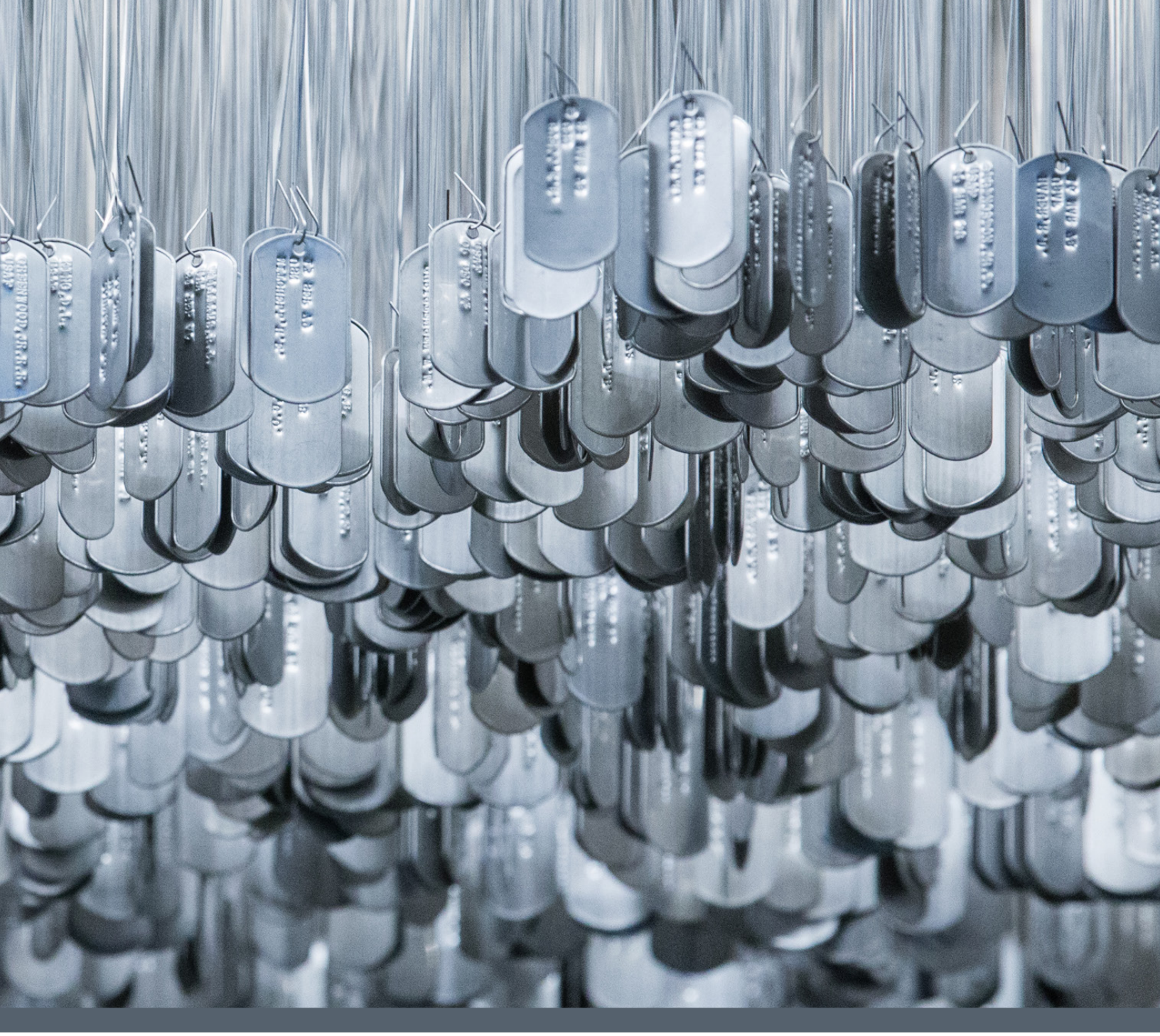


U.S. DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

SEMIANNUAL REPORT TO CONGRESS

Issue 81 | October 1, 2018–March 31, 2019

U.S. Department of Veterans Affairs
Office of Inspector General

MISSION

To serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs (VA) through independent audits, inspections, reviews, and investigations.

VISION

To be recognized as an independent and fair voice for veterans and their families that makes meaningful improvements to VA programs and services, while being responsive to the concerns of veterans service organizations, Congress, VA employees, and the public.

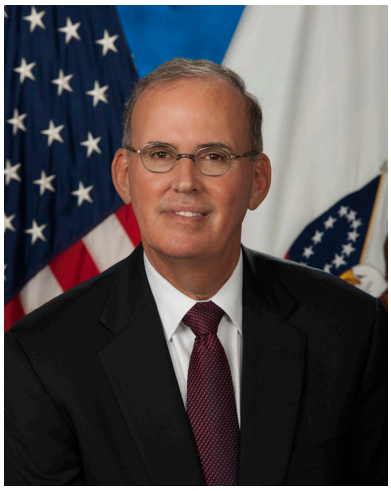
To achieve this vision, the Office of Inspector General (OIG) will

- Make meaningful recommendations that enhance VA programs and operations, as well as prevent and address fraud, waste, and abuse;
- Identify opportunities to promote economy, efficiency, and effectiveness throughout VA and help ensure taxpayer dollars are appropriately spent;
- Safeguard the OIG's independence, consistent with governing laws and policy;
- Identify impactful issues proactively and strategically;
- Produce reports that meet quality standards, including being accurate, timely, proportionate, objective, and thorough;
- Act with transparency by promptly releasing reports that are not otherwise prohibited from disclosure;
- Promote accountability of VA employees; and
- Treat whistleblowers and others who provide information with respect and dignity, including protecting the identities of individuals who wish to remain anonymous.

VALUES

- Meet the highest standards of professionalism, character, and integrity and accept responsibility for actions.
- Maintain a collaborative and engaging work environment that attracts, develops, and retains the highest quality staff.
- Promote diversity, individual perspectives and expertise, and equal opportunity throughout the OIG.
- Honor veterans and the individuals who serve them by continually striving for excellence.

A MESSAGE FROM THE INSPECTOR GENERAL



It is my honor to submit the 81st *Semiannual Report to Congress* on the activities and achievements of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for October 1, 2018, through March 31, 2019. The image on the cover of this report depicts more than 58,000 dog tags representing every American servicemember killed in the Vietnam War, as the nation continues to commemorate its 50th anniversary. This reporting period closed just days after National Vietnam War Veterans Day. We honor those individuals now—as we do all servicemembers, their families, and their caregivers—by remaining focused on our mission to help VA continuously improve its healthcare system, programs, services, and benefits.

OIG personnel continued to work during this reporting period to implement our strategic plan by responding to inquiries or complaints and expanding our proactive initiatives. Some of the more significant work during this period examined such varied areas as deficiencies in pain management and opioid prescribing, improper benefits decisions for veterans with Lou Gehrig's disease, education and construction fraud, coordination of behavioral health care, and falsification of errors in patients' test results. OIG reports and other work conducted in the last six months often centered on three themes:

Leadership and Governance

The OIG has worked to not only identify problems, but remains committed to revealing root causes, including the need for VA to more clearly define and communicate responsibilities and accountability for all efforts. This includes challenging a culture of complacency in some programs or facilities and encouraging effective governance structures.

Systems Planning and Implementation

The OIG has been monitoring the planning and forecasting challenges VA faces in implementing prodigious investments in systems, such as upgrading electronic health records; changes to benefits systems; and significant reforms to health care, particularly in the community. Information technology and financial management pose ongoing obstacles, as do inadequate or outdated policies and quality assurance processes.

Investments in Personnel

The OIG has identified numerous instances in which VA struggled with attracting and retaining qualified staff in particular areas, which affects many of its efforts. Communication, training, credentialing, and instilling a willingness to report problems has also repeatedly drawn the OIG's focus regarding many programs monitored during this period.

These themes emerge throughout the 100 reports issued in this first half of the 2019 fiscal year. The OIG has also produced 24 podcasts, monthly highlights of our criminal investigations, and other communications that help us promote transparency and context for our work. These efforts include the introduction of *Issue Statements* to provide perspectives on important concerns or persistent problems, as well as to help disclose information the OIG has provided to Congress for significant work in assessing the status of a VA implementation effort.

A MESSAGE FROM THE INSPECTOR GENERAL

In this six-month period, the OIG identified more than $3.85 billion in monetary impact for a return on investment of $49 for every dollar spent on oversight. The OIG Hotline received and triaged 15,669 contacts to help identify wrongdoing and concerns with VA programs and activities. Investigators opened 238 investigations and closed 297. Collectively, the OIG's work resulted in 790 administrative sanctions and corrective actions.

The OIG appreciates the opportunity to work with dedicated professionals within VA, Congress, veterans service organizations, and its many other stakeholders to advance programs, services, and health care for veterans and their families across the nation.

MICHAEL J. MISSAL

Inspector General

CONTENTS

ORGANIZATION PROFILE

THE DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) oversees VA's three administrations. The Veterans Health Administration (VHA) provides healthcare services, the Veterans Benefits Administration (VBA) provides monetary and readjustment benefits, and the National Cemetery Administration provides interment and memorial benefits.

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 their country.

VA is the second largest federal employer. For fiscal year (FY) 2019, VA is operating under a $201.1 billion budget, with over 395,000 employees serving an estimated 19.6 million veterans. VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands. It also operates the nation's largest integrated healthcare system. For more information, visit www.va.gov.

THE OFFICE OF INSPECTOR GENERAL

MISSION

The mission of the VA OIG is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, reviews, and investigations.

HISTORY AND STATUTORY AUTHORITY

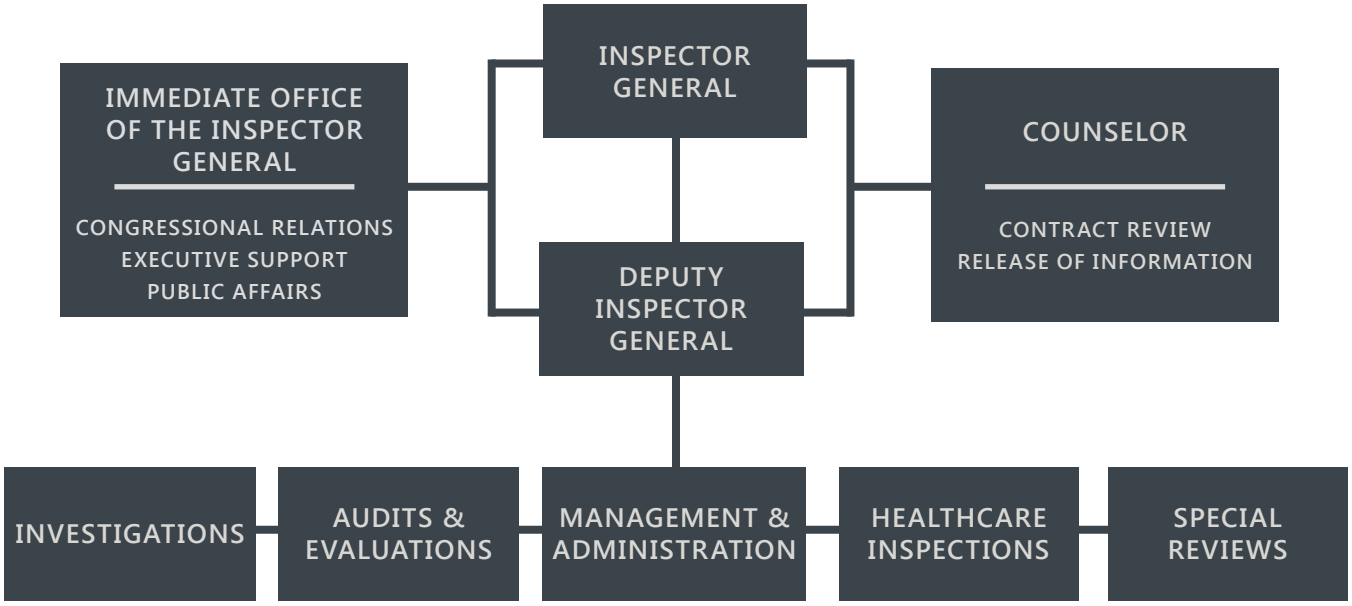
The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (IG Act) (Public Law (P.L.) 95-452, as amended). This act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies 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 and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The Inspector General has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements with the Department. In addition, the Veterans Benefits and Services Act of 1988 (P.L. 100-322) charged the OIG with overseeing the quality of VA health care. Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has more than 900 staff positions organized into six primary directorates: the Offices of Audits and Evaluations, Contract Review (which is overseen by the Office of the Counselor to the Inspector General), Healthcare Inspections, Investigations, Management and Administration (including the OIG Hotline), and Special Reviews. The OIG also has an office for congressional relations, public affairs, and executive support, as well as an Office of the Counselor to the Inspector General. The FY 2019 funding for OIG operations provided $192 million from ongoing appropriations.

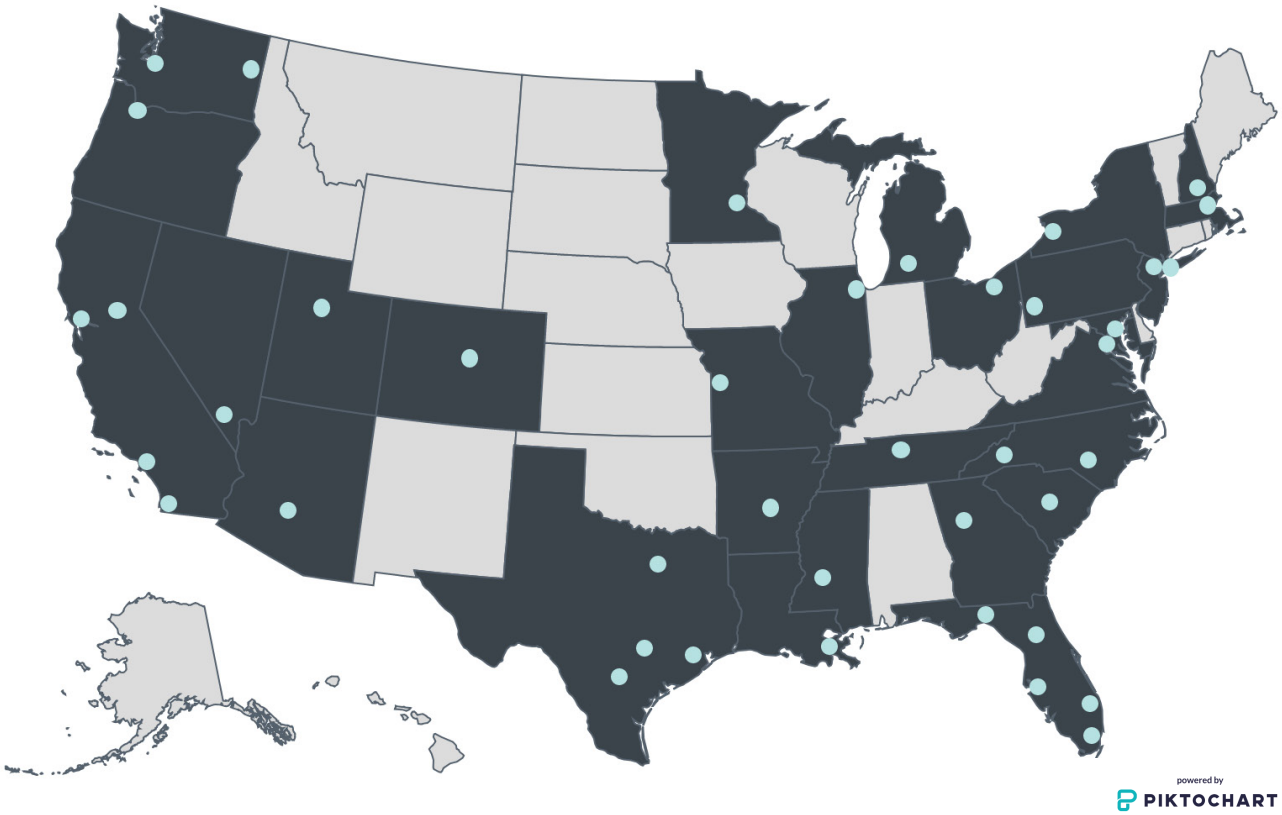
In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff are dedicated to performing their duties fairly, objectively, and with the highest professional integrity. For more information, visit www.va.gov/oig.

OIG ORGANIZATIONAL CHART



ORGANIZATION PROFILE

MAP OF OIG FIELD OFFICE LOCATIONS



ARLINGTON, VA	CLEVELAND, OH	LOS ANGELES, CA	SACRAMENTO, CA
ASHEVILLE, NC	COLUMBIA, SC	MANCHESTER, NH	SALT LAKE CITY, UT
ATLANTA, GA	DALLAS, TX	MINNEAPOLIS, MN	SAN ANTONIO, TX
AUSTIN, TX	DENVER, CO	NASHVILLE, TN	SAN DIEGO, CA
BALTIMORE, MD	FAYETTEVILLE, NC	NEW ORLEANS, LA	SAN FRANCISCO, CA
BATTLE CREEK, MI	HOUSTON, TX	NEW YORK, NY	SEATTLE, WA
BAY PINES, FL	JACKSON, MS	NEWARK, NJ	SPOKANE, WA
BEDFORD, MA	KANSAS CITY, MO	PHOENIX, AZ	TALLAHASSEE, FL
BUFFALO, NY	LAS VEGAS, NV	PITTSBURGH, PA	WASHINGTON, DC
CHICAGO, IL	LITTLE ROCK, AR	PORTLAND, OR	WEST PALM BEACH, FL

OFFICES OF THE INSPECTOR GENERAL

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The office serves as the central coordination point for all executive correspondence, congressional testimony, media inquiries, and stakeholder engagement. The Inspector General and Deputy Inspector General provide leadership and set the strategic direction for a nationwide staff of auditors, investigators, inspectors, attorneys, healthcare professionals, and support personnel who conduct independent oversight of the second-largest agency in the federal government. The office includes congressional relations and public affairs staff who ensure that information is accurately and promptly released and that requests from legislators and reporters are appropriately addressed.

THE OFFICE OF AUDITS AND EVALUATIONS

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Staff are involved in evaluating such diverse areas as healthcare inventory and financial systems, administration of benefits, resource utilization, acquisitions, construction, and information security. This work addresses VA program results; economy and efficiency; controls; fraud indicators; and compliance with legal mandates, policies, and other guidance. Staff also identify opportunities to enhance VA operations and veteran care and support.

THE OFFICE OF CONTRACT REVIEW

Under the supervision of the Counselor to the Inspector General, the office provides preaward, postaward, and other pricing reviews of Federal Supply Schedule, construction, and healthcare provider contracts. Preaward reviews provide VA contracting officers with assistance and information needed to negotiate fair and reasonable prices, and to protect the interests of veterans and taxpayers. Postaward reviews assess compliance with contract terms and conditions and help recover identified overcharges.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The counselor's office provides independent legal advice to OIG leaders and is involved in all aspects of office operations. OIG attorneys provide legal support for investigations, audits, and inspections; work with OIG investigators in developing *qui tam* and False Claims Act matters; represent the OIG in employment litigation and personnel matters; and inform legislative proposals and congressional briefings. The counselor's office also oversees the work of the Release of Information Office and the Office of Contract Review.

THE OFFICE OF HEALTHCARE INSPECTIONS

Healthcare Inspections assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG Hotline complaints, congressional requests, and other leads. The office also performs inspections of individual medical facilities and systems. Field staff participate in Comprehensive Healthcare Inspection Program (CHIP) site visits focusing on leadership, quality management, and adherence to requirements and standards for patient care provision and documentation. Facility results are aggregated into summary reports that identify national trends. This office also conducts statistically supported national reviews of topical issues and provides consultations to criminal investigators and audit staff as needed.

ORGANIZATION PROFILE

THE OFFICE OF INVESTIGATIONS

This office investigates crimes involving VA programs and operations by employees and nonemployees. Criminal investigations focus on such issues as benefits and procurement fraud (including Service-Disabled Veteran-Owned Small Business fraud); embezzlement, extortion, and bribery; drug theft and diversion; theft of VA resources and data; identity theft; homicide, manslaughter, sexual assault, and rape; and threats against VA employees, patients, facilities, and computer systems. Staff have also released reports in response to allegations of serious violations of policies and procedures by high-ranking VA leaders such as misuse of government resources and official time, preferential treatment, abuse of authority, nepotism, and travel irregularities. Going forward, administrative investigations of senior officials will be performed by the Office of Special Reviews.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

Staff provide comprehensive support services to the OIG. This office promotes organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, and information technology (IT) and data services to the organization. The office also oversees the OIG Hotline, which receives, screens, and refers all allegations and complaints for additional action. Cases are accepted on a select basis, prioritizing those having the most potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue of redress. In addition, through report follow-up, the office helps to ensure that corrective actions taken by VA in response to OIG recommendations are effectively monitored and resolved.

THE OFFICE OF SPECIAL REVIEWS

This office was created in January 2018 to increase the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. It is led by an executive director and a deputy director, who have staffed the office with professionals possessing a broad array of expertise. This office undertakes projects assigned to it by the Inspector General and Deputy Inspector General and also works collaboratively with the other directorates to review topics and issues of interest that span multiple offices.

HIGHLIGHTED ACTIVITIES AND FINDINGS

Pursuant to the Inspector General Act of 1978, this Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the reporting period October 1, 2018–March 31, 2019. Highlighted below are some of the activities conducted during this period by the VA OIG's offices and their impact, followed by statistical tables that summarize key performance measures. Subsequent sections of the report then feature examples of each office's high-impact publications and activities. This information is supplemented by appendixes that detail such information as titles of OIG publications released; the monetary impact of OIG products including savings, cost avoidance, and dollar recoveries; the status of VA's implementation of recommendations; and reporting requirements.

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

This office consists of the Inspector General and Deputy Inspector General's executive support staff, as well as congressional relations and public affairs personnel.

CONGRESSIONAL RELATIONS

The OIG actively engages Congress on critical issues facing veterans. During this reporting period, the OIG testified before Congress at two hearings: (1) the House Committee on Veterans' Affairs (HVAC) Subcommittee on Disability Assistance and Memorial Affairs on VA's development and implementation of policy initiatives, and (2) the House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies on challenges facing VA. OIG staff also participated in the HVAC Subcommittee on Health Roundtable discussion on veteran suicide prevention efforts. In addition, the Inspector General and OIG personnel had 30 briefings with congressional members and their staff during this period. These included prerelease briefings regarding the OIG reports on deficiencies in routine clinical evaluations in VA health facilities, opioid prescribing practices, and VBA benefit claims processing. OIG congressional relations staff fielded approximately 100 requests related to constituent casework for review or referral as well.

PUBLIC AFFAIRS

The OIG is committed to providing accurate and timely information to veterans and their families, the media, veterans service organizations, VA staff and leaders, and the public. During this reporting period, the OIG issued one press release on OIG leader Dr. John D. Daigh, Jr.'s, receipt of a 2018 Presidential Rank Award of Distinguished Executive, contributed to press releases from the U.S. Department of Justice on criminal investigations with which the OIG was involved, and responded to 55 queries from journalists. The OIG also produced 11 podcasts that provide context and perspectives on OIG's oversight work. The media relations staff oversees the social media functions and both internal and external communications with stakeholders to ensure the transparency of OIG work.

HIGHLIGHTED ACTIVITIES AND FINDINGS

THE OFFICE OF AUDITS AND EVALUATIONS

The OIG Office of Audits and Evaluations (OAE) performs audits, reviews, and inspections to help ensure that veterans receive the medical care and benefits to which they are entitled. OAE continues to organize and position itself to provide timely and high-quality oversight of VA programs and services. Key to this endeavor is OAE's ongoing effort to focus on the professional development of its staff, thereby building subject matter expertise in specific VA programs. This staff investment helps the OIG better understand the Department's program policies, performance metrics, outputs, and outcomes. For example, the staff of OAE's Atlanta Audit Operations Division are pursuing training and certification in supply chain management. This certification will position OIG auditors to better research, identify, and report on deficiencies in VA's inventory management and distribution that can put patients and assets at risk. This continuous drive for greater expertise is key to OIG's development of practical and applicable recommendations to VA leaders and program managers in audit reports.

During this reporting period, OAE identified an estimated $2.37 billion in potential monetary benefits. OAE's efforts continue to focus on oversight of specific, high-risk areas within VA. This proactive identification of areas of vulnerability within VA should help improve program management, delivery of care and benefits to veterans, and ensure that taxpayer dollars are well spent. This reporting period, OAE reports identified issues in key areas where VA struggles to manage its responsibilities, such as in the delivery of survivors' and dependents' educational assistance benefits, the oversight of State Approving Agency monitoring for Post-9/11 GI Bill students, and the governance of the VA Police program at medical facilities.

THE OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) conducts preaward and postaward reviews of significant VA proposals and contracts, and other projects concerning contracting matters as appropriate. The majority of OCR's reviews relate to contracts awarded by VA under the Federal Supply Schedule (FSS) program, construction contracts, and sole-source contracts with affiliated medical schools for physician services. These reviews assist VA in achieving the best prices during negotiations, resulting in cost savings to the government and ensuring contractors comply with all contract terms and conditions. The office also ensures pharmaceutical manufacturers' compliance with the pricing provisions contained in the Veterans Health Care Act of 1992 (P.L. 102-585) and provides support to the Department of Justice in litigation and investigations involving VA contracts, such as *qui tam* lawsuits and false claims. During this reporting period, OCR made recommendations for lower pricing with potential cost savings of nearly $1.3 billion and identified more than $22 million in contract overcharges. OCR's new special projects team has completed its first review and is finalizing the draft report to be published later in the fiscal year.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The Office of the Counselor continues to provide legal support to all components of the OIG. In this reporting period, such work included providing legal counsel to a combined team of OIG auditors and investigators in a review of mismanagement of the VA Executive Protection Division, assisting the Audits and Evaluations staff in completing a review of VA's oversight of State Approving Agencies, and teaming with Healthcare Inspections staff on a review of allegations concerning opioid prescribing practices at the Tomah VA Medical Center in Wisconsin. Attorneys also continued to represent the OIG in employment-related litigation and other employee relations matters. The office added two new attorneys during this reporting period to strengthen its litigation capabilities and provide expert advice on investigative and administrative matters. Attorneys also continued to work closely with the Office of Investigations on a number of *qui tam* matters and cases involving potential fraud in VA-administered programs. Finally, the Release of Information Office continued to make substantial contributions to the OIG's work this reporting period. This office represented the OIG in establishing data use agreements with several other federal Inspectors General to aid in ongoing criminal investigations. It also reviewed nearly 500 requests for agency records from the public and other government agencies, in addition to reviewing all OIG reports before publication for compliance with the Privacy Act of 1974 (P.L. 93-579) and other disclosure laws.

THE OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) remains focused on issues that impact the provision of quality care to veterans. In this SAR period, OHI continued to examine leadership lapses. The Comprehensive Healthcare Inspection Program (CHIP) reports of VA facilities assess leadership engagement and responsiveness to staff and veterans. Because many of OHI's publications have questioned the adequacy of information sharing and oversight between Veterans Integrated Service Networks (VISNs) and medical facilities, the CHIP teams have piloted five comprehensive VISN reviews to better understand how regional leadership contributes to resource allocation concerns, operations, and, ultimately, the performance of these local facilities. Even as OHI advances its leadership evaluations, staff are also prioritizing reviews of the frontline interface between healthcare providers and veterans. OIG publications issued during this reporting period have addressed such matters as ineffective or absent care coordination, delayed or missed notification of critical test results, and falsification of test results in patients' electronic health records. They highlight the challenges and unnecessary risks that must be addressed by implementing OIG recommendations, particularly those affecting care provided to veterans.

New initiatives include a series of reports that will focus on care provided to veterans outside of the traditional medical center environment. OHI will review how community-based outpatient clinics and other care settings or mechanisms, such as VA purchased care and telehealth, meet the needs of

veterans in rural or underserved regions. Building upon the last OIG report's approach to understanding facility leaders' noted gaps in staffing, this year's national review of Veterans Health Administration (VHA) staffing includes additional survey questions to understand how the landscape of critical shortages has changed and whether VHA has filled these gaps in staffing. In this sixth review of critical staffing shortages, OHI remains committed to reporting on the challenges of meeting the healthcare needs of veterans and recognizes the necessity for staffing models that can effectively support those needs. OHI also recognizes the significance of two major transformations planned for VHA. With implementation of the MISSION Act and the modernization of the electronic health record system, how veterans access and ultimately use VHA services may significantly change. With the potential for considerable expansion of care into the community, coordination among clinicians will become even more critical and will require a sophisticated electronic health record. OHI will monitor these efforts and evaluate the impact on care provided to veterans during the implementation phases and beyond.

THE OFFICE OF INVESTIGATIONS

The Office of Investigations (OI) addresses crimes involving VA programs and operations by employees and nonemployees. OIG staff's criminal investigations continue to focus on impactful issues that include benefits and procurement fraud (including Service-Disabled Veteran-Owned Small Business fraud); embezzlement, extortion, and bribery; drug theft and diversion; theft of VA resources and data; identity theft; homicide, manslaughter, sexual assault, and rape; and threats against VA employees, patients, facilities, and computer systems. Investigations yielded millions of dollars in recoveries for VA and resulted in significant judicial and administrative actions.

OI's Investigative Development Division (IDD) identified and investigated complex fraud cases that are related to construction, procurement, community care, and grants and education. The IDD continues to expand its capacity by adding experienced special agents and investigative analysts. OI also uses regional proactive working groups (PWGs) to help detect high-risk program areas that are susceptible to high-impact fraud. The IDD and PWGs coordinate closely to ensure that emerging criminal enterprises and important investigations receive adequate attention and resources. OI's growing forensic auditor program now has 12 personnel embedded with criminal investigators in OI offices in 10 states. In December 2018, OI also began coordinating with data analytics specialists to identify patterns of fraud in education and community care to help identify vulnerabilities within these programs, as discussed more fully below.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

The Office of Management and Administration (OMA) provides comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency, and to support the OIG's overall mission and goals. In the last six months, OMA had a central role in enhancing the OIG's predictive analytics and data modeling program. To that end,

OMA partnered with cross-directorate subject matter experts as well as staff from the National Technical Information System and joint venture partners from Booz Allen Hamilton to conduct thorough analyses of VA programs to identify fraud, waste, and abuse. This work generated leads for impactful oversight projects, with work ongoing by OI and OAE staff. The team also prepared multiple models for ongoing waste, fraud, and abuse-related surveillance for high-risk program areas.

OMA continued to enhance OIG's oversight capacity by spearheading efforts to recruit top talent and support the workforce. For example, in January 2019, OMA began transitioning responsibilities for staff acquisition—the process of classifying OIG positions, announcing opportunities, and identifying the best-qualified applicants—from a shared services provider to an internal team of human resources specialists. Over the long term, this transition is expected to enhance the OIG's ability to recruit top talent as internal specialists are positioned to identify applicants with the unique skillsets needed. Further, OMA took steps to support the professional development of OIG's workforce by finalizing an organizational needs analysis to inform enhancements to the OIG's centralized training program. That program will foster the knowledge, skills, and abilities staff require.

THE OFFICE OF SPECIAL REVIEWS

The Office of Special Reviews (OSR) is conducting work on a number of allegations concerning VA programs, operations, and staff that are not within the scope of another single directorate. In addition, the Administrative Investigations Division, formerly part of OIG's Office of Investigations, merged with the Office of Special Reviews in October 2018. OSR is continuing to build its staff. This office undertakes projects assigned to it by the Inspector General and Deputy Inspector General and also works collaboratively with the other directorates to review topics and issues of interest that span multiple offices. Among the work currently underway is a review of the implementation and operation of VA's Office of Accountability and Whistleblower Protection.

STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE REPORTING PERIOD

124 PUBLICATIONS

101 ARRESTS

97 CONVICTIONS, PRETRIAL DIVERSIONS, AND DEFERRED PROSECUTIONS

2 CONGRESSIONAL TESTIMONIES

790 ADMINISTRATIVE SANCTIONS AND CORRECTIVE ACTIONS

15,669 HOTLINE CONTACTS

$49:1 RETURN ON INVESTMENT

386 RECOMMENDATIONS TO VA

$3,855,514,183 MONETARY IMPACT

11 PODCASTS

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD
Better Use of Funds	$34,263,584
Dollar Recoveries	$28,121,022
Fines, Penalties, Restitution, and Civil Judgments	$40,713,881
Fugitive Felon Program	$110,700,000
Savings and Cost Avoidance	$1,305,415,696
Questioned Costs	$2,336,300,000
Total Dollar Impact	**$3,855,514,183**
Cost of OIG Operations[1]	$78,384,000
Return on Investment[2]	**$49:1**

1. The six-month operating cost for OHI ($17.6 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

2. The return on investment is calculated by dividing Total Dollar Impact by Cost of OIG Operations.

TABLE 2: REPORTS AND OTHER PUBLICATIONS

REPORT TYPE	THIS PERIOD
Administrative Investigations	5
Audits and Reviews	11
Claim Reviews	0
Comprehensive Healthcare Inspections	19
Hotline Healthcare Inspections	11
National Healthcare Reviews	1
Postaward Reviews	18
Preaward Reviews	35
Subtotal	**100**
OTHER PUBLICATION TYPE	**THIS PERIOD**
Administrative Summaries of Investigation	1
Congressional Testimony	2
Issue Statements	1
Major Management Challenges	1
Monthly Highlights	6
Peer Reviews of other Offices of Inspector General	1
Podcasts	11
Press Releases	1
Subtotal	**24**
Total	**124**

STATISTICAL PERFORMANCE

TABLE 3: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE[1]	THIS PERIOD
Arrests[2]	101
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	13
Indictments[3]	84
Indictments and Informations Resulting from Prior Referrals to Authorities	113
Criminal Complaints	25
Convictions	88
Pretrial Diversions and Deferred Prosecutions	9
Case Referrals to Department of Justice for Criminal Prosecution[4]	169
Cases Accepted	66
Cases Declined	65
Cases Pending	38
Case Referrals to State and Local Authorities for Criminal Prosecution[5]	34
Cases Accepted	19
Cases Declined	8
Cases Pending	7
Administrative Sanctions and Corrective Actions	245
Cases Opened	238
Cases Closed[6]	297

1. Pursuant to §5(a)(18) of the IG Act, all investigative data reported and analyzed were collected via the OIG's case management system. Although the IG Act, under §5(a)(17), requires federal inspectors general to list the total number of investigative reports issued during the reporting period, the VA OIG does not publish or issue investigative reports related to criminal investigations. Reports of noncriminal investigations are disclosed in Table 2. Summaries of arrests and other subsequent actions in selected criminal cases are summarized in the OIG's Monthly Highlights publication, available at www.va.gov/oig/publications/monthly-highlights.asp.

2. Total arrests include five apprehensions of fugitive felons by VA OIG agents. This total does not include fugitive felon arrests made by other agencies with VA OIG assistance.

3. Indictments may result from referrals made to prosecutorial authorities prior to the current reporting period.

4. The IG Act, under §5(a)(17), requires federal inspectors general to report the "total number of persons" referred to federal authorities for criminal prosecution. However, the VA OIG's case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

5. The IG Act also requires federal inspectors general to report the total number of persons referred to state and local authorities for criminal prosecution. However, the VA OIG's case management system does not track the number of individuals referred for prosecution, but rather tracks the number of cases referred.

6. This total also includes cases opened in previous fiscal years.

TABLE 4: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD
Contacts	15,669
Cases Opened	841
Cases Closed	834
Administrative Sanctions and Corrective Actions*	545
Substantiation of Allegations Percentage Rate	38%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	36
Individuals Provided Office of Special Counsel Contact Information	81
Individuals Provided Merit Systems Protection Board Contact Information	9
Individuals Provided Office of Resolution Management Contact Information	145

* The totals for these activities include cases that opened in previous fiscal years.

TABLE 5: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	4
Hotline Referrals Reviewed	1,773

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

OVERVIEW

OAE published 11 reports and one issue statement during this SAR reporting period. These include a focus on issues that have a meaningful impact on veterans' health and benefits, management of VA resources and taxpayer dollars, and the effective operations of VA programs and services. The list of all OAE report recommendations for corrective action made during the reporting period can be tracked on OIG's dashboard at www.va.gov/oig. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012.

12
PUBLICATIONS

70
RECOMMENDATIONS

$2.37B
MONETARY BENEFITS

FEATURED PUBLICATIONS

The following three publications provide examples of the type of work OAE conducts that focuses on identifying problems and making recommendations that can have a significant effect on VA and the veterans it serves. These reports address the processing and adjustment of compensation benefits in the Survivors' and Dependents' Educational Assistance Program, Post-9/11 GI Bill oversight, and the effectiveness of the law enforcement governance structure at VA medical facilities.

DELAYS IN THE PROCESSING OF SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE PROGRAM BENEFITS LED TO DUPLICATE PAYMENTS

The OIG conducted this audit to determine whether VBA adjusted compensation benefits in the Survivors' and Dependents' Educational Assistance (DEA) Program in a timely manner and accurately processed benefits payments. The DEA Program is VA's second-largest education program with more than $553 million in benefits paid in FY 2017. The OIG found that delays in the processing of DEA benefit adjustments led to overpayments totaling approximately $4.5 million through February 1, 2018. Continued delays could result in an estimated $22.5 million in improper payments over a five-year period if no improvements are made. The OIG recommended that VBA ensure monitoring of electronic mailboxes, implement a process to make certain benefit notifications are received by regional staff, develop system functionality to identify cases with potential duplication of benefits, process benefit adjustments when ready, and take prompt action to adjust benefits for cases in the OIG sample in which payment duplications had not been identified.

VA'S OVERSIGHT OF STATE APPROVING AGENCY PROGRAM MONITORING FOR POST-9/11 GI BILL STUDENTS

The OIG conducted this audit to determine if VA and State Approving Agencies (SAAs) were effectively reviewing and monitoring education and training programs that enrolled Post-9/11 GI Bill students to ensure only eligible programs participated. Prior OIG reports noted financial risks for these programs. Based on its review, the OIG estimated that 86 percent of SAAs did not adequately oversee the education and training programs to make certain only eligible programs participated. The OIG estimated that, without correction, VBA could issue an estimated $2.3 billion in improper payments

to ineligible programs over the next five years. Oversight deficiencies occurred, in part, because VBA maintained it has a limited role for oversight of SAAs. The OIG recommended clarifying requirements for approvals, requiring periodic re-approval of programs, reporting schools with misleading advertising, strengthening compliance, revising program assessment standards, and confirming that SAA funding can support the recommended steps.

INADEQUATE GOVERNANCE OF THE VA POLICE PROGRAM AT MEDICAL FACILITIES

The OIG audited the VA security and law enforcement program to determine whether there was an effective governance structure for reasonably assuring that the program was meeting its objectives, including protecting individuals at VA medical facilities. The OIG also examined whether the police workforce met staffing requirements and whether there was an adequate inspection program of its police units. The OIG found that VA did not have adequate governance over its police program to ensure effective management and oversight. Governance problems stemmed from confusion about police program roles and authority as well as the lack of a coordinated and centralized governance structure. The OIG made five recommendations for clarifying oversight responsibilities and evaluating the need for a centralized management entity, ensuring facility-appropriate police staffing models are implemented, addressing facilities' staffing challenges, providing resources for timely inspections of police units, and developing procedures for investigating medical facility leaders' alleged misconduct.

VETERANS HEALTH ADMINISTRATION PUBLICATION

OIG audits and evaluations of VHA programs focus on the effectiveness of healthcare delivery for veterans. These audits and evaluations identify opportunities for enhancing the management of program operations and provide VA with constructive recommendations to improve healthcare services.

EMERGENCY CACHE PROGRAM: INEFFECTIVE MANAGEMENT IMPAIRS MISSION READINESS

The OIG audited the VHA Emergency Cache Program to determine if it is maintained in a mission-ready status. The VA established the program after 9/11 to ensure drugs and medical supplies are available in the aftermath of a local mass casualty event. Valued at $44 million, VA maintains emergency caches at 141 VA medical facilities nationwide. The OIG found expired, missing, or excess drugs (or some combination) at all caches. Also, there were no wall-to-wall inventories conducted by VA as required. The OIG found the mission-ready status of the caches was impaired by ineffective management. The OIG recommended enhancing oversight of the program, developing requirements that all medical facilities with caches perform annual inventories, and improving cache inventory management. The OIG also recommended VHA assess whether the program is properly aligned and coordinate with other VA offices to determine responsibilities. Finally, the OIG recommended identifying drugs and supplies that can be used in medical facilities' general operations.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

VETERANS BENEFITS ADMINISTRATION PUBLICATIONS

The OIG performs audits and evaluations of veterans' benefits programs, focusing on the effectiveness of benefits delivery to veterans, eligible family members, and caregivers to identify ways in which program operations and services can be improved.

ACCURACY OF CLAIMS INVOLVING SERVICE-CONNECTED AMYOTROPHIC LATERAL SCLEROSIS

The OIG conducted this review to determine whether VBA accurately decided veterans' claims involving service-connected Amyotrophic Lateral Sclerosis (ALS), which is also known as Lou Gehrig's disease. The OIG found that claims processing involving service-connected ALS needs improvement. About 45 percent of ALS claims completed from April through September 2017 had erroneous decisions. These errors resulted in estimated underpayments of about $750,000 and overpayments of about $649,000. The errors were due to the complexity of ALS claims. Also, VBA staff generally do not tell veterans about special monthly compensation (SMC) benefits that may be available because VBA believes they are not required to do so. The OIG recommended that VBA implement a plan to improve and monitor decisions involving service-connected ALS. The OIG also recommended that VBA implement a plan to provide notice regarding additional SMC benefits that may be available to veterans with service-connected ALS.

FOR MORE INFORMATION

View the OIG's Recommendation Dashboard at www.va.gov/oig to track VA's progress in implementing OIG recommendations.

FOREVER GI BILL: EARLY IMPLEMENTATION CHALLENGES ISSUE STATEMENT

This Issue Statement discloses information the OIG provided to members of Congress with some additional context, following a November 30, 2018, request from 12 senators and one congressman to investigate allegations that VA planned to withhold retroactive payments for missed or underpaid monthly housing stipends for students under the Forever GI Bill. The OIG found that VBA failed to modify their electronic systems to make accurate housing allowance payments by the required implementation date under sections 107 and 501 of the Forever GI Bill. These sections fundamentally redesign how VBA pays monthly housing allowances to veterans using the Post-9/11 Educational Assistance Program. VA lacked an accountable official to oversee the project during most of the effort. This resulted in unclear communications and inadequately defined expectations. In November 2018, the Under Secretary for Benefits became the official responsible for implementing the Forever GI Bill.

FINANCIAL MANAGEMENT AND INFORMATION TECHNOLOGY PUBLICATIONS

The OIG performs audits of administrative support functions and financial management operations, focusing on the adequacy of VA systems in providing managers with information needed to efficiently and effectively oversee and safeguard VA assets and resources. OIG oversight work satisfies the Chief Financial Officers Act of 1990 (P.L. 101-576) audit requirements for federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

In addition, the OIG performs audits of IT and security operations and policies, focusing on the adequacy of VA's IT and security policies and procedures for managing and protecting veterans and VA employees, facilities, and information. OIG audit reports present VA with constructive recommendations to improve IT management and security. OIG oversight also includes meeting its statutory requirement to review VA's compliance with the Federal Information Security Modernization Act of 2014 (P.L. 113-283) as well as IT security evaluations conducted as part of the Consolidated Financial Statements audit.

LOST OPPORTUNITIES FOR EFFICIENCIES AND SAVINGS DURING DATA CENTER CONSOLIDATION

The OIG conducted this audit to determine whether VA met Federal Information Technology Acquisition Reform Act data center requirements. The OIG found that VA did not maintain complete data center inventories or sufficient plans for consolidation and for achieving cost savings and optimization targets. As a result, VA did not meet an FY 2018 target of $85.35 million in savings and cost avoidances. VA did not meet requirements primarily because a Deputy Chief Information Officer communicated standards and requirements to Office of Information Technology staff but not other staff maintaining IT systems and data centers. The OIG recommended VA determine which servers are subject to the June 2017 data center guidance, communicate requirements to all staff responsible for VA data centers, validate reported data center information, establish a VA-wide data center inventory process, and ensure all strategic plans are complete and align to target goals.

AUDIT OF VA'S FINANCIAL STATEMENTS FOR FISCAL YEARS 2018 AND 2017

The OIG contracted with the independent public accounting firm CliftonLarsonAllen LLP (CLA) to audit VA's financial statements. This audit is an annual legislative requirement. CLA provided an unmodified opinion on VA's financial statements for FYs 2018 and 2017. With respect to internal controls, CLA identified five material weaknesses within the following areas: (1) community care obligations, reconciliations, and accrued expenses; (2) financial systems and reporting; (3) IT security; (4) compensation, pension, burial, and education actuarial estimates; and (5) entity-level controls, including chief financial officer organizational structure. CLA also identified two other significant deficiencies: (1) loan guarantee liability; and (2) procurement, undelivered orders, accrued expenses, and reconciliations. The report also covers areas of noncompliance. CLA made recommendations for addressing each of the material weaknesses and significant deficiencies. CLA is responsible for its audit report dated November 26, 2018, and the conclusions expressed within it.

The VA OIG is required 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 Federal Financial Management Improvement Act (FFMIA). The audit of VA's FY 2018 consolidated financial statements reported that VA did not substantially comply with federal financial management systems requirements and the United States Standard General Ledger at the transaction level, as required by FFMIA. This condition was due to VA's complex, disjointed, and legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. VA continued to be challenged in its efforts to apply consistent enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems.

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

FEDERAL INFORMATION SECURITY MODERNIZATION ACT AUDIT FOR FISCAL YEAR 2018

The OIG also contracted with CLA to assess VA's information security program in accordance with the Federal Information Security Modernization Act of 2014 (FISMA). FISMA requires federal agencies to conduct annual reviews of their information security programs and to report the results to the Department of Homeland Security. CLA found that VA continues to face significant challenges complying with FISMA requirements. This report provides 28 recommendations for improving VA's information security program. Key areas for improvement include addressing a previously reported IT material weakness and better deploying security patches, system upgrades, and system configurations. These improvements will mitigate security vulnerabilities and impose a consistent process across all field offices. While CLA is responsible for the findings and recommendations included in this report, the OIG provided oversight of the contractor's performance and will monitor VA's progress in implementing the recommendations until all proposed actions are completed.

INDEPENDENT REVIEW OF VA'S FISCAL YEAR 2018 DETAILED ACCOUNTING SUBMISSION TO THE OFFICE OF NATIONAL DRUG CONTROL POLICY

In accordance with the Accounting of Drug Control Funding and Performance Summary circular, federal agencies must submit to the Executive Office of the President's Office of National Drug Control Policy (ONDCP) an annual accounting of agency funds and activities related to the National Drug Control Program. Inspectors General must then evaluate the reliability of the agency's information. In this report, the OIG evaluated whether VA reported erroneous obligations associated with drug abuse treatment to ONDCP and determined that the previous OIG report, *Audit of VA's Financial Statements for Fiscal Years 2018 and 2017*, identified five repeat material weaknesses that persisted from previous years' reporting as well as two additional significant deficiencies that could potentially have an effect on those obligation numbers. Beyond these identified issues, the OIG believes that the assertions in the submission of this report are fairly stated. This report is one of two OIG publications that examine VA's reporting requirements to ONDCP.

INDEPENDENT REVIEW OF VA'S FISCAL YEAR 2018 PERFORMANCE SUMMARY REPORT TO THE OFFICE OF NATIONAL DRUG CONTROL POLICY

ONDCP also requires federal agencies to submit annual performance-related information for National Drug Control Program activities, for which Inspectors General must evaluate the reliability. The OIG did not identify any information that caused its reviewers to believe VA lacked a system to accurately capture performance information or that the system was not properly applied to generate the performance data reported. This report is the second of two OIG publications that examine VA's reporting requirements to ONDCP.

OTHER PUBLICATION

MISMANAGEMENT OF THE VA EXECUTIVE PROTECTION DIVISION

In May and October 2017, the OIG received complaints alleging mismanagement and misuse of the VA Executive Protection Division. The complainants alleged ineffective procedures, overtime abuses, pay administration issues, time card fraud, and various policy violations. They also alleged the misuse of the Executive Protection Division by former VA Secretary Shulkin. The OIG substantiated that VA

mismanaged the division from at least 2015. There were insufficient written operational policies and a lack of adequate threat assessments. The OIG did not, however, substantiate that Secretary Shulkin misused division services beyond several instances of inappropriate use of transportation services for his wife. Recommendations include that VA publishes operational policies for the division on essential functions, develops adequate threat assessments, institutes procedures to address identified security lapses, ensures agents and supervisors are accountable for overtime and travel reimbursement abuses, and makes certain that the principal under protection receives a thorough orientation regarding proper use of the division's services.

RESULTS FROM THE OFFICE OF CONTRACT REVIEW

OVERVIEW

The Office of Contract Review provides VA's Office of Acquisition, Logistics, and Construction (OALC) with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, the OIG provides advisory services for OALC contracting activities. The OIG completed 53 reviews in this reporting period. The information that follows provides an overview of the Office of Contract Review's performance.

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. Thirty-five preaward reviews identified nearly $1.3 billion in potential cost savings during this reporting period.

In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews during this reporting period included 11 healthcare provider proposals, accounting for approximately $20 million of the identified potential savings.

35
PREAWARD REVIEWS

$1.3B
POTENTIAL COST SAVINGS

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. Postaward reviews resulted in VA recovering contract overcharges totaling over $22 million, including approximately $8.6 million related to the 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 18 postaward reviews performed, eight involved voluntary disclosures. In four of the eight voluntary disclosure reviews, the OIG identified additional funds due. VA recouped 100 percent of recommended recoveries for postaward contract reviews.

18
POSTAWARD REVIEWS

$22M
DOLLAR RECOVERIES

CLAIM REVIEWS

The OIG provides assistance to contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, the OIG had no claim reviews.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

OVERVIEW

During this reporting period, OHI published one national healthcare review and 11 inspection reports responsive to OIG Hotline complaints on topics that are related to Veterans Health Administration (VHA) operations and the access to and quality of care provided to patients. They addressed a broad range of issues on such topics as veteran suicide, delayed notification of abnormal testing results, controlled substance prescribing practices, and geriatric care. The office also published 19 Comprehensive Healthcare Inspection Program (CHIP) reports, which resulted from unannounced OIG inspections of VA facilities' key clinical and administrative processes that are associated with promoting positive healthcare outcomes for veterans. As with other OIG published reports, the OHI recommendations for corrective action are detailed at www.va.gov/oig. Dashboard users can track the status of report recommendations published since October 2012.

31
PUBLICATIONS

1,773
HOTLINE REFERRALS REVIEWED

4
IN-DEPTH CLINICAL CONSULTATIONS

FEATURED PUBLICATIONS

Highlighted below are three OHI reports that focused on issues and recommendations that can have significant impact on VA and the veterans it serves.

FALSIFICATION OF BLOOD PRESSURE READINGS AT THE DANVILLE COMMUNITY BASED OUTPATIENT CLINIC IN SALEM, VIRGINIA

The OIG determined that a primary care provider repeatedly falsified documentation of patients' blood pressure readings at the Danville Community Based Outpatient Clinic of the Salem VA Medical Center in Virginia. The facility is a contracted clinic staffed and operated by Valor Healthcare, Inc. The OIG immediately notified the chief of staff of the findings and recommended the facility conduct a comprehensive data analysis. However, the facility did not begin an in-depth review of the provider's practices until eight weeks later. The OIG determined the provider had not only falsified repeat blood pressure readings (documenting readings just below the threshold that triggers alerts to the provider to consider follow-up testing and possible treatment modifications), but also failed to provide appropriate hypertension management. The OIG made five recommendations related to patient care follow-up, data integrity, policy and procedure development, leadership responsiveness, and contract-related training.

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=44.

DELAYED RADIOLOGY TEST REPORTING AT THE DWIGHT D. EISENHOWER VA MEDICAL CENTER IN LEAVENWORTH, KANSAS (VA EASTERN KANSAS HEALTH CARE SYSTEM)

This healthcare inspection reviewed both the delays in a patient's diagnosis and care as well as the extent and causes of delays in communicating abnormal test results. It is one of three healthcare inspections in 2019 examining allegations concerning this system. Although there were delays in

providers reporting radiology test results and diagnoses to patients, the OIG could not determine whether the delays were due to missed "view alerts" (notifications regarding test results). There was evidence of ongoing patient evaluation and care, and the patients reviewed did not suffer adverse outcomes related to delays. However, the OIG found that providers failed to communicate abnormal test results within the required timeframe and that radiologists did not receive training for new national diagnostic codes or software that generates view alerts. A peer review, administrative investigation, and an institutional disclosure were not performed as required. The OIG made five recommendations related to these three deficiencies as well as communicating test results and training radiologists.

NATIONAL REVIEW OF HEPATITIS C VIRUS CARE WITHIN THE VETERANS HEALTH ADMINISTRATION

The OIG's study of the care provided to patients with chronic hepatitis C by VHA facilities revealed that, of the patients with the disease who did not receive a curing treatment (direct-acting antivirals), VHA providers documented acceptable reasons for nontreatment for 85.5 percent of patients. The OIG found, however, that 9.6 percent of those hepatitis C-positive patients who completed the direct-acting antiviral treatment did not receive posttreatment testing to confirm they were cured. Of all patients who tested positive for hepatitis C antibodies, an estimated 99.1 percent received further confirmatory testing for chronic hepatitis C infection as required by policy. The OIG made two recommendations related to provider documentation for treatment considerations and posttreatment follow-up testing.

Listen to the OIG's companion podcast for this report at https://www.va.gov/oig/podcasts/podcast-summary.asp?id=45.

HEALTHCARE INSPECTION PUBLICATIONS

Healthcare inspections assess the validity of allegations pertaining to VA medical care that are presented by patients or their families, VA employees, members of Congress, and other stakeholders. These inspections typically focus on allegations of serious harm to one or more patients, major lapses in accepted standards of patient care, systematic deficiencies that pose a significant impact to patient safety or quality of care, or major systems issues affecting VHA. They may also evaluate the design, implementation, or results of VHA's operations, programs, or policies.

ALLEGED CONCERNS IN STERILE PROCESSING SERVICES AT THE NEW MEXICO VA HEALTH CARE SYSTEM IN ALBUQUERQUE, NEW MEXICO

An inspection of Sterile Processing Services (SPS) at the New Mexico VA Health Care System did not substantiate tampering with equipment or incorrectly stored or damaged sterile sets. Some surgical procedures were, however, delayed or canceled due to unavailable sterile instruments and equipment. While no patients experienced adverse clinical outcomes, three patients were at increased risk. The OIG could not establish that a two-month increase in surgical delays after a contract for technicians lapsed in 2017 was related to staffing. Documentation deficiencies related to standard operating procedures and staff training were identified. The Veterans Integrated Service Network (VISN) did not provide adequate oversight and the facility did not effectively implement action plans, as evidenced by recurring findings reported in multiple inspections. Recommendations were made related to sterile sets, patient safety event reporting, SPS processes, implementation of action plans, the SPS risk assessment, and independent verification of action plans by the VISN.

PATIENT AND RADIATION SAFETY CONCERNS AT THE JOHN D. DINGELL VA MEDICAL CENTER IN DETROIT, MICHIGAN

In response to radiation safety concerns, the OIG reviewed the facility's radiation safety program and radiologists' fluoroscopy training and privileging. The OIG substantiated that annual radiologic equipment inspections were not performed as required, a radiologist performed fluoroscopy procedures without current training or privileging, and the radiology department did not conform to VHA radiation safety standards. The OIG substantiated that the Chief of Radiology changed the radiology privileging form and that the facility's Master Materials License permit was revoked in 2009, resulting in cancellation of nuclear medicine studies for that year. The permit was reinstated in 2010. Although the OIG found additional radiation safety issues and made recommendations, the deficiencies did not put patients and staff at immediate risk or warrant stopping patient care.

FOR MORE INFORMATION

View the OIG's Recommendation Dashboard at www.va.gov/oig to track VA's progress in implementing OIG recommendations.

PROVIDER ASSIGNMENT AND DERMATOLOGY CONSULT SCHEDULING DELAYS AT THE JOINT AMBULATORY CARE CENTER IN PENSACOLA, FLORIDA

An inspection was conducted to evaluate allegations related to a patient's care at the Joint Ambulatory Care Center in Pensacola, Florida—a clinic of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi. The OIG found that the patient did not have an assigned primary care provider for nine months and experienced a delay in dermatology care. Although the patient did not experience an adverse clinical outcome, the risk of one was increased by the delay. Scheduling delays for 46 percent of FY 2017 dermatology consults were also identified. For this cohort, the OIG team determined one patient experienced an increased risk of an adverse clinical outcome and communications were entered in a patient's record that did not meet documentation requirements. The OIG made four recommendations related to primary care provider assignment, dermatology scheduling, staffing level reviews, and electronic health record documentation.

DELAY IN CARE AND CARE COORDINATION AT CHEYENNE VA MEDICAL CENTER IN WYOMING AND THE IOWA CITY VA HEALTH CARE SYSTEM

In response to confidential allegations, the OIG reviewed delays in a patient's renal cancer care and care coordination. The OIG substantiated that Cheyenne clinicians failed to provide timely and proper surveillance (follow-up) for the patient's renal cell carcinoma and nephrectomy (kidney) surgery. Additionally, an institutional disclosure and peer reviews were not initiated. The OIG did not substantiate that Iowa City providers subsequently failed to provide care and determined that providers were unaware of the patient's cancer history. The OIG also reviewed patients' electronic health records to determine if Iowa City urology consults were timely and found that clinical care was provided and patients were not negatively impacted. However, Urology Clinic providers did not always complete e-consult documentation as required by VHA. The OIG made seven recommendations related to cancer surveillance, care coordination, provider communication, problem lists, institutional disclosure, and peer review.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

CONCERNS RELATED TO THE MANAGEMENT OF A PATIENT'S MEDICATION AT THREE VA MEDICAL CENTERS AND INACCURATE RESPONSE TO A CONGRESSIONAL INQUIRY AT THE VA ILLIANA HEALTH CARE SYSTEM IN DANVILLE, ILLINOIS

This healthcare inspection assessed allegations that care providers at three facilities ordered or continued to order a high dose of an antidepressant medication, amitriptyline, for a patient who was not told about the risks and that when asked about attempts to reduce the dose of the patient's medication, the VA Illiana Health Care System in Danville, Illinois, provided inaccurate information to then Senator Joe Donnelly. The OIG substantiated that providers did not explain that the amitriptyline dosing was higher than the drug labeling or the risks of the high dosage to the patient. The patient was also not informed about a 2012 electrocardiogram abnormality or a 2016 subtherapeutic amitriptyline blood level. Due to a failed 2017 collaboration between the system's treating psychiatrist and primary care provider, there was no follow-up on the patient's cardiac concerns. The OIG found the system's response to Senator Donnelly about these incidents also was not timely and included inaccurate information. The OIG made eight recommendations on test result notifications, clinical consultations, and congressional inquiry processes.

ALLEGED CLINICAL AND ADMINISTRATIVE CONCERNS INVOLVING A WOUND CARE PROVIDER IN VETERANS INTEGRATED SERVICE NETWORK 21

The OIG conducted an inspection at a VISN 21 medical facility to assess a provider's patient care practices and management of clinic resources, and whether leaders were responsive to concerns. The care provider evaluated three patients with suspected deep vein thrombosis (DVT) and did not document an assessment of pretest probability of risk for DVT. Two of the three patients later tested positive for DVT. The care provider completed a telephone consult rather than seeing the patient, but the OIG found this to be reasonable. The OIG was unable to determine whether the provider consistently adhered to good infection control practices or used high-cost items unnecessarily. The OIG did not substantiate that the provider mismanaged clinic time and resources or failed to follow a diabetic foot ulcer algorithm or evaluate a patient prior to a cardiopulmonary arrest. The OIG determined leaders took appropriate actions.

MEDICATION MANAGEMENT, DISPENSING, AND ADMINISTRATION DEFICIENCIES AT THE VA MARYLAND HEALTH CARE SYSTEM IN PERRY POINT, MARYLAND

The OIG reviewed the care of a hospice patient who died after receiving a potential overdose of oxycodone. The OIG found deficiencies in the facility's management of this high-risk medication, yet was unable to determine whether the potential overdose contributed to the patient's death. Pharmacy Service staff dispensed concentrated oxycodone solution from one bulk bottle, rather than in unit doses, increasing risks in all phases of medication management. Furthermore, nurses did not have the supplies to accurately measure small doses of the solution. VA facility leaders failed to recognize the risks and did not evaluate the patient's death following the potential overdose to determine causes or system issues. The OIG made eight recommendations related to evaluating the inaccuracies and risks involved with using bulk bottles of concentrated oxycodone solutions, quality reviews, and nurse processes.

DELAYS IN PROCESSING COMMUNITY-BASED PATIENT CARE AT THE ORLANDO VA MEDICAL CENTER IN FLORIDA

The OIG conducted a healthcare inspection at the Orlando VA Medical Center after receiving a request from Congressman Bill Posey to review allegations concerning delays in non-VA care coordination (NVCC) consults (requests for clinical services) resulting in adverse clinical outcomes, including a patient's death. Although the patient died before undergoing heart surgery, there was not a delay in the facility's approval of the NVCC consult. Facility staff generally complied with consult processing and scheduling guidelines for the patient. The OIG substantiated delays in the processing of other NVCC consults due to an increase in the number of consults along with limited staff but did not identify adverse clinical outcomes associated with the delays. The facility also lacked a fully implemented tool for tracking NVCC consults. Six recommendations were made related to a practitioner's care, providers' assigning of dates for scheduling appointments, and a tool to track the coordination of care process.

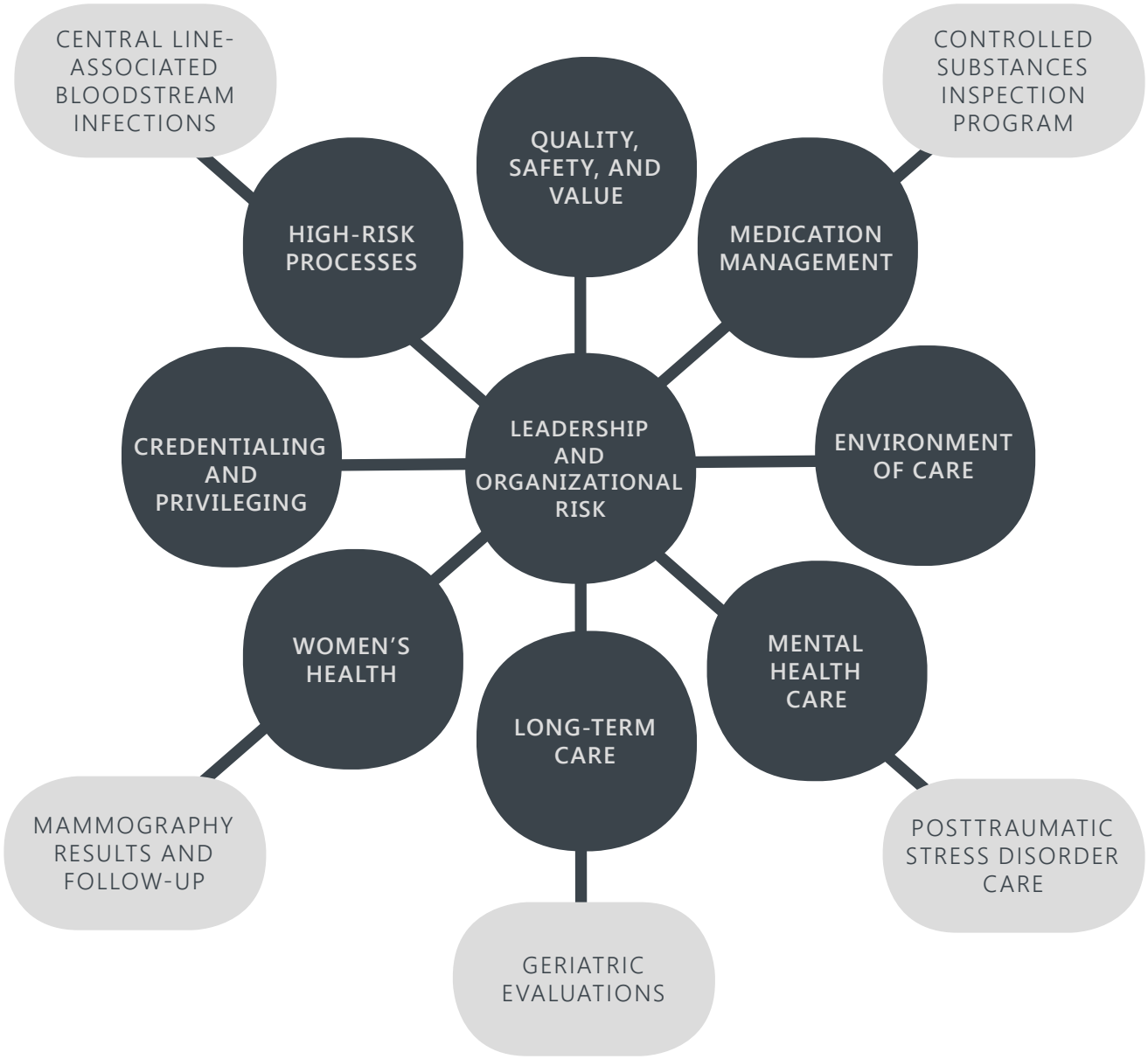
REVIEW OF OPIOID MONITORING AND ALLEGATIONS RELATED TO OPIOID PRESCRIBING PRACTICES AND OTHER CONCERNS AT THE TOMAH VA MEDICAL CENTER

The OIG found that while the facility had an opioid monitoring program in place, there were opportunities to improve compliance with risk mitigation strategies. The OIG did not substantiate allegations related to leaders' failures to monitor temporary or covering providers' opioid prescribing practices and to provide support, the number of opioid prescriptions, pain management consults, or provider change request restrictions. Allegations that physician assistants were being harassed and forced to write opioid prescriptions were also unsubstantiated. Interviewees reported leaders were supportive of tapering opioids and that non-opioid pain management resources were available and encouraged. The OIG was unable to determine whether providers were combining benzodiazepine and opioid prescriptions after another provider discontinued them. The facility was recruiting for needed primary care providers, and environment of care deficiencies at the Wausau Community Based Outpatient Clinic had largely been addressed. The OIG made a recommendation related to provider education and risk mitigation strategies.

COMPREHENSIVE HEALTHCARE INSPECTIONS

CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. The healthcare facility reviews are performed approximately every three years for each facility. There were 19 medical centers and healthcare systems reviewed in the six-month reporting period (see Appendix A for a full listing). The OIG selects and evaluates specific areas of focus on a rotating basis each year. For example, this past reporting period's areas of focus are depicted in the following illustration.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM AREAS OF FOCUS



RESULTS FROM THE OFFICE OF INVESTIGATIONS

OVERVIEW

The Office of Investigations (OI) focuses on a wide range of cases that can have the greatest impact on the lives of veterans and VA operations. Investigations target crimes that affect the benefits and services afforded eligible veterans and their families; criminal activity by and against any of VA's more than 395,000 employees; and offenses affecting the Department's programs and operations.

101
ARRESTS

88
CONVICTIONS

$87.1M
MONETARY BENEFITS

FEATURED INVESTIGATIONS

The cases highlighted below illustrate OI's emphasis on cases that ensure benefits and services meant for veterans are being received by the individuals for whom they were intended; result in monetary recoveries for VA that can be reinvested in programs, services, and benefits; address fraud, waste, and abuse by VA employees in positions of trust; and give some measure of relief to victims of crime.

FORMER VA VOCATIONAL REHABILITATION AND EMPLOYMENT COUNSELOR AND CO-CONSPIRATORS SENTENCED FOR FRAUD RESULTING IN $3 MILLION LOSS TO VA

A former VA Vocational Rehabilitation and Employment (VR&E) Counselor was sentenced to 132 months' imprisonment, 36 months' supervised release, and restitution of $155,000 after pleading guilty to wire fraud, bribery, and falsification of documents. The VA OIG and Federal Bureau of Investigation (FBI) revealed the defendant initiated kickback agreements with the owners of three educational institutions approved under the VR&E program. The defendant steered veterans to those three institutions without regard for the veterans' educational needs or preferences. In return, the school owners paid the defendant seven percent of all VR&E funds they received. The school owners fraudulently obtained VR&E benefits by providing false information to VA concerning the number of hours of instruction and the manner and quality of the instruction provided to enrolled veterans whose tuition was paid by VA. It was discovered that enrolled veterans rarely, if ever, received instruction from school employees. One co-conspirator was sentenced to 70 months' imprisonment and three years' supervised release, a second co-conspirator was sentenced to 20 months' imprisonment and three years' supervised release, and a third co-conspirator was sentenced to 30 months' imprisonment and three years' supervised release. These three co-conspirators were also ordered to pay combined restitution of $1,583,000. The loss to VA is over $3 million.

FORMER HOUSTON, TEXAS, VA MEDICAL CENTER PROSTHETICS REPRESENTATIVE PLED GUILTY TO CONSPIRACY TO COMMIT WIRE FRAUD

A former Houston, Texas, VA Medical Center prosthetics representative pled guilty to conspiracy to commit wire fraud related to a scheme to defraud VA by paying a codefendant for services that were not rendered to the facility's Prosthetics Department. A VA OIG investigation revealed that from January 2011 through December 2014, the defendants conspired to bill VA for false and fraudulent claims for services and then split the proceeds. The overall loss to VA is approximately $499,000.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

VETERAN AND FAMILY MEMBERS PLED GUILTY FOR ROLES IN COMPENSATION BENEFITS SCHEME

A veteran and his wife pled guilty to conspiracy to defraud VA for providing false statements to obtain additional VA compensation benefits and income from the VA Caregiver Support Program. The veteran's father pled guilty to charges related to providing misleading statements regarding his son's disabilities. An OIG investigation revealed the veteran owned and operated various companies while receiving Individual Unemployability benefits and claiming to be unemployed due to his service-connected disabilities. The veteran obtained multiple government set-aside contracts, most with VA, totaling over $1 million while being rated permanently and totally disabled with posttraumatic stress disorder (PTSD). An investigation revealed the veteran is a licensed private pilot and an aircraft mechanic who obtained both certifications within days after reporting multiple disabilities, including PTSD, to the VA. However, the veteran did not report these disabilities to the Federal Aviation Administration. The veteran, his father, and the veteran's company were also indefinitely suspended from obtaining future government contracts.

FOR MORE INFORMATION

See monthly criminal case summaries at www.va.gov/oig/publications/monthly-highlights and subscribe to email alerts at www.va.gov/oig.

SELECTED VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. For this SAR period, OI opened 73 cases; made 45 arrests; obtained over $6.1 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved more than $840,000 in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The selected case summaries that follow illustrate the type of VHA investigations conducted during this period.

INDIVIDUAL SENTENCED FOR SUBMITTING FALSE CLAIMS TO VA

A sales representative who previously served the VA St. Louis Health Care System in Missouri was sentenced to five years of probation and ordered to pay restitution to VA in the amount of $614,380. A VA OIG investigation revealed that from July 2012 to August 2017, the defendant submitted 220 false orders to the Jefferson Barracks Division of the VA St. Louis Health Care System, which totaled $644,380. These orders were primarily for drill bits and other supplies that were never requested nor received by the facility. The defendant provided false invoices to a VA employee who believed them to be legitimate. After the VA employee processed the orders, the defendant kept the items and sold what he could at flea markets. During the investigation, the defendant turned over approximately $30,000 worth of supplies that were stored in his garage.

FORMER TEMPLE, TEXAS, VA MEDICAL CENTER MAINTENANCE AND OPERATIONS SUPERVISOR AND TWO ACCOMPLICES PLED GUILTY IN THEFT SCHEME

A former VA Medical Center Maintenance and Operations Supervisor, his wife, and a third-party vendor pled guilty to theft of government funds and conspiracy. A VA OIG investigation resulted in charges that allege the defendants used the wife's company to steal funds from VA. The former VA supervisor and his wife provided the third-party vendor with fraudulent invoices from her company for goods and services that were not actually provided to the vendor. The vendor then fabricated his own set of fraudulent invoices to bill VA for goods and services. The amount of the invoices billed to VA equaled the amount the vendor paid to the wife's company plus a 30 percent commission. The former supervisor then used a VA purchase card to pay the vendor's fraudulent invoices. The loss to VA is approximately $308,380.

FORMER MARION, INDIANA, VA MEDICAL CENTER NURSING ASSISTANT SENTENCED FOR CRIMINAL DEVIATE CONDUCT

A former VA Medical Center Nursing Assistant was sentenced to 16 years' imprisonment, of which two years were suspended, after previously being convicted of criminal deviate conduct. A VA OIG and VA Police Service investigation revealed that the defendant engaged in a sexual act with a patient who was in the facility's dementia ward.

THREE DEFENDANTS PLED GUILTY TO DISTRIBUTION OF CRACK COCAINE

Three defendants pled guilty to distribution of crack cocaine as a result of a year-long VA OIG and Drug Enforcement Administration (DEA) investigation into the widespread sale of drugs at the Bedford, Massachusetts, VA Medical Center. This investigation, which garnered local media and congressional interest, identified two additional individuals who were working with the defendants to distribute drugs to veterans receiving addiction treatment at the medical center. These defendants were criminally charged and their cases are pending adjudication.

VETERAN PLED GUILTY TO DRUG DISTRIBUTION

The VA OIG, DEA, and local police conducted an investigation targeting the illegal sale of drugs and drug overdoses at the West Haven, Connecticut, VA Medical Center. This investigation identified multiple defendants involved in the distribution of illicit drugs and controlled pharmaceuticals at the medical center. Among the defendants, a veteran pled guilty to the drug distribution charges. To date, three defendants have pled guilty to these charges and one is awaiting trial.

VETERAN SENTENCED FOR DRUG DISTRIBUTION

A veteran was sentenced to 48 months' imprisonment and four years' supervised release. An OIG investigation revealed that while he was an inpatient at the Ann Arbor, Michigan, VA Medical Center, the defendant brought a mixture of heroin and fentanyl into the facility and provided a portion to another inpatient that resulted in the patient's death.

FORMER TAMPA, FLORIDA, VA MEDICAL CENTER PHYSICIAN SENTENCED FOR DRUG DISTRIBUTION

A former Tampa, Florida, VA Medical Center physician was sentenced to three years' probation and given an asset forfeiture order valued at $59,345. A VA OIG and DEA investigation revealed that the defendant was a former full-time VA doctor with a DEA registration that limited his authorization to

write prescriptions for controlled substances only as part of his official federal duties. From August 2017 to March 2018, after resigning from VA to work at a private pain management clinic in Tampa, the defendant used his VA DEA registration to write more than 2,000 prescriptions for controlled substances, to include over 1,000 prescriptions for oxycodone and over 600 prescriptions for hydromorphone.

FORMER MUSKOGEE, OKLAHOMA, VA MEDICAL CENTER PSYCHIATRIST SENTENCED FOR WITNESS INTIMIDATION AND TAMPERING

A former VA psychiatrist was sentenced to 21 months' incarceration, three years' supervised release, and the permanent loss of his medical license after previously pleading guilty to felony witness intimidation and tampering. An OIG investigation revealed the defendant engaged in a long-term sexual relationship with one of his psychiatric patients, who had suffered a service-connected traumatic brain injury that resulted in numerous psychological conditions. The defendant attempted to manipulate the victim through coercion and intimidation into lying to investigators about the nature of their relationship. The defendant ordered the victim to lie about their sexual encounters, financial assistance, and excessive narcotic prescriptions he provided to the victim, as well as his paternity to their unborn child.

NONVETERAN SENTENCED FOR ROLE IN COCAINE DISTRIBUTION SCHEME

A nonveteran was sentenced to 18 months' incarceration and 36 months' supervised release after pleading guilty to conspiracy to distribute, and possession with intent to distribute, cocaine. A VA OIG, U.S. Postal Inspection Service (USPIS), VA Police Service, and DEA New York Organized Crime Drug Enforcement Strike Force investigation identified the defendant as part of a criminal enterprise that sent six parcels through the U.S. Postal Service (USPS), each containing one to two kilograms of cocaine, from Puerto Rico to the Bronx, New York, VA Medical Center. The defendant took possession of these packages from a VA employee and subsequently drove off VA property. Six defendants pled guilty in this case, including two former VA employees.

VETERAN SENTENCED FOR POSSESSION WITH INTENT TO DISTRIBUTE A CONTROLLED SUBSTANCE

A veteran was sentenced to 12 months and one day of incarceration and three years' probation after pleading guilty to possession with intent to distribute a controlled substance. A VA OIG, VA Police Service, and DEA investigation revealed that while participating in an inpatient drug treatment program at the Bath, New York, VA Medical Center, the defendant provided fentanyl to two veterans, causing both to overdose. Both veterans subsequently recovered.

FORMER MEMPHIS, TENNESSEE, VA MEDICAL CENTER NURSING ASSISTANT SENTENCED FOR ASSAULT

A VA OIG, VA Police Service, and Memphis Police Department investigation revealed a former VA nursing assistant physically assaulted an inpatient inside the facility's locked mental health unit. The nursing assistant was sentenced to 12 months' home detention and 12 months' supervised release after having pled guilty to "deprivation of rights under color of law" (using power given by a governmental agency to deprive another person of any right protected by law).

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

VBA implements a number of programs for eligible veterans and family members, including education, insurance, and monetary benefits, as well as VA guaranteed home loans. Investigations routinely concentrate on benefits provided to ineligible individuals. With respect to home loans, the OIG conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties. The OIG also investigates allegations of fraud committed by VA-appointed fiduciaries and caregivers.

OIG's IT and Data Analysis Division, in coordination with OI, conducts an ongoing proactive data Death Match to identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. Within this reporting period, field personnel, including investigative assistants and special agents, teamed with headquarters personnel to process and work cases resulting in the arrest of seven individuals, recoveries of $1.1 million, and a projected five-year savings to VA estimated at $17.8 million.

OI opened 108 investigations involving the fraudulent receipt of VA monetary benefits including those for deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 39 arrests. OI obtained over $8.5 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than $33.4 million in savings, efficiencies, and cost avoidance; and recovered more than $5.9 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

VETERAN INDICTED FOR THEFT OF GOVERNMENT FUNDS

A VA OIG investigation resulted in charges that allege the defendant fraudulently led VA to believe he was blind. As a result, the defendant had been receiving 100 percent service-connected disability benefits for blindness since July 1991. The investigation determined that although the defendant had been discharged from the military in 1969 for vision issues, he was in possession of a valid driver's license that was issued in 2017 and had passed the vision test with 20/40 acuity in both eyes. The investigation also determined that the defendant drove on a routine basis and could perform other activities that were not consistent with blindness. The loss to VA is over $983,000.

VETERAN AND HUSBAND PLED GUILTY TO THEFT OF GOVERNMENT FUNDS AND FRAUDULENT ACCEPTANCE OF PAYMENTS

A veteran, with assistance from her husband, fraudulently led VA to believe that she was severely disabled. Based upon false statements and fraudulent documents, VA granted the highest possible disability rating to the veteran. This VA OIG investigation determined that the veteran had little to no limitations and received no living assistance from her husband. The loss to VA is approximately $903,900.

FORMER PHILADELPHIA, PENNSYLVANIA, VA REGIONAL OFFICE EMPLOYEE SENTENCED FOR ROLE IN THEFT SCHEME

A former VA Regional Office employee accessed the personally identifiable information of veterans and their spouses to manipulate previously submitted benefit claims and create fake claims in a scheme to defraud VA of approximately $838,000. Prior to authorizing the fictitious claims, the former employee

changed the direct deposit information to divert the stolen funds to his co-conspirators' accounts. After receiving the direct deposits from VA, his co-conspirators provided the former employee with a portion of the stolen funds as a kickback. The former VA employee was sentenced to 66 months' imprisonment, three years' supervised release, and restitution of $421,857. Eight co-conspirators were convicted and subsequently sentenced as a result of this VA OIG investigation.

VETERAN PLED GUILTY TO THEFT OF GOVERNMENT FUNDS AND SOCIAL SECURITY DISABILITY INSURANCE FRAUD

A VA OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant was witnessed driving a Harley-Davidson motorcycle while receiving Aid & Attendance compensation (financial help for in-home care) for the loss of the use of his hands and feet. Based on observations of his Compensation and Pension examination, the defendant was found to have misled the VA examiner about his ability to drive and walk. This investigation also yielded evidence that the defendant attempted to sell his VA-provided electric wheelchair. The loss to VA is $617,360, and the loss to SSA is $212,701.

DAUGHTER OF DECEASED VA BENEFICIARY PLED GUILTY TO THEFT OF GOVERNMENT FUNDS

A VA OIG investigation revealed that VA continued to directly deposit monthly payments into a beneficiary's bank account after the veteran's death. The defendant acknowledged during an interview that she spent these deposited VA funds intended for her deceased father. The loss to VA is approximately $367,700.

VETERAN INDICTED FOR COMPENSATION BENEFITS FRAUD SCHEME

A veteran was indicted for theft of government funds and making false statements. A VA OIG investigation resulted in charges alleging that the veteran maintained a full-time position as an auto service manager while receiving VA Individual Unemployability benefits, without reporting his income or employment to VA. The loss to VA is approximately $242,700.

VETERAN INDICTED FOR WIRE FRAUD AND AGGRAVATED IDENTITY THEFT

A VA OIG, SSA OIG, Office of Personnel Management (OPM) OIG, Department of Justice (DOJ) OIG, and Department of Labor (DOL) OIG investigation resulted in charges alleging the defendant repeatedly submitted false claims and information to VA and other federal agencies. Some of the false claims related to the defendant's military service, resulting in a VA disability rating of 100 percent and medical retirement from the Federal Bureau of Prisons at age 35. The total loss to the government is at least $575,000, which includes an approximate loss to VA of $230,500.

FORMER VA FIDUCIARY INDICTED FOR THEFT SCHEME

A former VA-appointed fiduciary was indicted on charges of misappropriation and theft of government property. The OIG investigation found that the fiduciary stole over $205,000 in VA funds intended for a veteran.

VETERAN INDICTED FOR THEFT OF GOVERNMENT FUNDS

A VA OIG investigation resulted in charges alleging the defendant worked as a plumber since 1999, yet intentionally withheld information about his employment and income from VA. As a result, he

continued to receive pension benefits. The defendant attempted to conceal his fraud by using the registered state license of another business as his own. The loss to VA is approximately $196,200.

VETERAN AND WIFE PLED GUILTY TO FRAUD CHARGES

A VA OIG and SSA OIG investigation exposed the defendants' submission of false claims to VA indicating the veteran was restricted to a wheelchair and had 100 percent loss of the use of both his arms and legs. To advance the scheme, the defendants made the same false representations to VA physicians. In a separate scheme, the wife also falsely stated to SSA that she needed assistance from the veteran with feeding, bathing, driving, preparing meals, and taking her medications due to her own debilitating physical condition, which resulted in SSA awarding her disability compensation. The total loss to the government is approximately $202,900, with VA's loss about $177,900.

VETERANS SENTENCED FOR COMPENSATION BENEFITS FRAUD

A veteran was sentenced to 18 months' incarceration and three years' probation and ordered to pay restitution of $165,174. A VA OIG investigation revealed that the defendant submitted an altered DD-214 (documentation issued upon a military servicemember's retirement, separation, or discharge from active duty) characterizing his service as "Honorable" and his reason for separation as "medical." The defendant's original DD-214 listed a "Bad Conduct" discharge resulting from a court-martial. Because of the altered DD-214, the defendant received $165,174 in VA compensation benefits to which he was not entitled.

FORMER VA FIDUCIARY SENTENCED FOR THEFT SCHEME

A former VA fiduciary was sentenced to 12 months' imprisonment and three years' supervised release and ordered to pay restitution to VA in the amount of $162,624. A VA OIG and FBI investigation revealed the defendant misappropriated approximately $162,624 of her brother's VA compensation benefits.

VETERAN SENTENCED FOR THEFT OF GOVERNMENT FUNDS

A veteran manufactured and forged fraudulent home healthcare records to obtain VA disability benefits based upon an alleged need for aid and attendance. While receiving these VA benefits and claiming to be unemployed, the veteran owned and operated a construction and home remodeling company. The veteran was sentenced to 10 months' incarceration, 36 months' supervised release, restitution of approximately $117,500 (the estimated loss to VA), and ordered to obtain mental health treatment.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. OI also investigates allegations of bribery and kickbacks; bid rigging and antitrust violations; false claims submitted by contractors; and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices alone, OI opened 48 cases and made 12 arrests. These investigations resulted in over $26 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $6 million in savings, efficiencies, and cost avoidance.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

INDIVIDUAL ARRESTED FOR ALLEGED ROLE IN SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

A former manager for a Service-Disabled Veteran-Owned Small Business (SDVOSB) was arrested after being indicted for filing false tax forms. A multiagency investigation led to charges alleging that the defendant, who also owned a non-SDVOSB, claimed a total of $1.6 million in business expenses related to that company while knowing that the actual expenses were substantially lower. The non-SDVOSB received payments from the SDVOSB, which was purportedly owned by a service-disabled veteran/minority (8a) owner but was actually owned and operated by the defendant and other ineligible individuals. The SDVOSB was awarded $335 million in set-aside contracts, of which $118 million was awarded by VA. The defendant and others allegedly formed or acquired two additional pass-through companies that were awarded $33 million in set-aside contracts, of which $21 million was awarded by VA. The investigation was conducted by the VA OIG, Defense Criminal Investigative Service (DCIS), Small Business Administration (SBA) OIG, DOL OIG, DOL Employee Benefits Security Administration, Army Criminal Investigation Command, Department of Agriculture OIG, General Services Administration OIG, Internal Revenue Service Criminal Investigation (IRS-CI), Air Force Office of Special Investigations, Naval Criminal Investigative Service (NCIS), and U.S. Secret Service.

MEDICAL DEVICE MANUFACTURER AGREED TO PLEAD GUILTY TO DISTRIBUTING AN ADULTERATED DEVICE

A medical device manufacturer agreed to plead guilty to a misdemeanor charge pertaining to the company's distribution of its neurovascular medical device in violation of the Food, Drug and Cosmetic Act. As part of the plea agreement, the company will plead guilty to distributing an adulterated device, pay a criminal fine of $11.9 million, and forfeit $6 million. A VA OIG, DCIS, Health and Human Services (HHS) OIG, FBI, and Food and Drug Administration (FDA) investigation revealed that the product, known as Onyx, was approved by the FDA for use inside the brain as a liquid embolization device that is surgically injected into blood vessels to block blood flow to arteriovenous malformations (abnormal connections between arteries and veins). Despite the FDA's limited approval, the manufacturer's sales representatives encouraged surgeons to use Onyx in large quantities for unproven and potentially dangerous surgical uses outside the brain even after FDA officials told company executives they had specific safety concerns regarding that type of use.

FORMER VA CONTRACTING OFFICER SENTENCED FOR ROLE IN CONSPIRACY SCHEME

Between 2003 and 2017, the owner of a parking services company bribed a former VA Contracting Officer (CO) with over $286,000 in cash to defraud VA of over $13 million. The company had entered into a sharing agreement with VA, which required the company to pay 60 percent of the collected gross parking revenue to VA. The owner underreported income and overreported improvements to VA, which allowed him to keep over $13 million that was owed to VA. The owner paid the bribes to the CO to continue the conspiracy after the CO retired from VA in 2014. This VA OIG, FBI, and IRS-CI investigation resulted in the former CO being sentenced to five months' imprisonment, five months' home detention, 12 months' supervised release, and ordered to pay restitution to VA of approximately $62,000.

NONVETERAN BUSINESS OWNER AND HIS CONSTRUCTION COMPANY CONVICTED FOR ROLES IN FRAUD SCHEME

A nonveteran business owner and his construction business were found guilty at trial of several fraud-related charges. An OIG investigation revealed the nonveteran and a veteran participated in a conspiracy to defraud the government by forming a joint venture and falsely representing that the joint venture and another company qualified as SDVOSBs. The defendants fraudulently obtained approximately $11 million in VA-funded SDVOSB set-aside construction contracts or task orders. The veteran previously pled guilty to the charges.

FIVE INDIVIDUALS INDICTED FOR FRAUD SCHEME

Five defendants were indicted for violations of wire fraud, major fraud against the United States, false claims, and conspiracy. Two additional defendants pled guilty to wire fraud and conspiracy. A joint investigation revealed the principal defendant used the financial stability of his company to "back-bond" smaller companies that were enrolled in different government contracting programs, including SBA's SDVOSB program. The smaller companies were awarded government contracts which were subsequently "passed" on to the principal defendant and his company. The investigation was conducted by the VA OIG, NASA OIG, NCIS, SBA OIG, and DCIS. The total loss to the government is approximately $15.6 million, with the loss to VA at about $4.4 million.

CO-CONSPIRATOR SENTENCED FOR COMPOUNDING PHARMACY FRAUD SCHEME

A co-conspirator was sentenced to 35 months' incarceration and two years' supervised release and ordered to pay restitution of roughly $4.7 million for his role in a compounding pharmacy fraud scheme. The defendant served as a middle man in a kickback scheme involving pharmacy marketers and the physicians who performed laboratory analyses. VA's portion of the restitution ordered is approximately $655,800. A VA OIG, DCIS, FBI, OPM OIG, and HHS OIG investigation resulted in the defendant's conviction for participating in a fraudulent scheme by which TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) were billed over $92 million through multiple fraudulent practices. Eleven additional co-conspirators were criminally charged and have pled guilty or await the adjudication of their case. The loss to VA is approximately $3.3 million.

FORMER PHARMACEUTICAL EXECUTIVES PLED GUILTY TO SCHEME INVOLVING PAYMENTS TO MEDICAL PROFESSIONALS TO PRESCRIBE COMPANY'S PAIN MEDICATION

The former Chief Executive Officer of a pharmaceutical company pled guilty to mail fraud and the company's former Vice President of Sales pled guilty to racketeering conspiracy. The defendants participated in a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe a fentanyl-based pain medication and to defraud healthcare insurers. To increase sales of the drug, the pharmaceutical company used a paid speaker program as a vehicle to bribe doctors and other clinicians to prescribe the pain medication. The pharmaceutical company also hired the medical practitioners' employees, relatives, and individuals with whom they had close relationships to reward high-volume prescribers. CHAMPVA paid the pharmaceutical company approximately $3.3 million for this pain medication. The investigation was conducted by the VA OIG, USPS OIG, USPIS, DEA, OPM OIG, FBI, FDA, HHS OIG, DOL OIG, and DCIS.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

MARKETER CHARGED IN COMPOUND PHARMACY KICKBACK SCHEME

A pharmacy marketer was charged for allegedly participating in a multimillion dollar kickback conspiracy in which physicians were offered money to fraudulently prescribe particular compounded pharmaceuticals. The VA OIG, DCIS, FBI, USPS OIG, DEA, and DOL OIG conducted the investigation. The resulting charges indicate that the scheme used multiple fraudulent practices to bill over $42.2 million to VA's CHAMPVA program and DOL's Office of Workers' Compensation Program (OWCP). The loss to VA is approximately $3 million.

ENGINEERING AND CONSTRUCTION SERVICES FIRM AGREES TO SETTLEMENT AGREEMENT

An engineering and construction services firm executed a settlement agreement with the DOJ in which it agreed to pay more than $5.2 million for alleged violations of the False Claims Act. Of this amount, VA is expected to receive $3 million. The violations involved federal engineering service contracts that were intended for SDVOSBs and other small businesses. A VA OIG, DCIS, and SBA OIG investigation was initiated based on the engineering and construction services firm's own disclosure. The firm was formed through the prior merger of two engineering firms. The self-disclosure indicated that prior to the merger, one of the merger participants conspired with a SDVOSB to obtain set-aside federal contracts for which the firm was ineligible. This merger participant and the SDVOSB misrepresented their office locations, project completions, and staffing capabilities to the government.

TWO MEDICAL OFFICER ADMINISTRATORS INDICTED FOR HEALTHCARE FRAUD CONSPIRACY

A VA OIG, DOJ OIG, DOL OIG, USPS OIG, and IRS-CI investigation resulted in charges that allege the defendants submitted false claims to DOL's OWCP on behalf of VA and other federal agencies. The defendants, who worked for a private healthcare provider, assigned inaccurate billing codes in an effort to increase the practice's OWCP reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not performed. The investigation revealed that the two defendants conspired with others to perpetuate the fraud for approximately six years. The loss to VA is approximately $2.9 million.

TWO INDIVIDUALS CHARGED WITH PARTICIPATING IN COMPOUNDING PHARMACY FRAUD SCHEME

Two individuals were charged with allegedly receiving approximately $1.7 million in illegal kickbacks. An OIG, U.S. Immigrations and Customs Enforcement Homeland Security Investigations, USPIS, DCIS, and FBI investigation resulted in charges that allege the defendants participated in a scheme by which TRICARE and CHAMPVA were billed over $15 million through multiple fraudulent practices. The defendants allegedly served as intermediaries in a kickback scheme involving pharmacy marketers and the physicians who prescribed compound pharmaceuticals. The loss to VA is approximately $618,800.

CONSTRUCTION COMPANY OWNER SENTENCED FOR FRAUD SCHEME

The owner of a construction company was sentenced to five years' probation and 100 hours of community service and ordered to repay approximately $532,500 in restitution to VA after pleading guilty to major fraud against the United States. An OIG and FBI investigation revealed the defendant falsely claimed to VA that the construction company had paid its bond premium and was entitled to reimbursement under the Federal Acquisition Regulation. The defendant sent correspondence to VA seeking reimbursement for the $532,500 bond premium and made false representations concerning the company's payment to the surety, to include documents that purported to be copies of canceled checks

indicating full payment of the bond premium. The construction company also received approximately $3.7 million from VA before workers walked off the job site and VA terminated the contract for default.

FIVE FORMER COMPOUNDING PHARMACY EMPLOYEES CONVICTED

Five former employees of a compounding pharmacy, including the pharmacy's part owner, were convicted of racketeering, conspiracy, and mail fraud after an eight-week trial. The compounding pharmacy was at the center of a 2012 nationwide fungal meningitis outbreak that killed 64 individuals and caused infections in 793 patients. An OIG, FDA, USPIS, DCIS, and FBI investigation revealed the defendants engaged in various schemes to defraud the government and patients. The schemes included authorizing the shipment of drugs before receiving test results confirming their sterility, not notifying customers of nonsterile results, and shipping compounded drugs with expired ingredients. Although no known VA patients died or became ill from the compounding pharmacy's product, VA purchased approximately $516,000 of products that were produced in unsanitary conditions and in an unsafe manner.

PRIVATE PHYSICIAN INDICTED FOR ROLE IN WORKERS' COMPENSATION FRAUD

A physician was indicted for his involvement with a pharmacy that provided prescription medication to OWCP patients. A VA OIG, Department of Homeland Security OIG, USPS OIG, DOL OIG, and IRS-CI investigation resulted in charges alleging that the defendant signed prescriptions for compounding medication for patients that he had not seen or evaluated and for patients who did not want or use the medication. The defendant was responsible for approximately $270,500 in prescriptions issued to VA's OWCP claimants and over $5.3 million in prescriptions issued to claimants from the impacted federal agencies.

ASSAULTS AND THREATS MADE AGAINST VA EMPLOYEES

During this reporting period, OI initiated 18 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against nine individuals. Investigations resulted in over $198,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

VETERAN SENTENCED FOR POSSESSION OF A FIREARM BY A CONVICTED FELON

A veteran who previously pled guilty to possessing a firearm as a convicted felon was sentenced to 12 months and one day of incarceration and three years' supervised release. An OIG and Bureau of Alcohol, Tobacco, Firearms and Explosives investigation revealed that the defendant threatened to shoot and kill VA employees at the Fayetteville, North Carolina, VA Medical Center. The defendant admitted during the investigation to possessing several firearms even though he was a convicted felon. As a result, several firearms were seized.

VETERAN SENTENCED FOR MAKING THREATS AGAINST NORTHERN ARIZONA VA HEALTHCARE SYSTEM EMPLOYEES

A veteran who previously pled guilty to threatening to shoot VA employees and physically damaged government property at the Prescott, Arizona, Northern Arizona VA Health Care System was sentenced to nine months' imprisonment and three years' supervised release and ordered to pay restitution to VA in the amount of $5,214. An OIG, FBI, U.S. Marshals Service, and Bureau of Alcohol, Tobacco, Firearms, and Explosives investigation was initiated after a VA employee reported that the defendant uttered, "If I have to go home and get a weapon and come back and shoot everybody, then that is what I am going to do." The defendant also attempted to throw a service kiosk across the room. After the defendant departed the facility, VA employees became aware of additional threats that he left via voicemail.

VETERAN INDICTED FOR MAKING THREATS AGAINST A FEDERAL EMPLOYEE AND ASSAULTING FEDERAL OFFICERS

A VA OIG and VA Police Service investigation resulted in charges alleging that on multiple occasions, a veteran threatened to inflict serious physical harm on a benefits fiduciary supervisor. The defendant made these threats after learning that VA was reviewing his ability to handle his own financial affairs. Also, the veteran resisted arrest and assaulted officers during the OIG and VA Police Service's execution of an arrest warrant at the Cleveland, Ohio, VA Medical Center.

VETERAN ARRESTED FOR ASSAULTING A SAN DIEGO, CALIFORNIA, VA MEDICAL CENTER SOCIAL WORKER AND THREATENING A VA OIG SPECIAL AGENT

A veteran was arrested on charges related to knocking over objects and throwing items in a VA medical center social worker's office, including a computer monitor. According to the VA OIG and VA Police investigation, when attempting to escape, the veteran allegedly grabbed the social worker's head and forcefully and repeatedly pulled it into his body. After the social worker escaped, the veteran continued to grab and throw items inside the room until the VA Police Service officers arrived. The social worker sustained head and neck injuries related to this assault. While in police custody, the veteran also threatened to assault an OIG special agent.

FUGITIVE FELON PROGRAM

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. Since 2002, 81 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 94,816 investigative leads being referred to law enforcement agencies. Over 2,615 fugitives have been apprehended by VA OIG special agents and other law enforcement agencies as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has identified nearly $1.5 billion in estimated overpayments with cost avoidance of more than $2 billion. During this reporting period, OI made five arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of 13 additional fugitive felons, and identified $110.7 million in estimated overpayments.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES

SUBSTANTIATED ALLEGATIONS OF MISCONDUCT AGAINST SENIOR GOVERNMENT OFFICIALS

Under §5(a)(19) of the IG Act, Inspectors General must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) in which allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether (1) the matter was referred to the DOJ, (2) the date of such referral, and (3) if applicable, the date of declination by the DOJ. During this reporting period, OI closed no criminal investigations with substantiated allegations against senior government employees.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES NOT DISCLOSED TO THE PUBLIC

Section 5(a)(22)(B) of the IG Act requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the public. When allegations in criminal investigations are unsubstantiated, or if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. During this reporting period, there were three instances of previously undisclosed investigations of senior government officials that were closed or referred out after allegations were unsubstantiated.

- The VA OIG received a referral stating that the father of the Buffalo, New York, VA Medical Center Associate Director was a resident of the facility's Community Living Center (CLC) despite not meeting the applicable eligibility criteria. The complainant estimated the monetary value of this medical care to be between $150,000 and $175,000 per year, resulting in over $600,000 in improper benefits. It was further alleged that the father received this care at the direction of the Associate Director, who pressured staff into allowing him to stay in the CLC. The investigation determined that from the time of his admission through his discharge, the father never met the criteria for residency in the CLC. However, the investigation did not substantiate the allegation that the Associate Director used his influence to maintain his father's residency in the CLC. This case was declined by the U.S. Attorney's Office, Buffalo, New York. After closing the case on January 22, 2019, the OIG referred the matter to the Office of Accountability and Whistleblower Protection (OAWP) for further review. On March 19, 2019, OAWP completed its investigation and forwarded the results to the medical center. The medical center director informed the VA OIG that administrative action against the Associate Director is currently under consideration.
- The VA OIG received a referral alleging that a Holdrege, Nebraska, Community Based Outpatient Clinic physician inappropriately touched a veteran patient during an annual physical in December 2017. During the exam, the physician allegedly asked the veteran if he wanted his "colon checked" (rectal examination) even though the patient was 29 years old and not at the age for the procedure to be part of the annual physical. When the veteran refused, the physician allegedly told the patient, "Most people find the procedure pleasurable." The investigation identified 36 veteran patients who had requested a change of provider from this physician to another VA physician in 2016 and 2017. Interviews of 29 of the 36 veteran patients revealed a variety of procedural issues with their care under this physician. This case was not referred to a prosecutor because no criminal conduct was identified. The physician resigned after he was

confronted by VA management about his practice patterns and behaviors. The OIG closed this case on December 18, 2018.

- The VA OIG received a referral from OAWP alleging that the Clarksburg, West Virginia, VA Medical Center Chief of Staff referred veterans to her husband's private medical practice for sleep studies. This investigation determined that, between March 2014 and March 2018, the medical center referred patients to this medical practice on 63 occasions. VA paid approximately $33,600 to this medical practice for the sleep studies. The investigation further determined that the medical center hired the husband as a physician (pulmonologist) in February 2017. This case was declined for criminal and civil action by the U.S. Attorney's Office, Clarksburg, West Virginia. After closing this case on December 6, 2018, the OIG referred this matter to the VA Capital Health Care Network (VISN 5). VISN 5 subsequently notified the OIG that the review determined the allegations were unsubstantiated.

ADMINISTRATIVE INVESTIGATIONS

The VA OIG's Administrative Investigations Division independently reviews allegations and conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress, the Department, and other stakeholders. This division formerly reported to the OIG's Office of Investigations, but in October 2018 merged with the Office of Special Reviews. The reports discussed in this section were initiated while the division was still a part of the Office of Investigations. Future reports by this division will be featured in the section discussing the results of the Office of Special Reviews.

Under §5(a)(19) of the IG Act, OIGs must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) where allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether the matter was referred to the DOJ, the date of such referral, and, if applicable, the date of declination by the DOJ. Section 5(a)(22)(B) also requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the public. The OIG publishes all closed administrative investigations, whether or not the allegations were substantiated. This reporting period, the OIG published five administrative investigations, which include those concerning senior government employees, and are discussed below.

ALLEGED MISUSE OF GOVERNMENT-OWNED VEHICLES AT THE SACRAMENTO VA MEDICAL CENTER IN CALIFORNIA

The VA OIG did not find that the VA Northern California Healthcare System Director violated VA policy regarding the use of government vehicles. The director was unaware employees drove these vehicles between work and home. The OIG found that the associate director of the Sacramento VA Medical Center improperly authorized a local policy permitting her to delegate authority for the approval of no-cost travel orders to the Chief of Logistics Management Service. The chief used this authority to allow employees to take government vehicles home overnight and on weekends under the provisions applicable to temporary duty assignment travel with the use of no-cost travel orders. The director said that upon learning of this policy, he immediately rescinded it.

ALLEGED IMPROPER CONTRACTING PRACTICES WITHIN THE OFFICE OF PRODUCT EFFECTIVENESS, WASHINGTON, DC

The VA OIG Administrative Investigations Division investigated an allegation that an employee in the VHA Office of Quality, Safety and Value inappropriately steered the award of a contract valued in excess of $1 million to a company whose chief executive officer was alleged to be a personal friend. The complainant claimed that an existing contracting vehicle was available to meet the requirement and should have been used to procure the services at issue, and that the employee instead improperly steered the contract to the company run by the employee's friend. The OIG did not substantiate the allegations.

ALLEGED IMPROPER CONTRACTING WITHIN THE OFFICE OF INFORMATION SECURITY

An investigation was conducted to follow up on an allegation that an employee in the Office of Information and Technology's Office of Information Security steered the award of two contracts (one for $43 million and a second for $47 million) to a company based on the employee's prior business relationship with a vendor's senior employee. The OIG did not substantiate those allegations and closed the matter with no recommendations for further action.

ALLEGED IMPROPER USE OF PERSONAL EMAIL AND MISUSE OF TRAVEL FUNDS

An administrative investigation was conducted in response to an allegation that an employee within VHA's National Center for Ethics in Health Care used personal email to conduct VA business for an extended period in disregard of federal law. In addition, the complainant alleged that the employee believed that the government should pay for the employee's travel home to the northeast, even though the employee's duty station was Washington, DC. The OIG did not substantiate the allegations. The matter is considered resolved with no recommendations for further action.

ALLEGED MISUSE OF OVERTIME AND COMPENSATORY TIME AND IMPROPER TELEWORK AT THE HUNTER HOLMES MCGUIRE VA MEDICAL CENTER, RICHMOND, VIRGINIA

OIG staff investigated an allegation that an employee of the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia, misused official time by recording more than 500 hours in overtime and 200 hours in compensatory time. Concurrent with the VA OIG investigation, the Veterans Integrated Service Network 6 (VISN 6) Financial Quality Assurance Manager audited the time worked by the employee and concluded that managers knew the extent of the employee's additional work hours, but documentation and internal controls governing the use of overtime were insufficient. VISN 6 recommended that the VA medical center prioritize the hiring of an additional staff member in the employee's work group to reduce the need for overtime and that facility managers establish and maintain proper internal controls for approving overtime and compensatory time. The OIG concurred with the findings and recommendations of the VISN 6 audit and made no additional recommendations.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERVIEW

15,669
HOTLINE CONTACTS

$795K
MONETARY BENEFITS

320
FOLLOW-UP INQUIRIES ON VA CORRECTIVE ACTIONS

The Office of Management and Administration (OMA) provides the structure and services needed to support OIG operations. The Human Resources Division works to recruit and retain qualified and committed staff and coordinates centralized training and staff development activities. The Operations Division prepares and disseminates published reports, conducts critical follow-up of OIG report recommendations to VA, and oversees the internal controls program and proper records management. The Information Technology (IT) Division provides nationwide IT support, systems development, and integration. The Space and Facilities Management Division oversees the process of obtaining and appropriately furnishing nationwide office space and property management. The Budget Division provides a broad range of budgetary formulation and execution services as well as a range of financial services, including administration of the employee travel and purchase card program. The Hotline Division receives, screens, and refers OIG mission-related complaints within VA. It also analyzes and synthesizes information to inform decisions to accept cases on a select basis regarding issues having the most potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue of redress. Finally, the Data Analysis Division manages access to information requests, helps identify fraud-related activities, and supports the OIG's comprehensive oversight initiatives. Together, these divisions ensure the efficiency and effectiveness of activities OIG-wide to best serve veterans and their families.

OVERSIGHT ACTIVITIES

OMA provides comprehensive services that promote organizational effectiveness and efficiency through reliable and timely management and administrative support. In addition to providing essential support services to advance the OIG's overall mission and goals, OMA has noteworthy oversight responsibilities related to the operation of the Hotline Division. The Hotline receives, screens, and takes action in response to complaints regarding VA programs and services. The Hotline director also serves as the Whistleblower Protection Coordinator. The coordinator is responsible for educating agency employees about prohibitions on retaliation for disclosing serious wrongdoing or gross mismanagement and the rights and remedies against retaliation associated with those disclosures. During this reporting period, the Hotline Division accomplished the following:

- Received and screened 15,669 contacts from complainants, including VA employees, veterans, and the public and directed potential cases to the appropriate OIG directorate for further review
- Referred 726 cases to and required a written response from applicable VA offices after determining that allegations pertained to higher-risk topics, but where insufficient resources were available for OIG staff to complete a prompt independent review at that time

- Made 597 non-case referrals to appropriate VA offices after determining that the allegations pertained to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated
- Closed 834 cases for which nearly 38 percent of allegations were substantiated, over 545 administrative sanctions and corrective actions were taken, and nearly $795,000 in monetary benefits were achieved
- Responded to more than 287 requests for record reviews from VA staff offices

FEATURED HOTLINE CASES

Highlighted below are cases opened by the OIG's Hotline that were not included in inspections, audits, investigations, or reviews by other VA OIG directorates.

IMPROPER SPECIAL MONTHLY COMPENSATION

After receiving allegations that a veteran was receiving disability compensation and special monthly compensation for conditions that he did not appear to have, the OIG Hotline referred the matter to a VA regional office (VARO). The VARO determined that the type of special monthly compensation awarded to the veteran was done so in error. The VARO corrected the error, resulting in a decrease of benefits to the veteran. However, the veteran was not charged for the overpayment because it was caused by a VA mistake. The five-year cost savings exceeds $277,000.

BENEFITS WHILE INCARCERATED

Following a report from law enforcement that a veteran was receiving compensation benefits despite being incarcerated for multiple federal felony convictions, OIG's Hotline referred the allegations to a VARO for review. The VARO subsequently investigated the allegations and determined that the veteran's compensation rate should have been reduced from 100 percent to 10 percent effective the 61st day of his incarceration. The VARO also initiated an overpayment of $10,156. The five-year cost savings is over $192,000.

DELAYS IN PROCESSING MENTAL HEALTH CONSULTS

OIG's Hotline referred a case to Veterans Integrated Service Network (VISN) 17 regarding concerns about mental health care at a VA clinic in El Paso, Texas, including delayed and unnecessary consults. The VA concluded that multiple senior management changes had resulted in inconsistent support for the consult team. To remedy this issue, the facility restructured staffing for better consult management, hired additional providers, and dedicated time in providers' schedules to process consults.

CONCERNING PATIENT ENCOUNTER AT THE COMMUNITY LIVING CENTER

OIG's Hotline referred a case to VISN 15 concerning allegations that a veteran was assaulted, provided an improper medication dosage, subject to delayed medical care, and a victim of a Health Insurance Portability and Accountability Act of 1996 (HIPAA) violation at a community living center at the Wichita, Kansas VA Medical Center. HIPAA provides data privacy and security provisions for safeguarding medical information. The facility leaders initiated an investigation of these claims and found that three

of the allegations were substantiated or partially substantiated. The facility leaders determined that a staff member did curse in the veteran's presence, but did not have physical contact with him. They also concluded that a HIPAA violation occurred when the veteran's spouse was asked to retrieve his medical records without the veteran's authorization. Further, they found that the veteran did not receive the proper amount of anti-seizure medication while being treated in the facility because the Bar Code Medication Administration Scanner was calibrated incorrectly. The facility implemented corrective actions, including recalibrating the scanner to correct improper dosing information and training staff on the proper way to obtain medical records.

PROSTHETICS DELAY

After receiving allegations that a veteran waited over six months for necessary prosthetics, which had been ordered and paid for by the facility, OIG's Hotline referred a case to the VA Medical Center in San Antonio, Texas. The medical center determined that the purchasing agent failed to follow up with the vendor to ensure that the required order had been received. As a result of the Hotline case referral, the purchasing agent received appropriate counseling, new cross-checks between purchase card transactions and receipts were implemented, and a new supervisory purchasing agent was hired.

FOR MORE INFORMATION

on the Hotline and how to report fraud, waste, abuse, or mismanagement, visit www.va.gov/oig/hotline.

TABLE 6. CONGRESSIONAL TESTIMONY

WITNESS	COMMITTEE	TOPIC	DATE
Inspector General Michael J. Missal	House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs	VA'S Development and Implementation of Policy Initiatives	11/29/2018
Inspector General Michael J. Missal	House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies	Challenges Facing the Department of Veterans Affairs	3/13/2019

TABLE 7. PRESS RELEASES

TITLE	ISSUE DATE
OIG Leader Dr. John D. Daigh, Jr., Receives 2018 Presidential Rank Award of Distinguished Executive	12/11/2018

TABLE 8. PODCASTS

All podcasts and their transcripts are available at www.va.gov/oig/podcasts/default.asp.

TITLE	ISSUE DATE
VA OIG September 2018 Highlights	10/2/2018
Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York	10/16/2018
VA OIG October 2018 Highlights	10/31/2018
Healthcare Inspection Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin	11/27/2018
VA OIG November 2018 Highlights	12/13/2018
VA OIG December 2018 Highlights	1/17/2019
VA OIG January 2019 Highlights	2/7/2019
VA OIG February 2019 Highlights	3/5/2019
Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia	3/14/2019
Review Of Hepatitis C Virus Care within the Veterans Health Administration	3/20/2019
VA OIG March 2019 Highlights	3/28/2019

OTHER REPORTING REQUIREMENTS

OIG REVIEWS OF PROPOSED LEGISLATION AND REGULATIONS

Inspectors General are required by §4(a)(2) of the Inspector General Act of 1978 (IG Act) (P.L. 95-452) to review existing and proposed legislation and regulations and make recommendations in the SAR concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, the OIG reviewed 13 legislative or regulatory proposals and made no comments.

REFUSALS TO PROVIDE INFORMATION OR ASSISTANCE TO THE OIG

The IG Act authorizes federal Inspectors General to have access to all VA records, documents, or other materials related to VA programs and operations. The Act also authorizes the OIG to request information or assistance from any federal, state, or local government agency or unit as necessary in order to carry out the duties and responsibilities prescribed to an OIG in the Act. OIGs are required under §5(a)(5) of the Act to provide a summary of instances when such information or assistance is refused. The VA OIG reports no such instances occurring during this reporting period.

PEER AND QUALITATIVE ASSESSMENT REVIEWS

Under §5(a)(14) and (15) of the IG Act, as amended by the Dodd-Frank Wall Street Reform and Consumer Protection Act (P.L. 111-203), Inspectors General must report the results of any peer review conducted of its operations by another Office of Inspector General during the reporting period or identify the date of the last peer review conducted by another Office of Inspector General, in addition to any outstanding recommendations that have not been fully implemented. Both the VA OIG's Office of Audits and Evaluations and the Office of Investigations are required to undergo a peer review of their individual organizations every three years. The purpose of the review is to ensure that the work completed by the respective organizations meets the applicable requirements and standards.

The IG Act also requires Inspectors General, under §5(a)(16), to report the results of any peer review they conducted of another Office of Inspector General's audit operations during the reporting period, including any outstanding recommendations that have not been fully implemented from any peer review conducted during or prior to the reporting period.

MOST RECENT PEER REVIEWS CONDUCTED OF THE VA OIG

On October 10, 2018, the Department of Energy OIG initiated a peer review of VA OIG's audit operations for the three-year period ending September 2018 and anticipates providing the results of their review in April 2019. Prior to this, the DOJ OIG completed a peer review of VA OIG's audit operations in December 2016. The DOJ OIG concluded VA OIG's system of quality controls provides reasonable assurance that the Office of Audits and Evaluations performs its work and reports its findings in conformity with applicable standards in all material respects.

On December 10, 2018, the NASA OIG completed a peer review of VA OIG's Office of Investigations for the three-year period ending September 2018. NASA OIG found VA OIG's internal system of safeguards

and management procedures for its investigative function to be in compliance with the quality standards established by the Council of the Inspectors General on Integrity Efficiency (CIGIE) and other applicable guidelines and statutes.

MOST RECENT PEER REVIEWS CONDUCTED BY THE VA OIG

The VA OIG completed a peer review of the SSA OIG's audit operation and issued a final report on August 8, 2018, determining that SSA OIG was in compliance with the quality standards established by CIGIE. The VA OIG made no recommendations as a result of this review.

The VA OIG completed a peer review of the Department of Education (ED) OIG's investigative operation and issued a final report on December 13, 2018, determining that ED OIG was in compliance with the quality standards established by CIGIE. There were no recommendations made as a result of this review.

INSTANCES OF WHISTLEBLOWER RETALIATION

Inspectors General are required by §5(a)(20) of the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires Inspectors General to detail the consequences imposed by the Department to hold those officials accountable. However, the VA OIG's current practice is to refer individuals making allegations of whistleblower reprisal to either the VA Office of Accountability and Whistleblower Protection or the Office of Special Counsel. As a result, the VA OIG has no information responsive to this requirement to report.

ATTEMPTS TO INTERFERE WITH THE INDEPENDENCE OF THE OFFICE OF INSPECTOR GENERAL

Section 5(21) of the IG Act requires the reporting of instances in which VA imposes budget constraints designed to limit OIG capabilities, resists oversight, or delays access to information. During this reporting period, there were no such incidents.

CLOSED OFFICE OF INSPECTOR GENERAL WORK NOT DISCLOSED TO THE PUBLIC

The VA OIG is required by §5(a)(22)(A) of the IG Act to provide detailed descriptions of the particular circumstances of each inspection, evaluation, and audit conducted by the OIG that is closed and was not disclosed to the public. The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure; therefore, the VA OIG has no information responsive to this reporting requirement.

OTHER REPORTING REQUIREMENTS

GOVERNMENT CONTRACT AUDIT FINDINGS

The IG Act, as amended by the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181), requires each Inspector General to submit an appendix on final, completed contract audit reports issued to the contracting activity (agency component) 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 SAR. During this reporting period, the VA OIG did not issue any reports meeting these requirements.

AWARDS AND RECOGNITION

EMPLOYEE RECOGNITION OF MILITARY PERSONNEL

The Inspector General and staff extend their thanks to the OIG employees listed below who are on or have returned from active military duty:

- Thea Sullivan, a health systems specialist in Decatur, Georgia, returned from duty in October 2018.
- Christopher Sizemore, an auditor in Bay Pines, Florida, returned from duty in November 2018.
- Randall Snow, a supervisory health system specialist in Arlington, Virginia, returned from duty in November 2018.
- Trevor Rogers, a management and program analyst in Decatur, Georgia, returned from duty in January 2019.
- Felix Beltran, Jr., a criminal investigator in Washington, DC, returned from duty in February 2019.
- Peter Moore, a criminal investigator in Dallas, Texas, was activated by the United States Army in February 2019.
- Brian Celatka, a criminal investigator in Nashville, Tennessee, returned from duty in March 2019.
- Christopher Dong, an attorney-advisor in Washington, DC, was activated by the United States Air Force in March 2019.
- George Kurtzer, an information technology specialist in Hines, Illinois, returned from active duty in March 2019.

STAY CONNECTED

For the latest news and information, follow the OIG on LinkedIn and Twitter, sign up to receive email alerts about new reports and website content, and subscribe to the RSS feeds.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

Federal Inspectors General are required to provide information on the reports it publishes and any associated monetary impact. Tables A.1. through A.4. provide a listing of VA OIG publications issued this period with results sorted according to the authoring directorate. If applicable, the total dollar value of questioned costs and recommendations that funds be put to better use are identified. Table A.5. summarizes all monetary benefits for OIG reports issued this reporting period. This information is required by §5(a)(6) of the IG Act.

Under §5(a)(8) and (9) of the Act, Offices of Inspector General must provide statistical tables showing the total number of reports issued during the reporting period with questioned costs or recommendations that funds be put to better use (1) for which no management decision had been made by the commencement of the reporting period, (2) which were issued during the reporting period, (3) for which a management decision was made during the reporting period, and (4) for which no management decision was made by the end of the current reporting period. This information is provided in tables A.6. and A.7.

Sections 5(a)(10)(A) and (B) of the IG Act require that Offices of Inspector General provide a summary of each report issued before the commencement of the reporting period for which no management decision had been made by the end of the current reporting period and for which VA did not provide substantive comments within 60 days of receipt of the draft report. In each case, there were no instances to report. As part of the report production process, the VA OIG transmits its draft report to VA for review, comment, and concurrence to implement recommendations. The OIG's goal is to receive substantive feedback from the Department within 30 days of transmitting the draft report. The reporting requirement under §5(a)(10)(C) is presented in Appendix B.

Federal Inspectors General are also required under §5(a)(11) and (12) of the IG Act to provide a description and explanation of the reasons for any significant revised management decision made during the reporting period, as well as information concerning any significant management decisions with which the Inspector General is in disagreement. While VA OIG reports that there were no significant revised management decisions made during the reporting period, there were four significant management decisions in two reports with which the Inspector General is in disagreement. In the report *VA's Federal Information Security Modernization Act Audit for Fiscal Year 2018*, the Department nonconcurred with OIG recommendations 1, 18, and 19 related to the completion of a risk management structure, improving security of back-up data, and reviewing system disruptions for contingency plan improvements. In the report *Lost Opportunities for Efficiencies and Savings During Data Center Consolidation*, the Department nonconcurred with OIG recommendation 5 related to the completion of a strategic plan that includes a timeline for achieving Office of Management and Budget cost savings targets, data center closure targets, and performance metrics. For these recommendations, the Department contended that adequate implementation actions had already been taken or that implementation actions were not necessary or feasible. However, the OIG stands by its findings and recommendations.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.1. PUBLICATIONS ISSUED BY THE OFFICE OF AUDITS AND EVALUATIONS

REPORT INFORMATION	BETTER USE OF FUNDS	QUESTIONED COSTS
Emergency Cache Program: Ineffective Management Impairs Mission Readiness *Issued 10/31/2018 | Report Number 18-01496-301*	$34,263,584	--
Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis *Issued 11/20/2018 | Report Number 18-00031-05*	--	$13,800,000
Audit of VA's Financial Statements for Fiscal Years 2018 and 2017 *Issued 11/26/2018 | Report Number 18-01642-09*	--	--
VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students *Issued 12/3/2018 | Report Number 16-00862-179*	--	$2,300,000,000
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	--	--
Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments *Issued 12/18/2018 | Report Number 18-01278-13*	--	$22,500,000
Mismanagement of the VA Executive Protection Division *Issued 1/17/2019 | Report Number 17-03499-20*	--	--
Lost Opportunities for Efficiencies and Savings During Data Center Consolidation *Issued 1/30/2019 | Report Number 16-04396-44*	--	--
Federal Information Security Modernization Act Audit for Fiscal Year 2018 *Issued 3/12/2019 | Report Number 18-02127-64*	--	--
Independent Review of VA's Fiscal Year 2018 Detailed Accounting Submission to the Office of National Drug Control Policy *Issued 3/19/2019 | Report Number 19-00224-87*	--	--
Independent Review of VA's Fiscal Year 2018 Performance Summary Report to the Office of National Drug Control Policy *Issued 3/19/2019 | Report Number 19-00225-86*	--	--

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.1. (CONTINUED)

REPORT INFORMATION	BETTER USE OF FUNDS	QUESTIONED COSTS
Forever GI Bill: Early Implementation Challenges Issue Statement *Issued 3/20/2019 | Number 19-06452-97*	--	--
Total Monetary Impact	**$34,263,584**	**$2,336,300,000**

TABLE A.2. PUBLICATIONS ISSUED BY THE OFFICE OF CONTRACT REVIEW

OCR preaward reviews of prospective VA contracts and postaward reviews of awarded contracts are submitted only to the Department and are not publicly released. These reports contain nonpublic, confidential, and proprietary data relating to the contractors' business and include trade secret information protected from public release by 18 U.S.C. § 1905. Section 1905 provides for criminal penalties for any government employee or contractor who publicly discloses such protected information. Further, the reports are exempt, in whole or in part, from mandatory public disclosure under subparagraphs (b)(3), (b)(4), and (b)(5) of the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Portions of the reports that pertain to contractor proposals are also protected from disclosure by 41 U.S.C. § 4702 (prohibiting disclosure of contractor proposals under FOIA).

PREAWARD REVIEWS

REPORT INFORMATION	SAVINGS AND COST AVOIDANCE
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/2/2018 | Report Number 18-04399-314*	--
Review of a Request for Modification (Product Additions) Submitted under a Federal Supply Schedule Contract *Issued 10/5/2018 | Report Number 18-04362-04*	$5,822,002
Review of a Proposal Submitted under a Solicitation *Issued 10/5/2018 | Report Number 18-06235-07*	$28,901
Review of a Proposal Submitted under a Solicitation *Issued 10/22/2018 | Report Number 18-06395-08*	$1,904,387
Review of a Proposal Submitted under a Solicitation *Issued 10/26/2018 | Report Number 19-00203-11*	--
Review of a Proposal Submitted under a Solicitation *Issued 11/9/2018 | Report Number 19-00073-12*	$1,565,354
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 11/13/2018 | Report Number 18-03395-18*	$2,046,870

PREAWARD REVIEWS (CONTINUED)

REPORT INFORMATION	SAVINGS AND COST AVOIDANCE
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/14/2018 | Report Number 18-05870-17*	--
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/19/2018 | Report Number 18-02513-21*	$274,683,700
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/21/2018 | Report Number 18-03358-22*	$6,721
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/29/2018 | Report Number 18-02758-32*	$11,828,622
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 11/29/2018 | Report Number 18-05777-30*	$1,951,898
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/6/2018 | Report Number 18-03359-37*	$14,083,325
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/6/2018 | Report Number 18-06348-39*	--
Review of a Proposal Submitted under a Solicitation *Issued 12/13/2018 | Report Number 18-06099-45*	$901,208
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/27/2018 | Report Number 18-04198-52*	$9,907,263
Review of a Proposal Submitted under a Solicitation *Issued 12/28/2018 | Report Number 19-05989-53*	$2,530,547
Review of a Proposal Submitted under a Solicitation *Issued 1/2/2019 | Report Number 19-06064-51*	$1,173,365
Review of a Proposal Submitted under a Solicitation *Issued 1/11/2019 | Report Number 19-06157-55*	$3,483,150
Review of a Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 1/17/2019 | Report Number 18-05068-60*	$100,460
Review of a Proposal Submitted under a Solicitation *Issued 1/22/2019 | Report Number 19-05867-61*	$2,436,149
Review of a Request for Modification Submitted under a Federal Supply Schedule Contract *Issued 1/23/2019 | Report Number 18-06436-65*	--

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)

REPORT INFORMATION	SAVINGS AND COST AVOIDANCE
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 1/24/2019 | Report Number 19-00275-63*	--
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 1/30/2019 | Report Number 19-00360-69*	--
Review of a Federal Supply Schedule Proposal Submitted under a Federal Supply Schedule Contract *Issued 1/30/2019 | Report Number 19-00056-70*	$1,952,549
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 1/31/2019 | Report Number 18-05083-68*	$660,433,845
Review of a Proposal Submitted under a Solicitation *Issued 2/4/2019 | Report Number 19-06216-71*	$4,098,614
Review of a Proposal Submitted under a Solicitation *Issued 2/6/2019 | Report Number 19-05847-72*	$1,923,007
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/11/2019 | Report Number 18-04808-75*	$185,995,052
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/14/2019 | Report Number 19-00591-77*	$325,360
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/15/2019 | Report Number 19-06069-79*	--
Review of a Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 2/21/2019 | Report Number 18-06349-81*	$73,393,219
Review of a Proposal Submitted under a Contract *Issued 2/27/2019 | Report Number 19-00384-88*	$922,212
Review of a Proposal Submitted under a Contract *Issued 2/28/2019 | Report Number 19-00003-89*	$113,699
Review of a Request for Modification Submitted under a Federal Supply Schedule Contract *Issued 3/21/2019 | Report Number 19-00103-101*	$620,794
Total Monetary Impact	**$1,264,232,273**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS

REPORT INFORMATION	DOLLAR RECOVERIES
Review of a Voluntary Disclosure of Price Reductions under a Federal Supply Schedule Contract *Issued 10/3/2018 | Report Number 17-01313-02*	$10,937,730
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 10/3/2018 | Report Number 18-03158-03*	$9,806
Review of Voluntary Disclosures and a Refund Offer under A Federal Supply Schedule Contract *Issued 11/27/2018 | Report Number 18-04259-29*	$79,510
Review of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 12/19/2018 | Report Number 16-01988-49*	$7,111,008
Review of a Voluntary Disclosure of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 12/19/2018 | Report Number 18-03859-40*	$300,877
Review of a Federal Supply Schedule Contract *Issued 1/9/2019 | Report Number 17-03334-56*	--
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 1/9/2019 | Report Number 17-00825-57*	$1,937,785
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 1/17/2019 | Report Number 18-06096-59*	$89,830
Review of a Voluntary Disclosure of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 1/30/2019 | Report Number 18-06001-67*	$44,243
Review of Voluntary Disclosures of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 2/6/2019 | Report Number 17-02930-73*	$46,238
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 2/8/2019 | Report Number 18-05515-76*	$295,833
Review of a Voluntary Disclosure of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 2/20/2019 | Report Number 18-06103-82*	$26,161

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS (CONTINUED)

REPORT INFORMATION	DOLLAR RECOVERIES
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 2/20/2019 | Report Number 19-06868-80*	$715
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 3/7/2019 | Report Number 14-00002-91*	$976,604
Review of Compliance with Public Law 102-585, Section 603, under an Interim Agreement *Issued 3/7/2019 | Report Number 19-06952-90*	$10,799
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 3/11/2019 | Report Number 19-07081-92*	$23,875
Review of a Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 3/12/2019 | Report Number 19-00208-93*	$175,018
Review of Compliance with Public Law 102-585, Section 603, under a Federal Supply Schedule Contract *Issued 3/15/2019 | Report Number 19-06875-100*	--
Total Monetary Impact	**$22,066,032**

TABLE A.3. PUBLICATIONS ISSUED BY THE OFFICE OF HEALTHCARE INSPECTIONS

COMPREHENSIVE HEALTHCARE INSPECTIONS

TITLE	ISSUE DATE	REPORT NUMBER
Charles George VA Medical Center, Asheville, North Carolina	10/16/2018	18-01140-312
VA Boston Healthcare System, Massachusetts	10/23/2018	17-05570-06
Louis A. Johnson VA Medical Center, Clarksburg, West Virginia	10/24/2018	18-01136-313
VA Maine Healthcare System, Augusta, Maine	11/28/2018	18-01152-14
Central Texas Veterans Health Care System, Temple, Texas	11/29/2018	18-01137-15
VA Southern Nevada Healthcare System, North Las Vegas, Nevada	12/4/2018	18-01145-26
G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi	12/6/2018	18-01142-25
Mann-Grandstaff VA Medical Center, Spokane, Washington	12/6/2018	18-01144-24

COMPREHENSIVE HEALTHCARE INSPECTIONS (CONTINUED)

TITLE	ISSUE DATE	REPORT NUMBER
Salem VA Medical Center, Virginia	12/17/2018	18-01161-28
VA Pittsburgh Healthcare System, Pennsylvania	12/17/2018	18-01154-27
Iowa City VA Health Care System, Iowa	12/18/2018	18-01157-31
West Palm Beach VA Medical Center, Florida	12/18/2018	18-01159-38
Durham VA Medical Center, North Carolina	12/19/2018	18-01146-35
Robley Rex VA Medical Center, Louisville, Kentucky	12/19/2018	18-01163-36
San Francisco VA Health Care System, California	12/20/2018	18-01153-43
William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin	12/20/2018	18-01147-47
Marion VA Medical Center, Illinois	12/27/2018	18-01155-48
VA New Jersey Health Care System, East Orange, New Jersey	12/27/2018	18-01164-42
Washington DC VA Medical Center	1/28/2019	17-01757-50

NATIONAL HEALTHCARE REVIEW

TITLE	ISSUE DATE	REPORT NUMBER
Review of Hepatitis C Virus Care within the Veterans Health Administration	3/20/2019	17-05297-85

HOTLINE HEALTHCARE INSPECTIONS

TITLE	ISSUE DATE	REPORT NUMBER
Alleged Concerns in Sterile Processing Services at the New Mexico VA Health Care System, Albuquerque, New Mexico	10/31/2018	17-04593-10
Patient and Radiation Safety Concerns at the John D. Dingell VA Medical Center, Detroit, Michigan	11/27/2018	18-02210-19
Provider Assignment and Dermatology Consult Scheduling Delays at the Joint Ambulatory Care Center, Pensacola, Florida	12/10/2018	17-02163-23
Delay in Care and Care Coordination at Cheyenne VA Medical Center, Wyoming, and Iowa City VA Health Care System, Iowa	12/19/2018	18-00693-41
Concerns Related to the Management of a Patient's Medication at Three VA Medical Centers and Inaccurate Response to a Congressional Inquiry at the VA Illiana Health Care System, Danville, Illinois	1/16/2019	18-02056-54
Alleged Clinical and Administrative Concerns Involving a Wound Care Provider in Veterans Integrated Service Network 21	1/24/2019	18-05264-58

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)

TITLE	ISSUE DATE	REPORT NUMBER
Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia	1/29/2019	18-05410-62
Medication Management, Dispensing, and Administration Deficiencies at the VA Maryland Health Care System, Perry Point, Maryland	2/6/2019	17-05742-66
Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center, Florida	2/20/2019	18-01766-78
Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas (VA Eastern Kansas Health Care System)	3/7/2019	18-00980-84
Review of Opioid Monitoring and Allegations Related to Opioid Prescribing Practices and Other Concerns at the Tomah VA Medical Center, Wisconsin	3/28/2019	18-05872-103

TABLE A.4. PUBLICATIONS ISSUED BY THE OFFICE OF INVESTIGATIONS

TITLE	ISSUE DATE	REPORT NUMBER
Alleged Misuse of Government-Owned Vehicles at the Sacramento VA Medical Center, California	11/8/2018	17-04127-266
Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times at the Baltimore VA Medical Center, Maryland	11/15/2018	14-02890-16
Alleged Improper Contracting Practices within the Office of Product Effectiveness, Washington, DC	12/12/2018	18-01819-33
Alleged Misuse of Overtime and Compensatory Time and Improper Telework at the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia	12/12/2018	18-02137-34
Alleged Improper Use of Personal Email and Misuse of Travel Funds	3/29/2019	18-04604-94
Alleged Improper Contracting within the Office of Information Security	3/29/2019	18-02005-96

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.5. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$2,336,300,000
Better Use of Funds	$34,263,584
Savings and Cost Avoidance	$1,264,232,273
Dollar Recoveries	$22,066,032
Total	**$3,656,861,889**

TABLE A.6. RESOLUTION STATUS OF PUBLICATIONS WITH QUESTIONED COSTS

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	3	$2,336,300,000
Total inventory this reporting period	**3**	**$2,336,300,000**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	3	$2,336,300,000
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**3**	**$2,336,300,000**
Total carried over to next reporting period	**0**	**$0**

TABLE A.7. RESOLUTION STATUS OF PUBLICATIONS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with recommended funds to be put to better use issued during the reporting period	1	$34,263,584
Total inventory this reporting period	**1**	**$34,263,584**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	1	$34,263,584
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**1**	**$34,263,584**
Total carried over to next reporting period	**0**	**$0**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

The follow-up reporting and tracking of federal Inspector General recommendations is required by the Federal Acquisition Streamlining Act of 1994 (P.L. 103-355), as amended by the National Defense Authorization Act of 1996 (P.L. 104-106). The acts require agencies to complete final action on each management decision required with regard to a recommendation in any federal Office of Inspector General report within 12 months of the report's issuance/publication. If the agency fails to complete final action within the 12-month period, federal Inspectors General are required by §5(a)(3) of the IG Act to identify the matter in each Semiannual Report to Congress until final action on the management decision is completed. The tables that follow identify all unimplemented VA OIG reports and recommendation. All data in the tables are current as of March 31, 2019. Real-time information on the status of VA OIG recommendations is available through the OIG's Recommendation Dashboard.

FOR MORE INFORMATION

View the OIG's Recommendation Dashboard at www.va.gov/oig to track VA's progress in implementing OIG recommendations.

TABLE B.1. NUMBER OF UNIMPLEMENTED REPORTS BY VA OFFICE

Table B.1. identifies the number of VA OIG reports with at least one unimplemented recommendation, with results sorted by action office. As of March 31, 2019, there are 124 total open reports, with 40 open more than a year and 84 open less than a year. However, Table B.1. shows a total of 130 open reports, with 42 open more than a year and 88 open less than a year. This is because six reports are counted twice in the table, as they have open recommendations at more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN 1 YEAR	OPEN LESS THAN 1 YEAR	TOTAL OPEN
Veterans Health Administration	30	70	100
Veterans Benefits Administration	4	12	16
Office of Acquisition, Logistics, and Construction	0	1	1
Office of General Counsel	2	0	2
Office of Human Resources and Administration	1	1	2
Office of Information and Technology	1	2	3
Office of Management	2	0	2
Office of Operations, Security, and Preparedness	1	2	3
Office of the Secretary	1	0	1
Totals	**42**	**88**	**130**

TABLE B.2. NUMBER OF UNIMPLEMENTED RECOMMENDATIONS BY VA OFFICE

Table B.2. identifies the number of open VA OIG recommendations with results sorted by action office. As of March 31, 2019, there are 536 total open recommendations, with 133 open more than a year and 403 open less than a year. However, Table B.2. shows a total of 544 open recommendations, with 136 open more than a year and 408 open less than a year. This is because eight recommendations are counted twice in the table as they have actions pending at more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN 1 YEAR	OPEN LESS THAN 1 YEAR	TOTAL OPEN
Veterans Health Administration	93	323	416
Veterans Benefits Administration	5	35	40
Office of Acquisition, Logistics, and Construction	0	3	3
Office of General Counsel	2	0	2
Office of Human Resources and Administration	2	12	14
Office of Information and Technology	1	30	31
Office of Management	22	0	22
Office of Operations, Security, and Preparedness	6	5	11
Office of The Secretary	5	0	5
Totals	**136**	**408**	**544**

TABLE B.3. UNIMPLEMENTED REPORTS AND RECOMMENDATIONS LESS THAN ONE YEAR OLD

Table B.3. identifies the 84 reports and 403 recommendations that, as of March 31, 2019, have been open less than one year. The total monetary benefit attached to these recommendations is $2,725,936,496.

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Testosterone Replacement Therapy Initiation and Follow-Up Evaluation in VA Male Patients *Issued 4/11/2018 | Report Number 15-03215-154*	VHA	1	--
Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact *Issued 5/2/2018 | Report Number 16-04555-138*	VBA	1, 3	$11,700,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	VHA	5	$34,500,000
VA's Compliance with the Improper Payments Elimination and Recovery Act for Fiscal Year 2017 *Issued 5/15/2018 | Report Number 17-05460-169*	VHA VBA	VHA: 1, 2, 4 VBA: 3, 5, 6	--
Comprehensive Healthcare Inspection Program Review of the Cincinnati VA Medical Center, Cincinnati, Ohio *Issued 5/23/2018 | Report Number 17-05398-172*	VHA	2–4	--
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2018 *Issued 6/14/2018 | Report Number 18-01693-196*	VHA	1, 2	--
Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Memphis, Tennessee *Issued 6/19/2018 | Report Number 18-00609-185*	VHA	4, 5, 7, 8, 12	--
Supervision and Care of a Residential Treatment Program Patient at a Veterans Integrated Service Network 10 Medical Facility *Issued 7/12/2018 | Report Number 16-03137-208*	VHA	2	--
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*	VBA	1, 4	$100,600,000
Comprehensive Healthcare Inspection Program Review of the VA Palo Alto Health Care System, Palo Alto, California *Issued 7/31/2018 | Report Number 18-00617-227*	VHA	4	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin *Issued 8/1/2018 | Report Number 17-02643-239*	VHA	7–11	--
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/8/2018 | Report Number 17-04156-234*	VHA	3	--
Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center, West Virginia *Issued 8/13/2018 | Report Number 17-05401-240*	VHA	1–3, 6, 7	--
Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, Ohio *Issued 8/14/2018 | Report Number 18-00619-242*	VHA	3, 5, 9	--
Comprehensive Healthcare Inspection Program Review of the VA Ann Arbor Healthcare System, Michigan *Issued 8/14/2018 | Report Number 18-00621-245*	VHA	1	--
Postoperative Care Concerns for a Vascular Surgical Patient at the Martinsburg VA Medical Center, West Virginia *Issued 8/16/2018 | Report Number 17-05381-258*	VHA	1, 3	--
Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed *Issued 8/16/2018 | Report Number 17-04003-222*	VHA	2–4, 6	$41,572,912

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma *Issued 8/21/2018 | Report Number 17-05248-241*	VBA	1, 3–5	--
Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits *Issued 8/21/2018 | Report Number 17-04919-210*	VBA	1	$72,500,000
Use of Not Otherwise Classified Codes for Prosthetic Limb Components *Issued 8/27/2018 | Report Number 16-01913-223*	VHA	1–5	$21,300,000
Accuracy of Effective Dates for Reduced Evaluations Needs Improvement *Issued 8/29/2018 | Report Number 17-05244-226*	VBA	2, 4, 6	$37,900,000
Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns, Samuel S. Stratton VA Medical Center, Albany, New York *Issued 8/29/2018 | Report Number 17-01770-188*	VHA	1, 5	--
Comprehensive Healthcare Inspection Program Review of the Central Arkansas Veterans Healthcare System, Little Rock, Arkansas *Issued 8/30/2018 | Report Number 18-01013-263*	VHA	8	--
Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts *Issued 9/6/2018 | Report Number 17-02713-231*	VHA	2	$35,300,000
Review of Accuracy of Reported Pending Disability Claims Backlog Statistics *Issued 9/10/2018 | Report Number 16-02103-265*	VBA	1, 2	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
VA Policy for Administering Traumatic Brain Injury Examinations *Issued 9/10/2018 | Report Number 16-04558-249*	VBA	2	--
Comprehensive Healthcare Inspection Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 9/11/2018 | Report Number 18-00608-247*	VHA	1, 3–7, 11, 13	--
Comprehensive Healthcare Inspection Program Review of the Battle Creek VA Medical Center, Michigan *Issued 9/12/2018 | Report Number 18-01139-267*	VHA	2, 3	--
Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center, New York *Issued 9/12/2018 | Report Number 17-01823-287*	VHA	1–3, 5	--
Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio *Issued 9/12/2018 | Report Number 17-04569-262*	VHA	3	--
Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Health Care System, Decatur, Georgia *Issued 9/13/2018 | Report Number 17-02679-283*	VHA	1–5	--
Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon *Issued 9/17/2018 | Report Number 18-00620-277*	VHA	1, 2, 4	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Pain Management Services in Veterans Health Administration Facilities *Issued 9/17/2018 | Report Number 16-00538-282*	VHA	1–6, 8	--
Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-293*	VHA	1–3	--
Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 17-03347-290*	VHA	1–5, 7–9	--
Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York *Issued 9/18/2018 | Report Number 18-01018-281*	VHA	2, 4–9	--
Comprehensive Healthcare Inspection Program Review of the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas *Issued 9/18/2018 | Report Number 18-00613-275*	VHA	1, 2, 5, 6	--
Alleged Nonacceptance of VA Authorizations by Community Care Providers *Issued 9/20/2018 | Report Number 17-05228-279*	VHA	1–6	--
Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky *Issued 9/20/2018 | Report Number 18-01963-284*	VHA	4–6	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota *Issued 9/25/2018 | Report Number 18-02875-305*	VHA	1–4, 6, 7	--
Comprehensive Healthcare Inspection Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois *Issued 9/27/2018 | Report Number 18-01143-302*	VHA	2, 3, 5	--
Comprehensive Healthcare Inspection Program Review of the Oklahoma City VA Health Care System, Oklahoma *Issued 9/27/2018 | Report Number 18-01141-309*	VHA	1, 2	--
Quality of Care Concerns in the Hemodialysis Unit at the Wilmington VA Medical Center, Delaware *Issued 9/27/2018 | Report Number 17-03676-307*	VHA	2, 6–9	--
Quality of Care Concerns Regarding a Patient Who had Cardiac Surgery at the VA Ann Arbor Healthcare System, Michigan *Issued 9/27/2018 | Report Number 17-04875-308*	VHA	1, 2	--
Timeliness of Final Competency Determinations *Issued 9/28/2018 | Report Number 17-05535-292*	VBA	1–4, 6	--
VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016 *Issued 9/28/2018 | Report Number 18-00474-300*	VHA OALC	VHA: 1–3, 5 OALC: 1, 2, 4	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina *Issued 10/16/2018 | Report Number 18-01140-312*	VHA	2, 5	--
Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts *Issued 10/23/2018 | Report Number 17-05570-06*	VHA	2–4	--
Comprehensive Healthcare Inspection Program Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia *Issued 10/24/2018 | Report Number 18-01136-313*	VHA	1–4, 6–9	--
Alleged Concerns in Sterile Processing Services at the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 10/31/2018 | Report Number 17-04593-10*	VHA	1–7, 9–12	--
Emergency Cache Program: Ineffective Management Impairs Mission Readiness *Issued 10/31/2018 | Report Number 18-01496-301*	VHA	1–7	$34,263,584
Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis *Issued 11/20/2018 | Report Number 18-00031-05*	VBA	1, 2	$13,800,000
Patient and Radiation Safety Concerns, John D. Dingell VA Medical Center, Detroit, Michigan *Issued 11/27/2018 | Report Number 18-02210-19*	VHA	1–3	--
Comprehensive Healthcare Inspection Program Review of the VA Maine Healthcare System, Augusta, Maine *Issued 11/28/2018 | Report Number 18-01152-14*	VHA	3–6	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the Central Texas Veterans Health Care System, Temple, Texas *Issued 11/29/2018 | Report Number 18-01137-15*	VHA	1–18	--
VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students *Issued 12/3/2018 | Report Number 16-00862-179*	VBA	1, 2, 4–6	$2,300,000,000
Comprehensive Healthcare Inspection Program Review of the VA Southern Nevada Healthcare System, North Las Vegas, Nevada *Issued 12/4/2018 | Report Number 18-01145-26*	VHA	1–8	--
Comprehensive Healthcare Inspection Program Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi *Issued 12/6/2018 | Report Number 18-01142-25*	VHA	1–4, 6–11	--
Comprehensive Healthcare Inspection Program Review of the Mann-Grandstaff VA Medical Center, Spokane, Washington *Issued 12/6/2018 | Report Number 18-01144-24*	VHA	1	--
Provider Assignment and Dermatology Consult Scheduling Delays at the Joint Ambulatory Care Center, Pensacola, Florida *Issued 12/10/2018 | Report Number 17-02163-23*	VHA	1–4	--
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	OSP VHA	OSP: 1, 2, 4, 5 VHA: 1–3	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the VA Pittsburgh Healthcare System, Pennsylvania *Issued 12/17/2018 | Report Number 18-01154-27*	VHA	1–4	--
Comprehensive Healthcare Inspection Program Review of the Iowa City VA Health Care System, Iowa *Issued 12/18/2018 | Report Number 18-01157-31*	VHA	1–3	--
Comprehensive Healthcare Inspection Program Review of the West Palm Beach VA Medical Center, Florida *Issued 12/18/2018 | Report Number 18-01159-38*	VHA	1–8	--
Delays in the Processing of Survivors' and Dependents' Educational Assistance Program Benefits Led to Duplicate Payments *Issued 12/18/2018 | Report Number 18-01278-13*	VBA	1–5	$22,500,000
Alleged Delay in Care and Care Coordination at Cheyenne VA Medical Center, Wyoming, and Iowa City VA Health Care System, Iowa *Issued 12/19/2018 | Report Number 18-00693-41*	VHA	1–3, 5–7	--
Comprehensive Healthcare Inspection Program Review of the Durham VA Medical Center, North Carolina *Issued 12/19/2018 | Report Number 18-01146-35*	VHA	1, 2	--
Comprehensive Healthcare Inspection Program Review of the Robley Rex VA Medical Center, Louisville, Kentucky *Issued 12/19/2018 | Report Number 18-01163-36*	VHA	1–9	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the San Francisco VA Health Care System, California *Issued 12/20/2018 | Report Number 18-01153-43*	VHA	1–12	--
Comprehensive Healthcare Inspection Program Review of the William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin *Issued 12/20/2018 | Report Number 18-01147-47*	VHA	1–4	--
Comprehensive Healthcare Inspection Program Review of the Marion VA Medical Center, Illinois *Issued 12/27/2018 | Report Number 18-01155-48*	VHA	1–6	--
Comprehensive Healthcare Inspection Program Review of the VA New Jersey Health Care System, East Orange, New Jersey *Issued 12/27/2018 | Report Number 18-01164-42*	VHA	1–6	--
Concerns Related to the Management of a Patient's Medication at Three VA Medical Centers and Inaccurate Response to a Congressional Inquiry at the VA Illiana Health Care System, Danville, Illinois *Issued 1/16/2019 | Report Number 18-02056-54*	VHA	1–8	--
Mismanagement of the VA Executive Protection Division *Issued 1/17/2019 | Report Number 17-03499-20*	OHRA OSP	OHRA: 1–12 OSP: 3	--
Alleged Clinical and Administrative Concerns Involving a Wound Care Provider in Veterans Integrated Service Network 21 *Issued 1/24/2019 | Report Number 18-05264-58*	VHA	1	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center *Issued 1/28/2019 | Report Number 17-01757-50*	VHA	1–13, 15–18	--
Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia *Issued 1/29/2019 | Report Number 18-05410-62*	VHA	1–5	--
Lost Opportunities for Efficiencies and Savings During Data Center Consolidation *Issued 1/30/2019 | Report Number 16-04396-44*	OIT	2, 3	--
Medication Management, Dispensing, and Administration Deficiencies at the VA Maryland Health Care System, Perry Point, Maryland *Issued 2/6/2019 | Report Number 17-05742-66*	VHA	1, 2, 4–7	--
Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center *Issued 2/20/2019 | Report Number 18-01766-78*	VHA	1–6	--
Delayed Radiology Test Reporting at the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas (VA Eastern Kansas Health Care System) *Issued 3/7/2019 | Report Number 18-00980-84*	VHA	1–5	--
Federal Information Security Modernization Act Audit for Fiscal Year 2018 *Issued 3/12/2019 | Report Number 18-02127-64*	OIT	1–28	--
Review of Hepatitis C Virus Care within the Veterans Health Administration *Issued 3/20/2019 | Report Number 17-05297-85*	VHA	1, 2	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION	ACTION OFFICES	OPEN RECOMMENDATIONS BY NUMBER	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Opioid Monitoring and Allegations Related to Opioid Prescribing Practices and Other Concerns at the Tomah VA Medical Center *Issued 3/28/2019 | Report Number 18-05872-103*	VHA	1	--
Total			**$2,725,936,496**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

TABLE B.4. UNIMPLEMENTED REPORTS AND RECOMMENDATIONS MORE THAN ONE YEAR OLD

Table B.4. identifies the 40 reports and 133 recommendations that, as of March 31, 2019, remain open for more than one year. The total monetary benefit attached to these reports is $329,207,000.

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of VA Regional Offices' Appeals Management Processes *Issued 5/30/2012 | Report Number 10-03166-75*	VBA	--
Recommendation 1: We recommended the Under Secretary for Benefits identify and request the staffing resources needed to meet Veterans Benefits Administration's processing goals and conduct de novo reviews on all appeals.		
Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.		
Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC *Issued 9/28/2012 | Report Number 12-00375-290*	OM OGC	--
Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel immediately determine what services VOA is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.		
Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments *Issued 7/11/2014 | Report Number 13-01452-214*	VBA	$205,000,000
Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.		
Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama *Issued 7/29/2015 | Report Number 14-04530-452*	VHA	--
Recommendation 2: We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of the Seismic Safety of VA's Facilities *Issued 11/12/2015 | Report Number 14-04756-32*	VHA	--
Recommendation 9: We recommended the Under Secretary for Health develop policies and procedures requiring Veterans Health Administration medical facilities to develop and test Continuity of Operations Plans, to include documenting the testing performed, in accordance with Federal Continuity Directive 1 requirements.		
Review of Claims-Related Documents Pending Destruction at VA Regional Offices *Issued 4/14/2016 | Report Number 15-04652-146*	VBA	--
Recommendation 1: We recommended the Acting Under Secretary for Benefits revise Veterans Benefits Administration's Policy on Management of Veterans' and Other Governmental Paper Records to ensure documents printed from Veterans Benefits Management System are clearly identified.		
Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System *Issued 4/26/2016 | Report Number 11-00826-261*	VHA	--
Recommendation 4: We recommended the Interim Director of Veterans Integrated Service Network 3 conduct a review of VA New Jersey Health Care System purchase card transactions for building renovations and take corrective action for all identified inappropriate transactions.		
Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses *Issued 12/6/2016 | Report Number 16-00790-417*	OIT	$7,200,000
Recommendation 1: We recommended the Assistant Secretary for Information and Technology implement a policy to ensure cost-effective utilization of information technology equipment, installed software, and services and ensure coordination of acquisitions with affected VA organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions.		
Audit of Recruitment, Relocation, and Retention Incentives *Issued 1/5/2017 | Report Number 14-04578-371*	OHRA	$77,500,000
Recommendation 1: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to ensure recruitment and relocation incentives are fully justified and authorized before being included on vacancy announcements for hard-to-fill positions or before the final selectee is identified in cases where a position is not filled through a vacancy announcement.		
Recommendation 3: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor compliance with its employee certification requirement before relocation incentives are authorized for payment.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of the Patient Advocacy Program *Issued 3/31/2017 | Report Number 15-05379-146*	VHA	--
Recommendation 5: We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.		
Evaluation of the Quality, Safety, and Value Program in Veterans Health Administration Facilities, Fiscal Year 2016 *Issued 3/31/2017 | Report Number 16-03743-193*	VHA	--
Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure clinical managers evaluate licensed independent practitioners' ongoing professional performance regularly according to the frequency required by facility policy.		
Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities *Issued 6/5/2017 | Report Number 15-01080-208*	VHA	--
Recommendation 3: We recommended the Under Secretary for Health issue bills of collection, as necessary and in accordance with VA policy, to recover physician-administered drug overpayments made by Florida VA facilities.		
Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 7/10/2017 | Report Number 16-02676-297*	VHA	--
Recommendation 17: We recommended that the System Director ensure that a Mental Health-related Strategic Analytics for Improvement and Learning workgroup identify priorities, and develop and implement improvement actions accordingly.		
Clinical Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan *Issued 7/17/2017 | Report Number 16-00549-302*	VHA	--
Recommendation 5: We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature and monitor compliance.		
Recommendation 6: We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Healthcare Inspection – Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care *Issued 8/1/2017 | Report Number 17-01846-316*	VHA	--
Recommendation 4: We recommended that the Acting Under Secretary for Health ensure that if facility leaders determine that a non-VA provider's opioid prescribing practices are in conflict with Opioid Safety Initiative guidelines, immediate action is taken to ensure the safety of all veterans receiving care from the non-VA provider.		
Clinical Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana *Issued 8/7/2017 | Report Number 16-00566-314*	VHA	--
Recommendation 2: We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.		
Audit of the Health Care Enrollment Program at Medical Facilities *Issued 8/14/2017 | Report Number 16-00355-296*	VHA	--
Recommendation 1: We recommended the Acting Under Secretary for Health develop standardized national policy and procedures for the health care enrollment program at VA medical facilities. Recommendation 2: We recommended the Acting Under Secretary for Health implement national oversight of the health care enrollment program to continually review operations and performance of Veterans Health Administration medical facilities. Recommendation 3: We recommended the Acting Under Secretary for Health provide mandatory and standardized training on eligibility and enrollment to ensure health care applications are processed accurately and timely. Recommendation 4: We recommended the Acting Under Secretary for Health develop and execute a process to distinguish new applications for health care enrollment in VistA from other registration data. Recommendation 5: We recommended the Acting Under Secretary for Health implement a plan to correct current data integrity issues in VistA to improve the accuracy and timeliness of enrollment data.		
OIG Determination of VHA Occupational Staffing Shortages, Fiscal Year 2017 *Issued 9/27/2017 | Report Number 17-00936-385*	VHA	--
Recommendation 1: We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations. Recommendation 3: We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.		
Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 9/29/2017 | Report Number 16-00546-388*	VHA	--
Recommendation 16: We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in transfer documentation and that facility managers monitor compliance. Recommendation 17: We recommended that facility managers ensure that for emergent transfers, provider transfer notes include patient stability for transfer and monitor compliance. Recommendation 18: We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance. Recommendation 19: We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance. Recommendation 25: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.		
Audit of VBA's National Pension Call Center *Issued 11/1/2017 | Report Number 16-03922-392*	VBA	--
Recommendation 2: We recommended the Acting Under Secretary for Benefits ensure Benefits Assistance Service has qualified staff to evaluate the quality of Spanish-speaking calls received at the National Pension Call Center.		
Audit of VA's Compliance With the DATA Act *Issued 11/8/2017 | Report Number 17-02811-21*	OM	--
Recommendation 1: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer continue progress with system modernization efforts. Ensure that current and upcoming DATA Act requirements are incorporated so that the detail level requirements for meeting the DATA Act will be made possible as automatic bulk file transmissions going forward.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer establish milestones to monitor VA's system modernization efforts. Coordination with the shared service provider should continue to incorporate current and upcoming DATA Act requirements to ensure that they will be met going forward.		
Recommendation 3: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer obtain procurement management system and if feasible, grants management system capabilities that are integrated with the financial system as part of VA's transition to a shared service provider.		
Recommendation 4: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer to the extent possible, reduce the amount of journal vouchers to those related to accrual adjustments or one time, unusual transactions. Journal vouchers recorded should contain data elements required for File B such as the program activity. In addition, if possible, automate efforts to combine FMS journal output files with the MinX-based Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) trial balance and resolve variances between the two systems.		
Recommendation 5: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer reduce the extensive use of 1358 obligations, and develop an automated procurement action capturing and reporting mechanism to timely capture all procurement activities greater than $3,500 for the File D1 submission.		
Recommendation 6: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer prepare the SBR and ensure reconciliation of File A, SF-133s and the SBR prior to File A submission.		
Recommendation 7: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer continue efforts to reduce the number of journal vouchers to those related to accrual adjustments or one time, unusual transactions. Journal vouchers recorded should contain data elements required for File B such as the program activity code and budget object class. In addition, if feasible, automate efforts to combine FMS journal output files with the MinX-based GTAS trial balance and identify and resolve variances between the two systems.		
Recommendation 8: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer where feasible, perform validation of MinX journal vouchers as they may contain errors and reside in the ultimate File B submission.		
Recommendation 9: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer research and resolve warnings identified by the broker before DATA Act files submission.		
Recommendation 10: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure that knowledge of DATA Act processes is not limited to one or a few people, and develop a succession plan to ensure the required expertise and capabilities will continue to remain available before personnel with highly technical and specialized knowledge leave or retire from the agency.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 11: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure complete reconciliations between the subsidiary and general ledger systems are performed. Differences should be researched and resolved to improve data accuracy, completeness and quality.		
Recommendation 12: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer for all TASes, ensure that amounts can be distinguished between general ledger accounts 4901 and 4902.		
Recommendation 13: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure a timely reconciliation process between File A and File B; File B to File C (when applicable); and File B to Files D1 and D2 such that procedures are completed prior to certifying each quarter's submission through the broker. Research and resolve variances identified through reconciliation processes.		
Recommendation 14: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer maintain documentation to support the various cost allocation methodologies used for aggregating VHA transactions included in File D2. Ensure File D2 VHA aggregated data includes only the required costs for DATA Act submission. Seek formal confirmation from OMB and Treasury that the direct services VHA is reporting should be included in File D2 as financial assistance awards and the employee payroll and File D1 duplicate contract cost data VHA is reporting should or should not be included in File D2 as financial assistance awards.		
Recommendation 15: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer provide targeted training to address specific issues identified to DATA Act points of contact on USASpending.gov requirements.		
Recommendation 16: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer implement PMO oversight of the reports submitted by VBA and VHA's ARC to ensure completeness, timeliness, quality, and accuracy of the information reported.		
Recommendation 17: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer implement internal controls related to the proper tracking and accounting for intragovernmental transfers as to their trading partner, type, and nature. Produce reliable subsidiary reports with transfer level details to facilitate management's reconciliation and reporting with the trading partner. Any differences between File A and B should be researched and corrected prior to file submission.		
Recommendation 18: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer research and identify the root cause of those transactions with default program activity names and implement corrective actions to address those issues. In addition, implement FMS and MinX JV edit checks to ensure all JVs contain the proper program activity name, program activity code and object class code or the JV will not be accepted by the system. The JV reviewer should ensure all those elements are properly recorded and are consistent with OMB A-11 and the President's Budget to improve the accuracy of the data.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 19: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer assess the impact of the internal control weaknesses reported and develop corrective actions to address data quality issues at the individual or aggregate transaction level.		
Recommendation 20: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer ensure the complete reporting of all required data elements. Establish and develop a process to validate data quality for all DATA Act files on a regular basis prior to file submission.		
Recommendation 21: We recommend the Acting Assistant Secretary for Management and Acting Chief Financial Officer continue to maintain communication with OMB and Treasury regarding VA's data reporting limitations and progress, and document such communication.		
Audit of VHA's Management of Primary Care Panels *Issued 12/6/2017 | Report Number 15-03364-380*	VHA	--
Recommendation 1: The OIG recommended the Acting Under Secretary for Health establish standardized primary care scheduling processes that provide newly enrolled veterans an opportunity to schedule an appointment at the time of enrollment.		
Comprehensive Healthcare Inspection Program Review of the Bath VA Medical Center, Bath, New York *Issued 12/7/2017 | Report Number 17-01752-32*	VHA	--
Recommendation 10: The Chief of Staff ensures that Domiciliary Residential Rehabilitation Treatment Program managers ensure the main point of entry has a keyless system and monitors compliance.		
Comprehensive Healthcare Inspection Program Review of the VA Eastern Kansas Health Care System Topeka, Kansas *Issued 12/7/2017 | Report Number 17-01850-38*	VHA	--
Recommendation 2: The Chief of Staff ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.		
Recommendation 4: The Assistant Director ensures all Interdisciplinary Safety Inspection Team members receive annual training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.		
Recommendation 5: The Chief of Staff and Associate Director for Patient Care Services ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitors their compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through FBCS *Issued 12/21/2017 | Report Number 15-03036-47*	VHA	$39,000,000
Recommendation 1: We recommended the Executive in Charge, Veterans Health Administration, develop and issue written payment policies to guide staff processing medical claims received from Third Party Administrators, as well as establish expectations and obligations for the Third Party Administrators that submit invoices for payment.		
Recommendation 2: We recommended the Executive in Charge, Veterans Health Administration, ensure payment processing staff have access to documentation from the Third Party Administrators verifying amounts paid to providers to ensure the Third Party Administrators are not billing VA more than they paid the provider for medical claims.		
Recommendation 3: We recommended the Executive in Charge, Veterans Health Administration, ensure Veterans Health Administration payment staff have access to accurate data regarding veterans' other health insurance coverage and establish appropriate processes for collecting payments from these health insurers.		
Recommendation 4: We recommended the Executive in Charge, Veterans Health Administration, ensure the new payment processing systems used for processing medical claims from Third Party Administrators have the ability to adjudicate reimbursement rates accurately and to ensure duplicate claims are not paid.		
Recommendation 5: We recommended the Executive in Charge, Veterans Health Administration, ensure VA performs post-payment audits on a periodic basis to determine if payments made to Third Party Administrators for medical care are accurate.		
Recommendation 6: We recommended the Executive in Charge, Veterans Health Administration, ensure that Office of Community Care staff and members of VA's Office of General Counsel continue to work collaboratively with relevant government authorities to review and determine an appropriate process for reimbursement.		
Recommendation 7: We recommended the Executive in Charge, Veterans Health Administration, ensure the Veterans Health Administration has sufficient claims processing capacity to timely meet and process expected claim volume from the Third Party Administrators.		
Healthcare Inspection Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility *Issued 1/4/2018 | Report Number 16-03576-53*	VHA	--
Recommendation 6: We recommended that the Facility Director ensure that non-VA care for psychiatric services is offered to patients who need to be seen sooner than VA appointment availability permits.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Combined Assessment Program Summary Report – Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities *Issued 1/30/2018 | Report Number 17-04460-84*	VHA	--
Recommendation 1: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure Facility Directors establish Employee Threat Assessment Teams. Recommendation 2: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require attendance by VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Board meetings and monitor compliance. Recommendation 3: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when Chiefs of Staff (or designees) issue Orders for Behavioral Restriction, they document that they informed patients that the Orders were issued and of the right to appeal the decisions and that facility senior managers monitor compliance. Recommendation 4: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require that within 90 days of hire, all employees complete Level I Prevention and Management of Disruptive Behavior training and additional training levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors and monitor compliance.		
Comprehensive Healthcare Inspection Program Review of the West Texas VA Health Care System, Big Spring, Texas *Issued 2/5/2018 | Report Number 17-01742-90*	VHA	--
Recommendation 9: The Chief of Staff ensures that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens and refer them and monitors providers' compliance.		
Comprehensive Healthcare Inspection Program Review of the VA New York Harbor Healthcare System, New York, New York *Issued 2/7/2018 | Report Number 17-01762-88*	VHA	--
Recommendation 12: The Chief of Staff ensures that the use of reversal agents in moderate sedation cases and the presence or absence of adverse events for all areas administering moderate sedation are reported to and trended by the Surgical, Procedural, Operative, and Therapeutic Committee and monitors compliance. Recommendation 13: The Chief of Staff ensures providers include a review of abnormalities of major organ systems; an airway assessment; and a review of alcohol, tobacco, or substance use or abuse in the history and physical exams and/or pre-sedation assessments and monitors providers' compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 14: The Chief of Staff ensures providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record and monitors providers' compliance.		
Critical Deficiencies at the Washington DC VA Medical Center *Issued 3/7/2018 | Report Number 17-02644-130*	VHA	--
Recommendation 1: The Medical Center Director ensures that necessary supplies, instruments, and equipment are available in patient care areas at the Medical Center when and where they are needed.		
Recommendation 2: The Medical Center Director requires operating room staff to conduct the final validation that all supplies, instruments, and equipment needed to perform the planned procedure and to address potential complications are in the operating room and available for use.		
Recommendation 3: The Medical Center Director makes certain that the OR staff have accurate lists of surgical instruments needed for particular procedures.		
Recommendation 6: The Medical Center Director requires Medical Center oversight committees to follow up and initiate action as necessary on quality assurance matters related to supplies, instruments, or equipment.		
Recommendation 7: The Medical Center Director confirms the full utilization of a VHA-authorized inventory system that contains accurate and reliable information regarding the availability of supplies throughout the Medical Center.		
Recommendation 9: The Medical Center Director ensures there are clearly defined and effective procedures for replacing missing or broken instruments, and that staff responsible for this function have been educated on the process.		
Recommendation 10: The Medical Center Director confirms that clearly defined and effective procedures address the disposition of discolored instruments during reprocessing and that staff responsible for this function have been educated on the process.		
Recommendation 11: The Medical Center Director ensures that the Sterile Processing Service (SPS) implements a quality assurance program to verify the cleanliness, functionality, and completeness of instrument sets prior to their reaching clinical areas.		
Recommendation 12: The Medical Center Director makes certain that SPS and OR personnel comply with policies and procedures for the proper reprocessing of loaner instruments and trays.		
Recommendation 14: The Medical Center Director ensures that the SPS maintains updated and readily accessible standard operating procedures for all instruments and equipment within SPS and its satellite areas in accordance with VHA policy.		
Recommendation 15: The Medical Center Director verifies that all SPS employees have appropriate, updated competencies and a demonstrated proficiency to perform their assigned duties.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 19: The VISN 5 Director, together with Medical Center leaders, develops a staffing plan to fill vacancies that includes accurate numbers of authorized positions by service that is based on clinical and administrative workload and other appropriate measures, and includes contingencies for staffing areas with high attrition rates.		
Recommendation 20: The VISN 5 Director ensures the timely completion of hiring actions at the Medical Center until staffing deficiencies in Logistics Service and Sterile Processing Services are fully resolved.		
Recommendation 22: The Medical Center Director ensures that medical supply items are added to the prime vendor formulary in order to meet prime vendor purchasing goals.		
Recommendation 25: The VISN 5 Director ensures that the Medical Center updates and maintains the Equipment Inventory List (EIL) as required by VA policy and makes certain that the Medical Center Director and Chief Logistics Officer are held accountable for the timely and accurate reporting of the Medical Center EIL.		
Recommendation 29: The Medical Center Director designates an official records manager, alternate records manager, and official records liaisons, as well as implements a records management program in accordance with the National Archives and Records Administration requirements.		
Recommendation 31: The Medical Center Director verifies that accurate and complete financial documentation to support medical supply and equipment purchases is readily available in accordance with GAO Standards for Internal Control in the Federal Government.		
Recommendation 33: The Deputy Under Secretary for Health for Operations and Management ensures that the VHA Procurement and Logistics Office conducts regular audits of the logistics services within VHA medical centers to assess compliance with VA and VHA policies pertaining to procurement and logistics, and makes certain that timely and effective remediation occurs in response to all noncompliant conditions identified as a result of those audits.		
Recommendation 35: The VISN 5 Director institutes procedures designed to ensure the accuracy of future representations made by Washington DC VA Medical Center staff in connection with action plans submitted to oversight bodies such as VHA program offices.		
Recommendation 38: The Under Secretary for Health takes appropriate administrative action to address the conditions identified in this report.		
Recommendation 39: The VISN 5 Director oversees implementation of recommendations directed to the Medical Center Director.		
Recommendation 40: The Under Secretary for Health verifies the successful implementation of all recommendations contained within this report.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Healthcare Inspection – Mismanagement of Resuscitation and Other Concerns at the Buffalo VA Medical Center, Buffalo, New York *Issued 3/12/2018 | Report Number 17-01485-128*	OGC	--
Recommendation 1: We recommended that the VA Office of the General Counsel, pursuant to VA Directive 6311, work in conjunction with the Office of Information Technology, Veterans Health Administration offices, and other interested offices to advise the Under Secretary for Health regarding the refinement (or development) of policies reasonably designed to ensure the preservation of electronically stored information when legally necessary (or desirable for purposes of quality improvement), including, but not limited to electronically stored information that is subject to auto-deletion, such as telemetry data.		
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 *Issued 3/13/2018 | Report Number 17-00481-117*	VHA	--
Recommendation 7: The OIG recommended the Veterans Health Administration Executive in Charge implement controls to ensure Choice medical documentation is received timely in accordance with Choice contracts.		
VHA Review of Selected Construction Projects at Oklahoma City VA Health Care System *Issued 3/22/2018 | Report Number 17-00253-102*	VHA	--
Recommendation 1: The OIG recommended the Acting Under Secretary for Health ensure the construction areas in the Surgical Intensive Care Unit project are sealed to prevent further weather damage.		
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	VHA OSP	--
Recommendation 2: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.		
Recommendation 4: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage the background investigation workload.		
Recommendation 5: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Office of the Under Secretary for Health, to implement a plan to review the suitability status of all Veterans Health Administration personnel and correct delinquencies to ensure a properly vetted workforce.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 6: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, improve management oversight of the personnel suitability program at VA medical facilities and ensure background investigations are properly initiated and adjudicated nationwide, and internal control mechanisms required by policy are properly implemented.		
Recommendation 8: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.		
Recommendation 9: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.		
Recommendation 10: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.		
Recommendation 11: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, coordinate with the Assistant Secretary for Operations, Security, and Preparedness to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.		
Comprehensive Healthcare Inspection Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee *Issued 3/27/2018 | Report Number 17-01764-143*	VHA	--
Recommendation 4: The Facility Director ensures inter-facility patient transfer data are analyzed and reported to an identified quality oversight committee and monitors compliance.		
Recommendation 5: The Chief of Staff ensures providers consistently document patient or surrogate informed consent and the patient's medical and behavior stability when patients are transferred out of the facility and monitors the providers' compliance.		
Recommendation 6: The Chief of Staff ensures providers countersign the acceptable designees' transfer/progress notes when patients are transferred out of the facility and monitors compliance.		
Recommendation 12: The Associate Director ensures all mental health unit employees and Interdisciplinary Safety Inspection Team members complete the required training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.		
Recommendation 15: The Chief of Staff ensures clinical employees who perform, assist with, or supervise moderate sedation procedures have current moderate sedation training and monitors their compliance.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Resident and Part-Time Physician Time and Attendance at Oklahoma City VA Health Care System *Issued 3/28/2018 | Report Number 17-00253-93*	VHA	$507,000
Recommendation 11: The OIG recommended the Oklahoma City VA Health Care System Director ensure that all overdue reconciliations of part-time physicians' adjustable work hour agreements identified in the report are performed and actions are taken to address over- and underpayments.		
Comprehensive Healthcare Inspection Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina *Issued 3/28/2018 | Report Number 17-01856-135*	VHA	--
Recommendation 3: The Facility Interim Director ensures that required representatives of the interdisciplinary group consistently attend meetings and review utilization management data, and monitors the group's compliance.		
Recommendation 6: The Chief of Staff ensures providers consistently document patient or surrogate informed consent and identify the receiving provider for patients transferred out of the facility and monitors the providers' compliance.		
Recommendation 7: The Chief of Staff ensures that clinicians consistently communicate pertinent patient information to the receiving facility when patients are transferred out of the facility and monitors the clinicians' compliance.		
Recommendation 9: The Chief of Staff ensures that acceptable providers perform suicide risk assessments for all patients with positive post-traumatic stress disorder screens and monitors providers' compliance.		
Recommendation 10: The Chief of Staff ensures that acceptable providers complete diagnostic evaluations for patients with positive post-traumatic stress disorder screens within 30 days of the referral and monitors providers' compliance.		
Administrative Investigation – Conflict of Interest, Nepotism, and False Statements, VA Office of General Counsel, Washington, DC *Issued 3/29/2018 | Report Number 17-03324-123*	OSVA	--
Recommendation 1: The VA Deputy Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate administrative action to take, if any, against Mr. Fleck.		
Recommendation 2: The VA Deputy Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate administrative action to take, if any, against Ms. KW.		
Recommendation 3: The VA Deputy Secretary confers with the Offices of General Counsel and Human Resources to determine the total amount of funds unlawfully expended to pay for Ms. KW's salary since her initial VA appointment on January 8, 2017, and ensures that a bill of collection is issued to Ms. KW in that amount.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The VA Deputy Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate corrective action to take concerning Ms. KW's VA appointment and takes such action.		
Recommendation 5: The VA Deputy Secretary confers with VA's Designated Agency Ethics Official to ensure Deputy General Counsel for Legal Policy staff members receive appropriate ethics training as related to our findings in this report.		
Comprehensive Healthcare Inspection Program Review of the VA North Texas Health Care System, Dallas, Texas *Issued 3/29/2018 | Report Number 17-05404-149*	VHA	--
Recommendation 3: The Chief of Staff ensures that Ongoing Professional Practice Evaluations include the utilization of service-specific criteria and monitors compliance.		
Recommendation 4: The Chief of Staff and Associate Director for Patient Care Services ensure personal protective equipment is readily accessible and monitor compliance.		
Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York *Issued 3/29/2018 | Report Number 17-05407-141*	VHA	--
Recommendation 4: The Facility Director ensures the Patient Safety Manager or designee provides feedback about root cause analysis actions to the reporting individuals or departments and monitors the Patient Safety Manager's compliance.		
Recommendation 5: The Associate Director ensures environment of care rounds are conducted in all areas of the facility at the required frequency and monitors compliance.		
Recommendation 6: The Associate Director ensures required team members consistently participate on environment of care rounds and monitors team members' compliance.		
Recommendation 7: The Associate Director ensures medical biohazardous waste storage rooms are secured and monitors compliance.		
Recommendation 8: The Facility Director ensures that controlled substances inspectors perform controlled substances order verification as required and monitors inspectors' compliance.		
Recommendation 9: The Facility Director ensures controlled substances inspectors complete monthly pharmacy prescription pad inventories and monitors inspectors' compliance.		
Recommendation 10: The Chief of Staff ensures providers communicate mammogram results to patients and monitors providers' compliance.		
Total		**$329,207,000**

APPENDIX C: REPORTING REQUIREMENTS

Table C.1. lists the reporting requirements for Inspectors General as set out in the IG Act. It also lists the sections within this report that satisfy those requirements.

TABLE C.1. REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
§ 4. Duties and responsibilities; report of criminal violations to Attorney General (a) It shall be the duty and responsibility of each Inspector General, with respect to the establishment within which his Office is established—	Other Reporting Requirements
(2) to review existing and proposed legislation and regulations and make recommendations in the semiannual reports concerning the impact of such legislation or regulations on the economy and efficiency in the administration of programs and operations administered or financed by such establishment or the prevention and detection of fraud and abuse in such programs and operations;	
§ 5. Semiannual reports; transmittal to Congress; availability to public; immediate report on serious or flagrant problems; disclosure of information; definitions (a) Each Inspector General shall, not later than April 30 and October 31 of each year, prepare semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to—	Results from the Office of Audits and Evaluations Results from the Office of Contract Review Results from the Office of Healthcare Inspections Results from the Office of Investigations
(1) a description of significant problems, abuses, and deficiencies relating to the administration of [VA] programs and operations disclosed during the reporting period;	
(2) a description of the recommendations for corrective action made by the Office during the reporting period;	Results from the Office of Audits and Evaluations Results from the Office of Healthcare Inspections Results from the Office of Investigations
(3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed;	Appendix B

REQUIREMENT	SAR SECTION(S)
(4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted;	Statistical Performance Results from the Office of Investigations
(5) a summary of each report made to the [VA Secretary] concerning instances when information or assistance requested was, in the judgment of the IG, unreasonably refused or not provided;	Other Reporting Requirements
(6) a listing, subdivided according to subject matter, of each audit, inspection, and evaluation report issued during the reporting period and for each report, where applicable, the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs) and the dollar value of recommendations that funds be put to better use;	Appendix A
(7) a summary of each particularly significant report;	Results from the Office of Audits and Evaluations Results from the Office of Healthcare Inspections Results from the Office of Investigations
(8) statistical tables showing the total number of audit, inspection, and evaluation reports and the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs), for reports— (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— (i) the dollar value of disallowed costs; and (ii) the dollar value of costs not disallowed; and (D) for which no management decision has been made by the end of the reporting period;	Statistical Performance Appendix A

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(9) statistical tables showing the total number of audit, inspection, and evaluation reports and the dollar value of recommendations that funds be put to better use by management, for reports— (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— (i) the dollar value of recommendations that were agreed to by management; and (ii) the dollar value of recommendations that were not agreed to by management; and (D) for which no management decision has been made by the end of the reporting period;	Statistical Performance Appendix A
(10) a summary of each audit, inspection, and evaluation report issued before the commencement of the reporting period— (A) for which no management decision has been made by the end of the reporting period (including the date and title of each such report), an explanation of the reasons such management decision has not been made, and a statement concerning the desired timetable for achieving a management decision on each such report; (B) for which no establishment comment was returned within 60 days of providing the report to the establishment; and (C) for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations;	Appendix A Appendix B
(11) a description and explanation of the reasons for any significant revised management decision made during the reporting period;	Appendix A
(12) information concerning any significant management decision with which the Inspector General is in disagreement;	Appendix A

REQUIREMENT	SAR SECTION(S)
(13) the information described under section 804(b) of the Federal Financial Management Improvement Act of 1996;	Results from the Office of Audits and Evaluations
(14)(A) an appendix containing the results of any peer review conducted by another OIG during the reporting period; or (B) if no peer review was conducted within that reporting period, a statement identifying the date of the last peer review conducted by another OIG;	Other Reporting Requirements
(15) a list of any outstanding recommendations from any peer review conducted by another Office of Inspector General that have not been fully implemented, including a statement describing the status of the implementation and why implementation is not complete;	Other Reporting Requirements
(16) a list of any peer reviews conducted by the Inspector General of another Office of the Inspector General during the reporting period, including a list of any outstanding recommendations made from any previous peer review (including any peer review conducted before the reporting period) that remain outstanding or have not been fully implemented;	Other Reporting Requirements
(17) statistical tables showing— (A) the total number of investigative reports issued during the reporting period; (B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period; (C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and (D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities;	Statistical Performance
(18) a description of the metrics used for developing the data for the statistical tables under paragraph (17);	Statistical Performance

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including a detailed description of— (A) the facts and circumstances of the investigation; and (B) the status and disposition of the matter, including— (i) if the matter was referred to the Department of Justice, the date of the referral; and (ii) if the Department of Justice declined the referral, the date of the declination;	Results from the Office of Investigations
(20)(A) a detailed description of any instance of whistleblower retaliation, including information about the official found to have engaged in retaliation; and (B) what, if any, consequences the establishment actually imposed to hold the official described in subparagraph (A) accountable;	Other Reporting Requirements
(21) a detailed description of any attempt by the establishment to interfere with the independence of the Office, including— (A) with budget constraints designed to limit the capabilities of the Office; and (B) incidents where the establishment has resisted or objected to oversight activities of the Office or restricted or significantly delayed access to information, including the justification of the establishment for such action; and	Other Reporting Requirements
(22) detailed descriptions of the particular circumstances of each— (A) inspection, evaluation, and audit conducted by the Office that is closed and was not disclosed to the public; and (B) investigation conducted by the Office involving a senior Government employee that is closed and was not disclosed to the public.	Statistical Performance Other Reporting Requirements

DEFINITIONS

As defined in the IG Act—

Questioned cost means a cost that is questioned by the [VA OIG] because of—

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

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

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

Unsupported cost means a cost that is questioned by the [VA OIG] because the [VA OIG] found that, at the time of the audit, such cost is not supported by adequate documentation.

Disallowed cost means a questioned cost that [VA] management, in a management decision, has sustained or agreed should not be charged to the government.

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

(A) Reductions in outlays;

(B) Deobligation of funds from programs or operations;

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

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

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

(F) Any other savings which are specifically identified.

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

Final action means

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

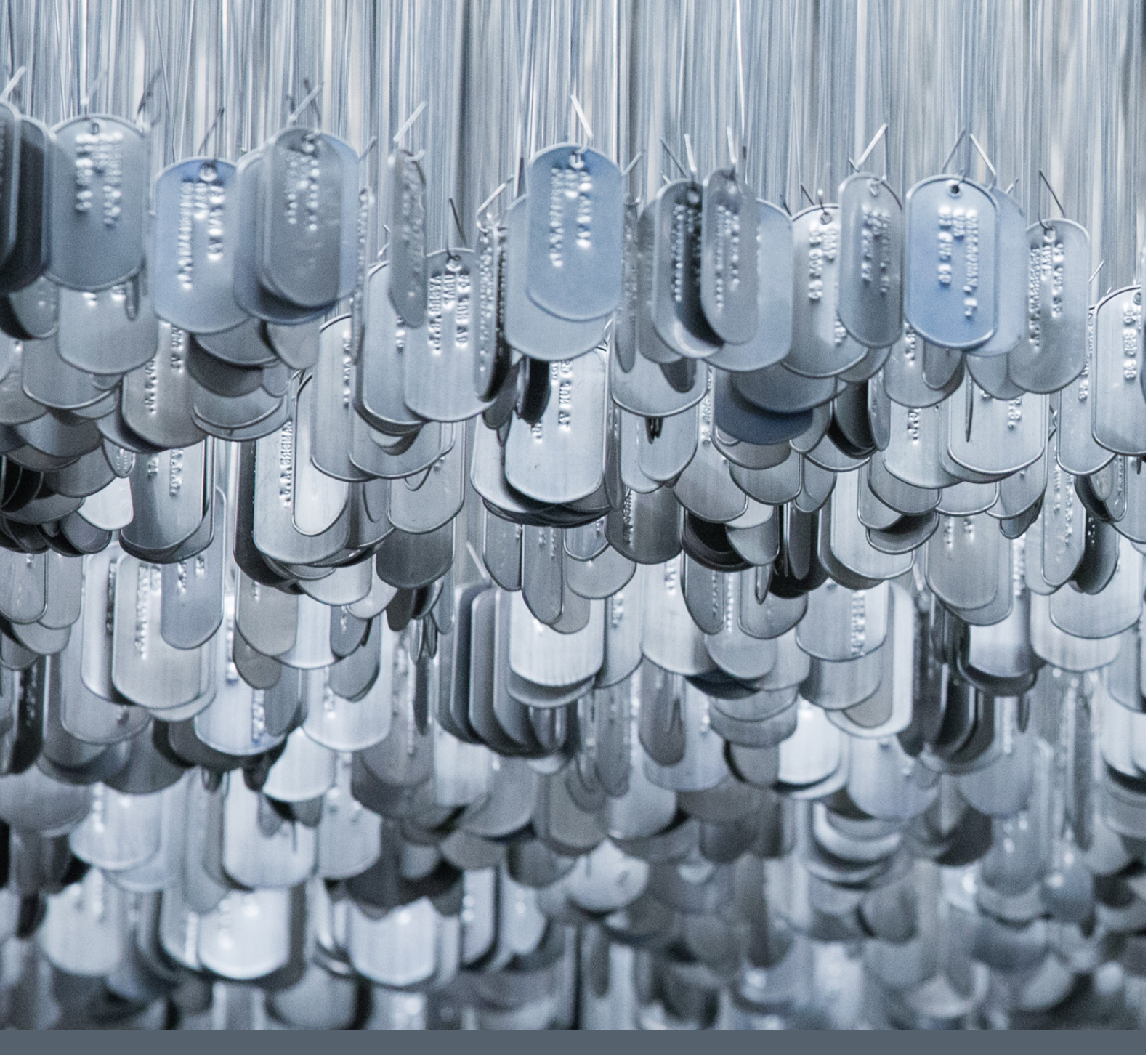
(B) In the event that the management of an establishment concludes no action is necessary, final action occurs when a management decision has been made.

Senior government employee means

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

(B) Any commissioned officer in the Armed Forces in pay grades O-6 and above.

Connect with the OIG



CONTACT THE OIG HOTLINE

to report suspected criminal activity or other wrongdoing.

www.va.gov/oig/hotline

Telephone: (800) 488-8244 | Fax: (202) 495-5861

VA Inspector General Hotline (53E)
810 Vermont Avenue, NW, Washington, DC 20420

Above and Beyond is a Vietnam memorial installation comprising 58,307 dog tags representing each American whose life was lost in the Vietnam War. *Above and Beyond* was commissioned by the National Veterans Art Museum and created by veteran artists Rick Steinbock, Ned Broderick, Joe Fornelli, and Mike Helbing. The memorial installation is part of the National Veterans Art Museum's permanent collection, and is on exhibit at the Harold Washington Library Center in downtown Chicago until April 2020. Photo courtesy of the National Veterans Art Museum, Chicago, Illinois.