to resolve civil liabilities in connection with their billing practices with the Government. A joint investigation disclosed that since 1998, the company provided medical transcription services to several Federal government clients, including VA, the Department of Defense, and the Public Health Service and billed more for their services than they were contractually permitted. Of the total $6.6 million settlement, approximately $4.2 million related to VA contracts.

Former Fresno Employee and Two Others Plead Guilty in Bribery Case

A former Fresno, CA, VA employee pled guilty to bribery after an OIG investigation determined that the former employee, in his capacity as a contracting officer's technical representative, colluded with the owners of two construction companies to submit inflated change orders in return for kickback payments. The owners each pled guilty to illegally supplementing the salary of a Federal employee. The former VA employee also

received cash payments from the owners of the companies in return for certifying payroll submittals, progress payments, and the awarding of future contracts. This bribery scheme impacted three VAMC construction projects worth nearly $3.5 million.

OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) operates under a reimbursable agreement with VA's Office of Acquisition, Logistics and Construction (OALC) to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OCR provides advisory services to OALC contracting activities. OCR completed 46 reviews in this reporting period. The tables that follow provide an overview of OCR performance during this reporting period.

Preaward Reviews

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Preaward reviews identified $65.3 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule proposals, preaward reviews during this reporting period included 19 health care provider proposals—accounting for almost $15 million of the identified potential savings. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings. For 27 reports, the sustained savings rate was 50 percent.

	October 1, 2008 — March 31, 2009
Preaward Reports Issued	31
Potential Cost Savings	$65,338,316

Postaward Reviews

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the *Veterans Health Care Act of 1992*, P.L. 102-585, for pharmaceutical products. OCR reviews resulted in VA recovering contract overcharges totaling over $31 million, including $561,309 related to Veterans Health Care Act compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 15 postaward reviews performed, 10 involved voluntary disclosures. In 3 of the 10 reviews, OCR identified additional funds due.

	October 1, 2008 — March 31, 2009
Postaward Reports Issued	15
Dollar Recoveries	$31,012,987

COUNSELOR TO THE INSPECTOR GENERAL

Tuscaloosa, Alabama, VAMC in Violation of Federal Acquisition Regulations

As a result of a complaint filed with the OIG Hotline, a review was initiated of procurement practices of the Human Resources Management Services (HRMS) department at the Tuscaloosa, AL, VAMC. OIG found that HRMS violated the Federal Acquisition Regulation (FAR) when it identified and arranged for the hiring of two retired VA employees to provide services to the VAMC through an expedited procurement request. OIG found that

the purchasing agent who completed the request was not aware of the FAR provisions. Moreover, the purchasing agent's actions may have been due in part to inconsistencies between the purchasing agent's performance plan to complete special requests within 3 workdays and with the requirement to comply with the FAR.

Acquisition Rules Not Followed at the Central Alabama Veterans HCS

OIG substantiated that the Central Alabama Veterans HCS failed to comply with the FAR when taking action to procure the services of two retired VA employees. OIG made four recommendations to improve procurement practices within Veterans Integrated Service Network (VISN) 7. OIG also noted that the findings and conclusions in this report mirror those in a prior OIG report pertaining to contracting irregularities at the Tuscaloosa, AL, VAMC, which suggests that problems relating to the procurement of services are more widespread within VISN 7 than previously realized.

Title 38 Fee-Basis Violations Committed at Portland, Oregon, VAMC

OIG substantiated allegations that the Portland, OR, VAMC inappropriately approved and managed fee-basis appointments. The Portland VAMC failed to comply with VA policy when it not only paid retired nurses on a fee-basis instead of a time-basis, but also paid the retired nurses in excess of the amount approved in the fee-basis agreements. The Portland VAMC also violated VA policy by failing to obtain a waiver from the facility director in some cases when it agreed to pay fees to the retired nurses in excess of the annual $15,000 limitation. Lastly, the VAMC neglected to reduce the retired nurses' fees by the amount of their corresponding retirement annuities.

Information Management

OIG oversight work in the IT area reflects the critical role IT plays in all VA operations, and includes audits, criminal investigations, and reviews of IT security policies and procedures. The loss of significant amounts of VA data in May 2006 and January 2007 have highlighted challenges facing VA information security. VA continues to show increased awareness of IT security concerns and has completed some efforts aimed at improvement. OIG has particularly noted VA's commitment to centralizing IT functions, funding, and staff under the direction of the VA's Chief Information Officer. Serious problems remain, however, and OIG will continue close oversight of extensive VA IT activity.

OFFICE OF AUDIT

OIG performs audits of information management operations and policies, focusing on adequacy of VA IT security policies and procedures for managing and safeguarding VA program integrity and patient information security. OIG oversight in IT includes meeting its statutory requirement to review VA's compliance with the *Federal Information Security Management Act of 2002 (FISMA),* P.L. 107-347, as well as IT security reviews conducted as part of the CFS audit. These reviews have led OIG to report information security and security of data and data systems as a major management challenge for VA. OIG's audit reports present constructive recommendations needed for VA to improve its IT management and security.

Federal Information Security Management Act Compliance

OIG contracted with Deloitte to perform the audit of VA's compliance with FISMA. VA continues to face significant challenges in complying with the requirements of FISMA due to the developing nature of its information security program. In order to achieve the FISMA objectives, VA needs to focus on several key areas:

- Remediating the significant number of unresolved Plans of Action and Milestones in the near term, while focusing efforts on addressing high-risk system security deficiencies and vulnerabilities.
- Ensuring that the VA's password complexity standards are enforced on all major application and general support systems across the enterprise.
- Identifying and remediating system security weaknesses on VA's network infrastructure, database platforms, and web application servers across the enterprise.
- Reviewing user accounts to identify and eliminate incompatible system functions, system permissions in excess of required functional responsibilities, and unauthorized system user accounts.
- Reviewing security violations and system audit logs on VA's financial management systems.
- Ensuring that system contingency plans are fully tested and documented in accordance with VA policy.

OFFICE OF INVESTIGATIONS

OI investigates theft of IT equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened five cases, made two arrests, and has $442,010 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Subject Arrested for Theft of Computers at Decatur, Georgia, VA Facility

A subject was arrested for burglary and theft at a Decatur, GA, VA outpatient clinic following an OIG, VA Police, and local police investigation. The defendant was charged with burglarizing the clinic on two separate occasions and stealing two VA computers and accessories. No personal or confidential data was stored on any of the computers. Subsequent to the defendant's arrest, additional warrants were issued by other police agencies for other burglaries committed throughout the metropolitan Atlanta area.

Other Significant OIG Activities

CONGRESSIONAL TESTIMONY

AIGs for Auditing and Investigations Testify on Claims Mishandling and Document Tampering

On March 3, 2009, Assistant Inspector General (AIG) for Auditing Belinda Finn and AIG for Investigations James O'Neill testified at a joint hearing of the U.S. House Veterans' Affairs Subcommittees on Disability Assistance & Memorial Affairs and Oversight & Investigations regarding mishandling and tampering of documents at VAROs. Testimony covered how and what OIG discovered regarding document shredding during an audit of claims-related mail processing; the response from VA and VBA management upon the discovery; OIG's criminal investigations at seven VAROs; and mail amnesty periods held at some VAROs to encourage employees to turn in unprocessed mail without penalty. Other testimony included OIG's audit findings that inaccurate claim receipt dates were likely unintentional.

OIG Officials Testify Before House Appropriations Subcommittee on Challenges Facing VA

On March 12, 2009, AIG for Healthcare Inspections John Daigh, MD; AIG for Auditing Belinda Finn; and Counselor to the Inspector General Maureen Regan testified before the U.S. House of Representatives Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, regarding challenges facing VA in the areas of mental health treatment, quality management, medical research, claims processing, information technology, and procurement. Other issues raised during the hearing were VA's progress on implementing Post 9/11 GI Bill and community based out-patient clinics.

OIG Physician Testifies on Recovery from Traumatic Brain Injury Before the Social Security Administration

Jerome E. Herbers, Jr., M.D., testified at a November 18, 2008, hearing before the SSA Commissioner. The topic of the hearing was to discuss the results of an OIG OHI study conducted on 52 service members who had suffered a traumatic brain injury (TBI) in order to evaluate their recovery progress. Dr. Herbers emphasized the short- and long-term challenges faced by patients with severe TBI and their families.

OTHER VA EMPLOYEE-RELATED INVESTIGATIONS

Calverton, New York, Cemetery Worker Arrested for Compensation Fraud

A Calverton, NY, National Cemetery mechanic was arrested for workers' compensation fraud after an OIG investigation revealed that the employee, who filed a workers' compensation claim for an on-the-job injury that occurred in 2006, was working as a mechanic at an auto body shop. The defendant refused to return to VA employment in any capacity and subsequently earned in excess of $10,000 from the unreported employment. At the time of the arrest, the defendant had been paid approximately $86,000 in workers' compensation.

Threats Made Against VA Employees

During this reporting period, the OIG opened 24 criminal investigations resulting from threats made against VA facilities and employees. Among the 11 defendants charged with making threats were the following:

- The co-owner of a residential facility in Jackson, MS, was convicted of exploitation of a vulnerable adult after an OIG and State investigation revealed that the co-owner and her husband failed to provide adequate living conditions and medical care for Veterans and others residents. In addition, the co-owner and her husband embezzled both VA and Social Security benefit funds from the Veterans. All the residents of the facility, including Veterans, were relocated to other care homes in the local area after the facility was ordered closed by State authorities.
- A Veteran was arrested by OIG and local law enforcement after mailing threatening correspondence to the Baton Rouge, LA, VAMC Outpatient Clinic. The Veteran

threatened various actions if his VA compensation benefits were not increased within a specific time frame. The Veteran referred to ways of causing significant catastrophes, including blowing up Federal buildings. In 2007 the Veteran was arrested by OIG for making similar threats to VA. The Veteran is being held pending extradition to Louisiana.

- A Veteran was indicted after an OIG investigation revealed that the Veteran made several telephone calls to a VA facility and a U.S. Senator's office threatening to commit multiple acts of violence, to include blowing up a VA facility and also threatening to kill a VA fiduciary.

Fugitive Felons Arrested with Assistance of OIG

Veterans and VA employees continue to be identified and apprehended as a direct result of the OIG Fugitive Felon Program. To date, 28.3 million felon warrants have been received from the National Crime Information Center and participating states resulting in 45,099 investigative leads being referred to law enforcement agencies. Over 1,946 fugitives have been apprehended as a direct result of these leads. Since the inception of the program in 2002, OIG has identified $630.1 million in estimated overpayments with an estimated cost avoidance of $714.7 million. Among the 64 fugitive felon program arrests made by OIG, VA police, U.S. Marshals, and local police during this reporting period were the following:

- Two Veterans, previously convicted of sex offenses involving children, had violated conditions of their probation.
- Another Veteran indicted for pandering obscenity involving a minor and illegal use of a minor in nudity-oriented material was arrested by OIG and FBI agents after fleeing to another state.
- A Veteran wanted on a parole violation based on a previous conviction for armed robbery was arrested by local police with assistance of OIG agents.

Additionally, 12 VAMC employees were arrested at various medical centers with the assistance of OIG and VA Police. The employees were wanted on charges to include parole and probation violations, aggravated assault, weapon offenses, and drug violations.

EXTERNAL RECOGNITION

President's Council on Integrity & Efficiency 2008 Awards

- *Investigation Award for Excellence,* Awarded to the Unapproved Drug Distribution Investigation Team in recognition of significant contributions that resulted in the successful prosecution of Bryan Corporation for the sale and distribution of unapproved drugs: Dan Bonda, Chris Fiesel, Sara Hawkins, Sean Smith, Jean Zanewski.
- *Audit Award for Excellence,* Awarded to the Veterans Health Administration Outpatient Waiting Times Audit Team in recognition of significant contributions to enhance patient scheduling and enable Veteran patients to receive timely health care at VA outpatient clinics: Robin Frazier, Joseph Janasz, Brad Lewis, Daniel Morris, Dao Pham, Carla Reid, Larry Reinkemeyer, Lynn Scheffner, Jason Schuenemann, Marcia Schumacher, Oscar Williams.
- *Evaluations Award for Excellence,* Awarded to the VA Medical Center Marion, Illinois, Quality of Care Issues Evaluation Team in recognition of significant contributions by VA OIG in the review of a high mortality rate at the VA Medical Center in Marion, IL, leading to improvements across VA facilities in quality management, hiring and screening of physicians, and patient safety: Andrea C. Buck, Shirley Carlile, Patricia Christ, Limin X. Clegg, Debra Crawford, Linda Delong, Dorothy Duncan, Scott J. Eastman, Jerome E. Herbers, Ashley Y. Ketchum, Jennifer Kubiak, Alan S. Levine, Robert E. Oshel, Reba Ransom, Jennifer Reed, James Seitz, Virginia Solana, Marilyn Stones, Carol Torczon, Brian Tullis, George B. Wesley.

U.S. Attorney's Office Law Enforcement Public Service Award

- Special Agents Paul Powis and James O'Neill, in recognition of their benefits fraud investigation that resulted in the successful prosecution of the son and wife of a Veteran missing for over 15 years who continued to receive the Veteran's VA benefits.

Federal Law Enforcement Officers Association 2008 National Award for Heroism

- Special Agent David Spilker, in recognition of his involvement in a shoot-out with a suspect who was a convicted murder and cop-killer in Chester, PA, as a member of the U.S. Marshals Service Violent Crime Task Force.

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
REPORTS

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
COMBINED ASSESSMENT PROGRAM REVIEWS				
10/16/2008 07-03175-09	Combined Assessment Program Review of the Northampton VA Medical Center Leeds, Massachusetts			
10/17/2008 08-00003-10	Combined Assessment Program Review of the Jesse Brown VA Medical Center Chicago, Illinois			
10/21/2008 08-01428-11	Combined Assessment Program Review of the Wilmington VA Medical Center Wilmington, Delaware			
10/29/2008 08-00402-16	Combined Assessment Program Review of the Minneapolis VA Medical Center Minneapolis, Minnesota			
11/03/2008 07-03176-17	Combined Assessment Program Review of the Togus VA Medical Center Augusta, Maine			
12/02/2008 08-01331-32	Combined Assessment Program Review of the West Palm Beach VA Medical Center West Palm Beach, Florida			
12/03/2008 08-02413-34	Combined Assessment Program Review of the Cheyenne VA Medical Center Cheyenne, Wyoming			
12/11/2008 08-02643-42	Combined Assessment Program Review of the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas			
12/15/2008 08-02445-44	Combined Assessment Program Review of the San Francisco VA Medical Center San Francisco, California			
12/30/2008 08-02559-50	Combined Assessment Program Review of the White River Junction VA Medical Center White River Junction, Vermont			
01/13/2009 08-02871-52	Combined Assessment Program Review of the VA Pittsburgh Healthcare System Pittsburgh, Pennsylvania			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
01/23/2009 08-03085-57	Combined Assessment Program Review of the VA San Diego Healthcare System San Diego, California			
02/03/2009 08-02597-63	Combined Assessment Program Review of the VA Central Iowa Health Care System Des Moines, Iowa			
02/04/2009 08-03042-65	Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System Little Rock, Arkansas			
02/05/2009 08-02986-67	Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona			
02/17/2009 08-01447-68	Combined Assessment Program Review of the Fayetteville VA Medical Center Fayetteville, North Carolina			
02/19/2009 08-03043-70	Combined Assessment Program Review of the West Texas VA Health Care System, Big Spring, Texas			
02/19/2009 08-03275-71	Combined Assessment Program Review of the Lebanon VA Medical Center Lebanon, Pennsylvania			
02/24/2009 08-02561-75	Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital Bedford, Massachusetts			
02/25/2009 08-01332-76	Combined Assessment Program Review of the Birmingham VA Medical Center Birmingham, Alabama			
03/03/2009 08-02414-82	Combined Assessment Program Review of the Robert J. Dole VA Medical Center Wichita, Kansas			
03/10/2009 08-01446-93	Combined Assessment Program Review of the Tennessee Valley Healthcare System Nashville, Tennessee			
03/16/2009 09-00517-97	Combined Assessment Program Review of VA Butler Healthcare Butler, Pennsylvania			
03/24/2009 08-02600-100	Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin			
03/31/2009 08-03074-101	Combined Assessment Program Review of the Lexington VA Medical Center Lexington, Kentucky			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
HEALTHCARE INSPECTIONS				
10/06/2008 08-01362-03	Healthcare Inspection Quality of Care Issues at a VA Healthcare System			
10/16/2008 08-01863-08	Healthcare Inspection Allegations of Delayed Access to Care and Lack of Concern, Bay Pines VA Healthcare System, Bay Pines, Florida			
11/06/2008 08-01825-20	Healthcare Inspection Quality of Care, South Texas Veterans Health Care System, San Antonio, Texas			
11/12/2008 08-02620-22	Healthcare Inspection Questionable Cause of Death VA Puget Sound Health Care System Seattle, Washington			
11/18/2008 08-02317-26	Healthcare Inspection Allegations Regarding the Homeless Women Veterans Program VA Medical Center Atlanta, Georgia			
12/02/2008 08-01711-31	Healthcare Inspection Gastroenterology Service Issues at the VA Southern Nevada Healthcare System Las Vegas, Nevada			
12/03/2008 08-02335-33	Healthcare Inspection Alleged Neglect by a Social Worker Charles George VA Medical Center Asheville, North Carolina			
12/08/2008 08-01634-38	Healthcare Inspection Review of Hospice Care Issues VA Maryland Health Care System Baltimore, Maryland			
12/08/2008 08-02526-39	Healthcare Inspection Oversight of the Community Nursing Home Program Oklahoma City VA Medical Center Oklahoma City, Oklahoma			
12/18/2008 08-02888-48	Healthcare Inspection Credentialing, Privileging, and Infection Control Practices, VA Western New York Healthcare System Buffalo, New York			
12/29/2008 07-00348-49	Healthcare Inspection, Abdominal Aortic Aneurysm Management in VA Medical Facilities			
01/13/2009 08-01850-54	Healthcare Inspection Quality of Care Issues, North Florida/South Georgia Veterans Health System Lake City, Florida			
01/28/2009 08-02089-59	Healthcare Inspection Allegations of Mental Health Diagnosis Irregularities at the Olin E. Teague VA Medical Center Temple, Texas			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
02/02/2009 08-01866-62	Healthcare Inspection Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma			
02/27/2009 08-03007-80	Healthcare Inspection Review of the Veterans Health Administration's Use of Appropriated Funds for Research			
03/04/2009 08-03039-83	Healthcare Inspection Alleged Continuity of Care Issues and Questionable Death Salt Lake City VA Medical Center Salt Lake City, Utah			
03/05/2009 08-03128-85	Healthcare Inspection Certified Registered Nurse Anesthetist Practicing with a Lapsed Certification WJB Dorn VA Medical Center Columbia, South Carolina			
03/31/2009 08-00069-102	Healthcare Inspection, Access to VA Mental Health Care for Montana Veterans			
INTERNAL AUDITS				
10/09/2008 08-01030-05	Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy			
11/17/2008 08-00870-24	Audit of VA's Consolidated Financial Statements for Fiscal Years 2008 and 2007			
12/04/2008 08-03327-35	Review of Alleged Manipulation of Waiting Times, North Florida/South Georgia Veterans Health System			
12/04/2008 08-00879-36	Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments	$380,000,000	$380,000,000	
02/26/2009 08-01076-74	Fiscal Year 2008 Federal Information Security Management Act Assessment			
02/27/2009 09-00189-81	Review of VA Regional Office Compensation and Pension Benefit Claim Receipt Dates			
03/12/2009 08-02073-96	Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Reviews			
OTHER OFFICE OF AUDIT REVIEWS				
03/06/2009 09-00863-87	Independent Review of VA's Fiscal Year 2008 Detailed Accounting Submission to the Office of National Drug Control Policy			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
03/06/2009 09-00864-88	Independent Review of VA's Fiscal Year 2008 Performance Summary Report to the Office of National Drug Control Policy			
ADMINISTRATIVE INVESTIGATION				
12/17/2008 08-01596-45	Administrative Investigation Abuse of Authority and Preferential Treatment, Charlie Norwood VA Medical Center, Augusta, Georgia			
COUNSELOR TO THE INSPECTOR GENERAL SPECIAL REPORTS				
10/06/2008 08-02110-02	Review of Allegations of Contracting Irregularities, VA Medical Center, Tuscaloosa, Alabama			
02/02/2009 08-01866-61	Review of Allegations of Mismanagement, Central Alabama Veterans Health Care System			
03/04/2009 08-02512-84	Review of Allegations of Mismanagement of Fee-basis Appointments VA Medical Center Portland, Oregon			
OFFICE OF CONTRACT REVIEW PREAWARD REVIEWS				
10/01/2008 07-00210-01	Review of Proposed Contract Extension Submitted by Valleylab, a Division of Tyco Healthcare, for Federal Supply Schedule Contract Number V797P-4181a			$2,147,043
10/14/2008 08-02915-06	Review of Proposal Submitted by Reckitt Benckiser Inc. Under Solicitation Number M5-Q50A-03-R2			
10/14/2008 08-02816-19	Review of Proposal Submitted by IU University of Illinois-Chicago, Under Solicitation Number VA-69D-08-RP-0322, for Pathology Services to the Jesse Brown VA Medical Center			$133,631
10/21/2008 08-03022-12	Review of Proposal Submitted by Columbia Heart Clinic, PA, Under Solicitation Number VA-247-08-RP-0132 for Cardiology Services to WJB Dorn VA Medical Center in Columbia, South Carolina			$543,246
10/21/2008 08-02968-13	Review of Proposal Submitted by the University of South Carolina Under Solicitation Number RFP VA-247-08-RP-0087 for Ophthalmology Services for WJB Dorn VA Medical Center in Columbia, South Carolina			$3,362,195

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
10/22/2008 08-02914-14	Review of Proposal Submitted by IU Health Care Associates, Inc., Under Solicitation Number VA-251-08-RP-0196, for Pathology Services to Richard L. Roudebush VAMC	$1,304,112		
10/28/2008 08-02902-15	Review of Proposal Submitted by IU Health Care Associates, Inc., Under Solicitation Number VA-251-07-RP-0125, for Cardiologist Services at Richard L. Roudebush VAMC	$591,931		
11/05/2008 08-02913-21	Review of Proposal Submitted by IU Health Care Associates, Inc., Under Solicitation Number VA-251-08-RP-0130, for Otolaryngology Services to Richard L. Roudebush VAMC	$506		
11/06/2008 08-03194-23	Review of Proposal Submitted by University of New Mexico Health Sciences Center Under Solicitation Number RFP VA-258-08-RP-0083 for Radiology Services at New Mexico VA Health Care System, Albuquerque, New Mexico	$2,159,445	$2,159,445	
11/18/2008 08-01949-25	Review of Contract Extension Proposal Submitted by Zoll Medical Corporation for Federal Supply Schedule Contract Number V797P-4549a	$1,135,538		
11/18/2008 08-03091-27	Review of Proposal Submitted by Interventional Associates of Memphis, Under Solicitation Number VA-249-08-RP-0072, for Angio/Interventional Radiology Services to VA Medical Center, Memphis, Tennessee	$2,887,146		
11/24/2008 08-02798-29	Review of Federal Supply Schedule Proposal Submitted by Bayer Healthcare LLC, Under Solicitation Number M5-Q52A-04-R1			
12/04/2008 09-00095-30	Review of Proposal Submitted by Emory University Under Solicitation Number 247-09-RP-005 for Oncology Services at VA Medical Center Atlanta	$374,865		
12/08/2008 09-00152-40	Review of Proposal Submitted by University of Alabama, Under Solicitation Number VA 247-08-RP-082b, for Cardiothoracic Anesthesia Services to VA Medical Center, Birmingham, Alabama	$507,571		
12/09/2008 08-02635-41	Pre-extension Review of Federal Supply Schedule Proposal Submitted by KCI USA, Inc. Under Contract Number V797P-4443a	$36,815,795		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
12/11/2008 09-00288-43	Review of Proposal Submitted by The Curators of the University of Missouri on behalf of Missouri Rehabilitation Center, Under Solicitation Number VA-256-08-RP-0159, for Ancillary Medical Services at the Gene Taylor Community Based Outpatient Clinic, Mount Vernon, Missouri	$9,068		
12/17/2008 09-00097-47	Review of Proposal Submitted by Toshiba America Medical Systems, Inc. Under Solicitation Numbers M6-Q8-06 & SPO200-06-R8005			
12/19/2008 09-00436-46	Review of Proposal Submitted by Denver Health and Hospitals Authority, Under Solicitation Number VA 259-08-RP-0045	$219,723		
01/07/2009 08-03313-51	Review of Proposal Submitted by Cephalon, Inc. Under Solicitation Number M5-Q50A-03-R2			
01/12/2009 08-02537-53	Review of Proposal Submitted by Virginia Commonwealth University Health System Under Solicitation Number VA-246-07-RP-0029 for Heart Transplant Services to the VA Medical Center in Richmond, Virginia	$1,022,043		
01/22/2009 09-00143-56	Review of Proposal Submitted by Siemens Medical Solutions USA, Inc. Under Solicitation Numbers M6-Q8-06 & SPO200-06-R8005	$6,726,524		
01/23/2009 08-02827-55	Review of Federal Supply Schedule Proposal Submitted by Genentech USA, Inc. Under Solicitation Number M5-Q50A-03-R2	$2,020,930		
01/29/2009 09-00619-64	Review of Proposal Submitted by University of Alabama at Birmingham Under Solicitation Number VA-247-08-RP-0282, for Professional Radiology Services to Birmingham VA Medical Center	$81,288		
02/04/2009 08-02534-66	Review of Proposal Submitted by Virginia Commonwealth University Health System Under Solicitation Number VA-246-07-RP-0030 for Artificial Heart Implant Services to the VA Medical Center in Richmond, Virginia	$949,547		
02/18/2009 09-00918-73	Review of Proposal Submitted by the University of Illinois at Chicago, Under Solicitation Number VA-69D-08-RP-0618 for Interventional Radiology Services at the Jesse Brown VA Medical Center	$498,160		
02/19/2009 09-00070-69	Review of Federal Supply Schedule Proposal Submitted by UDL Laboratories Under Solicitation Number M5-Q50A-03-R2			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
03/05/2009 09-01325-86	Review of Proposal Submitted by St. Louis College of Pharmacy Under Solicitation Number VA-255-08-RQ-0248, for Pharmacy Services to the John Cochran Division of the St. Louis VA Medical Center			
03/06/2009 07-03295-90	Review of Cardinal Health's Contract Extension Request Under Federal Supply Schedule Contract Number V797P-5521x	$1,015,138		
03/09/2009 09-01068-92	Review of Proposals Submitted by University of Colorado Hospital Authority and University Physicians, Inc. Under Solicitation Numbers RFP VA-259-09-RP-0061 and RFP VA-259-09-RP-062 for Radiation Oncology Services for VA Eastern Colorado Health Care System, Denver, Colorado			
03/17/2009 08-02010-99	Review of Federal Supply Schedule Proposal Submitted by Baxter Healthcare Corporation Under Solicitation Number M5-Q50A-03-R2	$510,448		
03/18/2009 08-03155-98	Review of Proposal Submitted by the University of Iowa, Under Solicitation Number VA-263-08-RP-0126 for Casculare Surgery Services to VA Medical Center, Iowa City, Iowa	$322,423		
OFFICE OF CONTRACT REVIEW POSTAWARD REVIEWS				
10/01/2008 08-02711-212	Review of Mylan Pharmaceuticals, Inc.'s Voluntary Disclosures and Refund Offers, Under Federal Supply Schedule Contract Number V797P-5891x			$210,813
10/01/2008 08-02552-214	Review of Voluntary Disclosure and Refund Offer Submitted By Buffalo Supply, Inc., for Pricing Errors Under Federal Supply Contract V797P-4582a			$7,106
10/10/2008 08-01701-04	Review of Merck/Schering-Plough Pharmaceuticals, Inc.'s Implementation of Section 603 Drug Pricing Provisions Under Public Law 102-55 and Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5630x			$410,989
11/18/2008 08-00092-28	Post-Award Review of Pelton and Crane's Federal Supply Schedule Contract V797P-3056m			$41,098
12/03/2008 08-00555-37	Review of Novartis Consumer Health, Inc's Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5354x and V797P-5881x			$384,368

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
01/22/2009 08-01839-58	Review of Watson Pharma's Self Audit Under Federal Supply Schedule Contract Number V797P-5931x			$324,424
01/30/2009 09-00818-60	Review of Contract Modification Number 0014 Under Schering-Plough Corporation's Federal Supply Schedule Number V797P-5777x			
02/18/2009 08-02942-72	Review of Hospira Worldwide Inc. Voluntary Disclosure and Refund Offer of Public Law 102-585 -- 603 Errors Under Contract Number V79P-5396x			$247,303
02/25/2009 08-02944-77	Review of Mayne Pharma Inc.'s Voluntary Disclosure and Refund Offer of Public Law 102-585 -- 603 Errors Under Contract Number V797P-5738x			$127,739
02/25/2009 09-00819-79	Review of Sandoz, Inc.'s Addition of Covered Drugs Under Federal Supply Schedule Contract Number V797P-5894x			$887
02/27/2009 07-02026-78	Post-Award Review of TeamStaff Government Solutions, Inc.'s Federal Supply Schedule Contract V797P-4348a			$30,423
03/06/2009 08-02439-91	Review of Mylan Pharmaceuticals, Inc.'s Voluntary Disclosure of Overpricing, Under Federal Supply Schedule Contract Number V797P-5891x			$8,362,191
03/10/2009 08-01824-94	Report of Monetary Recovery Regarding Off-Label Use of Zyprexa by Eli Lilly and Company			$20,680,373
03/12/2009 07-02596-89	Review of Dey L.P.'s Compliance with Public Law 102-585 (603) Under Federal Supply Schedule Contract Number V797P-5658x			$150,320
03/16/2009 08-03266-95	Post-Award Review of Professional Health Care Services Inc.'s Reported Sales and Industrial Funding Fees Under Federal Supply Schedule Contract V797P-4554a			$34,953

TOTALS

Reports Issued:	**102**
Funds Recommended for Better Use by OIG:	**$445,338,316**
Funds Recommended for Better Use by OIG and Agreed to by Management:	**$382,159,445**
Questioned Costs:	**$31,012,987**

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The *Federal Acquisition Streamlining Act of 1994*, P.L. 103-355, requires Federal agencies to complete final action on each OIG report recommendation within 12 months after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (March 31, 2008, and earlier). The FY 2008 FISMA audit, which contains unimplemented OIG recommendations from previous years' FISMA audits, is included in the total of unimplemented reports and recommendations, but because it was issued after March 31, 2008, it is not included in the reports that are over 1 year old on the right side of the table. Some reports are counted more than once because they have actions at more than one office. Of the reports open less than 1 year, one report has actions at two offices.

Unimplemented OIG Reports and Recommendations				
VA Office	**Total**		**Issued 3/31/08 and Earlier**	
	Reports	Recommendations	Reports	Recommendations
VHA	**62**	**268**	**8**	**17**
VBA	**4**	**10**	**0**	**0**
OI&T[1]	**4**	**52**	**2**	**9**
OM[2]	**1**	**3**	**0**	**0**
OSP[3]	**1**	**1**	**0**	**0**

[1] Office of Information and Technology (OI&T)
[2] Office of Management (OM)
[3] Office of Operations, Security & Preparedness (OSP)

Reports Unimplemented for Over 1 Year					
Report Number	Date of Issue	Title	Responsible Organization(s)	Open Recommendations	Monetary Impact
04-02887-169	07/08/2005	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures	VHA	5 of 8	
04-02330-212	09/30/2005	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	VHA	1 of 3	
05-03028-145	05/17/2006	Review of Access to Care in the Veterans Health Administration	VHA	2 of 9	
06-02238-163	07/11/2006	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans	OI&T	1 of 6	
07-00616-199	09/10/2007	Audit of the Veterans Health Administration's Outpatient Waiting Times	VHA	4 of 5	
06-03677-221	09/28/2007	Audit of the Acquisition and Management of Selected Surgical Device Implants	VHA	2 of 7	$21,948,162
06-00801-30	11/28/2007	Audit of the Veterans Health Administration's Home Respiratory Care Program	VHA	1 of 5	
05-00266-39	12/13/2007	Healthcare Inspection, Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program	VHA	1 of 4	
06-03424-70	02/08/2008	Audit of Veterans Health Administration Blood Bank Modernization Project	OI&T	8 of 9	
08-00373-99	03/20/2008	Combined Assessment Program Review of the VA Long Beach Healthcare System, Long Beach, California	VHA	1 of 10	
TOTALS				**26**	**$21,948,162**

Note: Although the FY 2008 FISMA audit contains 18 unimplemented OIG recommendations from previous years' FISMA audits, it is not included in the table above because these recommendations are reviewed annually in the FISMA audit.

APPENDIX C
INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

The table below cross-references the specific pages in this Semiannual Report to the reporting requirements where they are prescribed by the *Inspector General Act*, as amended by the *Inspector General Act Amendments of 1988,* P.L. 100-504, and the *Omnibus Consolidated Appropriations Act of 1997*, P.L. 104-208.

The *Federal Financial Management Improvement Act of 1996*, P.L. 104-208, (FFMIA) requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the Act. The audit of VA's consolidated financial statements for FY 2008 and 2007 reported three material weaknesses, all of which are repeat conditions from the prior year's audit. The audit also indicated that VA is not in substantial compliance with FFMIA because VA did not substantially comply with Federal financial management systems requirements. VA is in the process of revising and expanding existing remediation plans for the three repeat material weaknesses identified in the FY 2008 and 2007 audit.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	Commented on 312 items
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 7-25
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 7-25
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 35-36
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 7-25
Section 5 (a) (5)	Summary of instances where information was refused	None
Section 5 (a) (6)	List of reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	See pages 26-34
Section 5 (a) (7)	Summary of each particularly significant report	See pages 7-25
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 38
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	See page 38
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	See page 38
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 5(b) of FFMIA	See top of this page

Table 1: Resolution Status of Reports with Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2008	0	$0
Issued during reporting period	14	$31
Total inventory this period	**14**	**$31**
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	14	$31
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**14**	**$31**
Total carried over to next period	**0**	**$0**

Table 2: Resolution Status of Reports with Recommended Funds To Be Put To Better Use By Management

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 09/30/2008	0	$0
Issued during reporting period	1	$380.0
Total inventory this period	**1**	**$380.0**
Management decisions during the reporting period		
Agreed to by management	1	$380.0
Not agreed to by management	0	$0
Total management decisions this reporting period	**1**	**$380.0**
Total carried over to next period	**0**	**$0**

APPENDIX D

GOVERNMENT CONTRACTOR AUDIT FINDINGS

The *National Defense Authorization Act for Fiscal Year 2008*, P.L. 110-181, requires each Inspector General appointed under the *Inspector General Act of 1978* to submit an appendix on final, completed contract audit reports issued to the contracting activity that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the Semiannual Report to Congress. During this reporting period, OIG issued no contract review reports under this requirement.

Copies of this report are available to the public. Written requests should be sent to:

Office of the Inspector General (53A)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

The report is also available on our website:

http://www.va.gov/oig/publications/semiann/reports.asp

For further information regarding VA OIG, you may call 202-461-4720.

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To FAX: (202) 565-7936

To Send Correspondence: Department of Veterans Affairs
Inspector General Hotline (53E)
P.O. Box 50410
Washington, DC 20091-0410

Internet Homepage: http://www.va.gov/oig/contacts/hotline.asp

E-mail Address: vaoighotline@va.gov

Department of Veterans Affairs
Office of Inspector General
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