Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
October 1, 2006 - March 31, 2007

Message from the Inspector General

This Semiannual Report to Congress focuses on the accomplishments of the VA Office of Inspector General (OIG) for the period of October 1, 2006, through March 31, 2007. Issued in accordance with the *Inspector General Act of 1978*, as amended, it presents results based on OIG strategic goals, which cover the areas of health care delivery, benefits processing, financial management, procurement practices, and information management.

During this reporting period, OIG issued 108 reports on VA programs and operations. We recommended systemic improvements and efficiencies in quality of care, accuracy of benefits, budget processes, economy in procurement, and information security. OIG audits, investigations, and other reviews identified over $310 million in monetary benefits, for a return of $9 for every dollar expended on OIG oversight. Our criminal investigators closed 668 investigations and made 305 arrests. OIG investigative work also resulted in 380 administrative sanctions.

Our Office of Healthcare Inspections continued a focus on quality management in veterans health care, with a national review of patient safety in the operating room. Healthcare Inspections has also issued reports on research activities in the Veterans Health Administration, including the merit review process, research irregularities, and protection of human subjects.

Our Office of Audit oversaw an independent audit of the VA FY 2006 consolidated financial statements. While this report provided an unqualified ("clean") audit opinion, it identified material weaknesses in information technology security controls, lack of an integrated financial management system, and operational oversight. We will follow up and evaluate the implementation of corrective actions during the audit of the VA FY 2007 consolidated financial statements.

The Office of Contract Review collaborated with the VA Office of Acquisition and Materiel Management on preaward and postaward reviews specifically designed to improve the VA procurement process. Those efforts resulted in savings and dollar recoveries of nearly $75 million.

On February 15, 2007, I testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. I discussed our accomplishments and the challenges OIG faces in providing oversight of VA to ensure it effectively serves America's veterans. The testimony outlined key challenges facing VA in need of additional oversight, including health care and benefits for returning Operation Enduring Freedom/Operation Iraqi Freedom veterans, research, protection of VA data, information technology, and procurement.

OIG values the ongoing support we receive from the VA Secretary, Deputy Secretary, and senior management. We look forward to further cooperation with VA and Congress to make VA as effective as possible in caring for our Nation's veterans.

George J. Opfer

GEORGE J. OPFER
Inspector General

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RETURN ON INVESTMENT

Dollar Impact ($310.2)/Cost of OIG Operations ($35.3)	9:1
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OTHER IMPACT

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Opened	622
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Cases Opened	508
Cases Closed	592

[1] Includes the apprehension of 104 fugitive felons by OIG.

VA and OIG Mission, Organization, and Resources

The Department of Veterans Affairs

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

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2007, VA has a $76.9 billion budget and almost 220,000 employees serving an estimated 24 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

VA has three administrations that serve veterans:

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

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

VA Office of Inspector General

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

OIG, with 445 employees, is organized into three line elements: the Offices of Investigations, Audit, and Healthcare Inspections, plus a contract review office and a support element. FY 2007 funding for OIG operations provides $70.6 million from appropriations. The contract review office receives $3.4 million through a reimbursable agreement with VA for contract review services to perform preaward and postaward contract reviews and other pricing reviews of Federal Supply Schedule contracts. In addition to the Washington, DC, headquarters, OIG has field offices located in 23 cities throughout the country.

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

Health Care Delivery

The health care that VHA provides veterans, including those recently returned from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), is consistently ranked among the best in the Nation. OIG oversight helps VHA maintain a fully functional QM program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events.

OFFICE OF HEALTHCARE INSPECTIONS

The OIG Office of Healthcare Inspections (OHI) focuses on quality of care issues in VHA and assesses VHA services. OHI published 23 cyclical Combined Assessment Program (CAP) reviews to evaluate quality of care issues in VHA medical facilities, 19 hotline reports, and 5 national reviews.

Study Finds VHA Operating Rooms Inconsistent in Following Policy

OIG evaluated VHA medical facility efforts to ensure patient safety in the operating room (OR) and found that most OR personnel followed the five steps outlined in VHA policy to ensure correct surgery, but not consistently. Several environment of care issues needed management attention. The way facilities collected, trended, and analyzed data made it difficult to analyze some OR issues. Facilities did not properly document surgical resident supervision or disclose adverse events in the medical records. Mortality assessments were not consistent with VHA policy, and morbidity and mortality peer reviews were not completed for quality improvement as required. Local policies did not clarify which OR providers require basic or advanced cardiac life support training. OIG also found that VHA Supply, Processing, and Distribution was not consistently providing a continuous flow of processed sterile and non-sterile supplies, instruments, and equipment to the ORs. OIG made recommendations for corrective action. *(Review of Patient Safety in the Operating Room in Veterans Health Administration Facilities)*

Review Recommends Additional Quality Management Improvements

OIG conducted an evaluation to determine whether VHA facilities had comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts, and whether VHA facility senior managers actively supported QM efforts and appropriately responded to QM results. All 47 facilities reviewed had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. Healthcare inspectors noted improvements in many areas in this report compared with the OIG FY 2003 report. However, facility senior managers needed to continue to strengthen QM programs by improving compliance in peer review, adverse event disclosure, utilization management, action item tracking, and mortality analyses. OIG made recommendations for improvement to the Acting Under Secretary for Health. *(Healthcare Inspection, Quality Management in Veterans Health Administration Facilities Fiscal Year 2006)*

Inspectors Find VHA Needs to Tighten Conflict of Interest Rules

An OIG review found that members of a VA research merit review subcommittee reviewed each others' proposals despite possible conflicts of interest. This highlighted a systemic problem that VHA policies do not define personal or professional relationships constituting a conflict of interest in terms applicable to peer review, nor do they specify the extent and nature of Office of Research and Development responsibility to identify these conflicts. In the specific case, when the designated agency ethics official exempted merit review subcommittee members from the requirements of annual financial disclosure statements in 1996, the exemption also included annual ethics statements otherwise required of special Government employees. The Acting Under Secretary for Health provided acceptable improvement plans. In the future, members will be required to review a conflict of interest statement and certify both before and after the review period that they have no conflict, but the designated agency ethics official determined that it was appropriate to continue exempting merit review committee members from the annual financial disclosure requirement. *(Healthcare Inspection, Alleged Conflict of Interest and Breach of Confidentiality in VHA's Merit Review Process)*

Inspectors Find Areas Needing Management Attention in Dallas

OIG evaluated selected operations focusing on patient care administration and QM, and also conducted follow-up on aspects of our 2004 review. The health care system complied with standards in the following five areas: environment of care, diabetes and atypical antipsychotic medications, breast cancer management, patient satisfaction, and the all employee survey. The following opportunities were identified to improve operations:

- Construct a comprehensive effective QM program that includes all appropriate patient care and patient safety elements.
- Appoint and train the utilization management physician advisor.
- Improve veteran visitation, medical record and travel documentation, and conduct oversight in the contract nursing home program.
- Improve administrative operations and oversight at the Greenville community-based outpatient clinic.
- Require completed informed consents for cardiac catheterization procedures.

(Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas)

Healthcare Review Calls for OR Improvements in Tampa

OIG conducted this review to determine the validity of multiple allegations made concerning the management of the James A. Haley VA Medical Center (VAMC) OR and quality of care issues. To improve operations, OIG made several recommendations, which included:

- Assess all aspects of OR utilization including staffing, specialty needs, OR scheduling, and patient flow.
- Perform surgeon-specific peer reviews.
- Analyze the high mortality and morbidity identified in National Surgical Quality Improvement Program data and take actions as needed.
- Institute a comprehensive QM program within the surgery service and anesthesiology service.
- Review the causes of surgical delays and make appropriate management changes to improve OR efficiency.

In addition, OIG recommended administrative and hygienic changes. The Veterans Integrated Service Network (VISN) and VAMC directors provided acceptable improvement plans. *(Healthcare Inspection, Management of the Operating Room and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, Florida)*

Inspectors Find Poor Communication in Discharge of Charleston Patient

OIG reviewed an allegation that a registered nurse discontinued an intravenous line (IV) without authorization on an unstable patient. Healthcare inspectors substantiated that the nurse discontinued the IV, but the patient showed no symptoms, met discharge criteria, and had a valid discharge order. However, OIG determined the nurse did not clarify the patient's condition before discharge, and the nurse and the physician did not communicate adequately on the patient's status despite the patient's developing pneumothorax, a known complication of the patient's procedure. Inspectors also found staff did not follow policy related to orders, and the complainant did not use the patient incident reporting (PIR) system to notify responsible managers of the event. OIG recommended that managers develop policy to standardize the hand-off communication process. The review also recommended that staff adhere to medical center policies as they relate to orders, and be educated on the use of the PIR system for reporting real or potentially harmful patient related occurrences. The VISN and VAMC directors provided acceptable improvement plans. *(Healthcare Inspection, Clinical and Administrative Issues, Ralph H. Johnson VA Medical Center, Charleston, South Carolina)*

Emergency Shows Need to Improve Response Process in Oklahoma City

OIG conducted a review to determine the validity of allegations of inappropriate treatment of a patient. The patient was admitted to the cardiac intensive care unit (CICU) with uncontrolled diabetes. He became infected and was placed on a ventilator. His condition deteriorated, and several physicians and nurses performed an emergency amputation of his right lower leg at his CICU bedside. Complainants alleged that performing the amputation in the CICU was inappropriate, several staff members declined to be involved, the amputation was performed without an anesthesiologist, and the patient did not receive adequate pain management. Healthcare inspectors did not substantiate the allegations. However, OIG determined the patient had previously called the facility Telcare program and reported pain and swelling in his right lower leg. A primary care nurse attempted to call the patient 2 days later, but the line was busy. Inspectors did not find documentation of earlier attempts to contact the patient. OIG recommended the VISN and VAMC directors take action to review the Telcare triage and response process to ensure calls are appropriately prioritized and followed up in an efficient and timely manner. The VISN and VAMC directors provided acceptable improvement plans. *(Healthcare Inspection, Alleged Inappropriate Treatment, Oklahoma City VA Medical Center, Oklahoma City, Oklahoma)*

OFFICE OF AUDIT

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

OIG Identifies Ways to Improve Controls over Prescription Drugs

In a summary report of OIG CAP reviews at 22 VHA medical facilities between January and September 2005, OIG reported that staff at 16 facilities did not always comply with internal controls for detecting, preventing, and reporting thefts of prescription drugs. OIG recommended the Acting Under Secretary for Health, in conjunction with the Chief Network Officer (CNO), ensure that medical facility managers use the findings in CAP reports during their internal review to assess the adequacy of controlled substances inspection procedures and physical security efforts, take action to improve them where needed, enforce theft reporting requirements, and ensure controlled substances retained by research service staff are included in all related internal control procedures. OIG further recommended the Acting Under Secretary for Health, also in conjunction with the CNO, make certain that medical facility managers ensure the use of required automated inventory control systems and enforce compliance with controlled substances receiving and physical inventory requirements. The Acting Under Secretary for Health provided acceptable improvement plans. *(Review of VA Medical Facility Compliance with Controls over Prescription Drugs)*

OFFICE OF INVESTIGATIONS

The OIG Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, facility security, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 127 cases, made 90 arrests, and obtained $194,176,882 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Conspiracy to Steal Drugs Nets Former Pharmacist 18-month Sentence

An OIG investigation determined that a former VA pharmacist conspired with two business associates to steal drugs and other pharmaceutical products from a VA pharmacy. He was sentenced to serve 18 months' incarceration and 3 years' probation, and was ordered to pay $670,000 in restitution.

Fraud Nets Veteran $230,000 in Health Care and $134,000 in Benefits

OIG investigators determined that a veteran provided false statements in applying for benefits for post-traumatic stress disorder (PTSD) regarding stressors he claimed exposure to. He also submitted altered letters from VA and Social Security Administration (SSA) to obtain fraudulent Department of Defense and state identification and then used them to

commit bank fraud. The loss to VA was $230,000 in health care costs and $134,000 in benefits. The veteran was arrested for making false claims, mail fraud, wire fraud, and health care fraud.

Veteran's Brother Admits Identity Theft to Receive Medical Care

An investigation by OIG and VA police determined that the brother of a veteran fraudulently received VA medical treatment for approximately 3 years. The veteran's brother pled guilty to making false statements, admitting to fraudulently receiving $94,000 in VA medical care as a result of impersonating his brother.

VA Employee Convicted in $225,475 in Workers' Compensation Scheme

A former VA employee who falsely reported that he was unemployed and had no earned income—when in fact he operated his own business as a general contractor—was found guilty of making false statements and bankruptcy fraud in a scheme to fraudulently obtain approximately $225,475 in workers' compensation benefits. He also failed to report his benefits as income to a bankruptcy court.

VA Nurse Charged with Diverting 1,050 Narcotics Doses in a Year

A joint OIG and VA police investigation determined that a VAMC registered nurse diverted narcotics in the names of patients who had been discharged from the facility or had no physician's order for the narcotics. The nurse, who diverted a total of 1,050 doses of percocet, hydromorphine, morphine, and other narcotics during a 1-year period, was charged with theft of controlled narcotics.

False Claim Costs VA Approximately $460,000

A veteran pled guilty to making false statements after an OIG investigation revealed that he misrepresented the existence and severity of several injuries, which he fraudulently claimed were related to his military service. He also used the alleged injuries as the basis for filing a $2 million tort claim against the U.S. Air Force. The loss to VA is approximately $460,000.

OIG HOTLINE

In the area of health care, the OIG Hotline receives allegations that include patient abuse, theft of VA pharmaceuticals or medical equipment, and false claims for health care benefits. The Hotline oversees the review and resolution of serious problems, and by doing so, contributes to raising the quality of care for the Nation's veterans.

Review Addresses Questionable Practices in Intensive Care Unit

A VHA review found multiple examples of questionable medical and nursing practices at an intensive care unit. Deficiencies included employees' failure to report physician errors, decreased levels of staff supervision, and lack of knowledge of current medical procedures. Management addressed these deficiencies through staff training and education, internal reviews, and an ongoing monitoring program.

Hotline Notes Communication and Treatment Lapses, Helps Veteran

A VHA review determined that lapses in communication between a veteran's treatment providers at two VAMCs, and a physician's failure to order a diagnostic test at the facility nearest to the veteran led to the veteran's surgery being delayed. Medical management authorized full payment for the veteran's surgery at a private facility of his choice.

Administrative Errors Result in Switched Medications

A VHA review found that administrative errors resulted at least twice in veterans with the same name receiving each other's medications. Additionally, because the labels on the prescriptions included sensitive personal data, the review substantiated privacy violations related to the incidents. In response, management took action to ensure employees assembling the shipments are able to see the addresses of these individuals in order to select the appropriate recipient, and established a procedure to reissue medications if such errors occur in the future.

Benefits Processing

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

OFFICE OF AUDIT

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

VBA, VHA Coordination Needs Improvement for Hospitalized Veterans

OIG evaluated the effectiveness of VBA procedures for adjusting compensation and pension (C&P) benefits for hospitalized veterans. The objectives were to evaluate the effectiveness of:

- VA regional office (VARO) procedures for adjusting compensation benefits of veterans hospitalized at Government expense for more than 90 days.
- VARO procedures for adjusting pension benefits of veterans who were hospitalized at Government expense before a November 7, 2003, VBA training letter directed pension maintenance centers (PMC) to make hospital adjustments for veterans in receipt of VA pension benefits.
- PMC procedures for adjusting pension benefits of veterans hospitalized at Government expense for more than 90 days.
- The exchange of information for hospitalized veterans between the PMCs and the VAROs.
- Plans implemented in response to a prior OIG recommendation.
- Local and VHA policies and procedures used to provide patient data for the automated medical information exchange and C&P record interchange systems.

The auditors found inefficiencies and inadequacies in procedures, training, information exchanges, accuracy of information, and priority of making hospital adjustments, totalling $10,203,975 in better use of funds. OIG made recommendations for increased VBA-VHA coordination. *(Audit of Adjustments of Hospitalized Veterans' Compensation and Pension Benefits)*

Inaccuracies Revealed in VBA PMC Payment Processing

In January 2002, VBA consolidated its pension maintenance processing into three PMCs. The OIG audit of VBA consolidation efforts found VBA could improve the accuracy of processing beneficiary income adjustments, processing eligibility verification reports, and scanning and filing documents, as well as the timeliness of processing of C&P system messages. OIG estimated that 5.2 percent of beneficiaries received inaccurate award payments totaling $13.4 million. Of the $13.4 million, beneficiaries received $9.4 million in overpayments and $4.0 million in underpayments. OIG recommended the Under Secretary for Benefits standardize and implement more effective procedures and provide appropriate training. *(Audit of Veterans Benefits Administration's Pension Maintenance Program Administered by the Pension Maintenance Centers)*

OFFICE OF INVESTIGATIONS

VA administers a number of financial benefits programs for eligible veterans and certain family members. Among the benefits are VA guaranteed home loans, education, insurance, and monetary benefits provided by the C&P Service. With respect to VA

guaranteed loans, OI conducts investigations of loan origination fraud, equity skimming, and criminal conduct related to management of foreclosed loans or properties.

C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. An ongoing proactive income verification match identifies possible fraud in the pension program. OI also conducts an ongoing death match project that identifies deceased beneficiaries of the VA C&P program whose benefits continue because VA was not notified of the death. In this reporting period, the death match project recovered $2.7 million, with another $2.1 million in anticipated recoveries. Generally, family members of the deceased are responsible for this type of fraud. In the area of benefits processing, OIG opened 357 cases, made 95 arrests, and had $23,515,213 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Marine's Wife Poisons Him in Attempt to Gain Survivor's Benefits

The widow of an active duty Marine was convicted of murder for financial gain. A joint Naval Criminal Investigative Service and OIG investigation determined that the widow poisoned her husband with arsenic for the purpose of obtaining his $250,000 military life insurance benefit and VA dependency and indemnity compensation (DIC) benefits.

Suspect Convicted of Making $220,000 in False Benefits Claims

A veteran was convicted of wire fraud after OIG investigators determined he made false claims to qualify for compensation related to PTSD and collected benefits to which he was not entitled. The loss to VA was approximately $220,000.

Two Sentenced, Ordered to Repay $231,386 in Benefits Conspiracy

Two defendants were sentenced after pleading guilty to theft of Government funds and conspiracy. The first defendant was sentenced to 5 months' incarceration and 2 years' probation, and the second defendant was sentenced to 1 year of probation. They were ordered to pay combined restitution of $231,386. An OIG investigation revealed that since 1975 both defendants conspired to defraud VA of DIC benefits by failing to report the remarriage of one of the defendants.

Employed Man Charged with Fraud for Claiming Unemployability

A veteran receiving VA compensation benefits based on his unemployability mailed an employment questionnaire to VA stating he had not been employed at any time during the past 12 months, when, in fact, he had worked continuously from 1990 through 2005. In an effort to conceal his employment from VA, the veteran had paychecks made out to his wife and son. The VA loss was approximately $170,000. He was charged with mail fraud.

Veteran's Daughter, Son-in-law Sentenced for Misappropriating $500,000

An OIG investigation determined that while acting as fiduciaries the daughter and son-in-law of an incompetent veteran misappropriated approximately $500,000 of the veteran's funds. The son-in-law was sentenced to 6 months' incarceration and 36 months' probation. The veteran's daughter was sentenced to 60 months' probation. Both defendants were ordered to make restitution of $185,000 to the veteran's estate after pleading guilty to misappropriating funds by a fiduciary and misprision of a felony.

Daughter Caught Cashing Deceased Mother's Checks Since 1984

The daughter of a VA beneficiary was sentenced to 6 months' home confinement and 5 years' probation, and was ordered to pay $185,984 in restitution after being convicted of theft of Government funds. An OIG investigation revealed that the daughter received, forged, and negotiated her deceased mother's VA beneficiary checks since 1984.

Veteran and Wife Convicted of Defrauding VA and Social Security

After a complaint called into the OIG Hotline, a joint investigation with SSA OIG determined a veteran and his wife submitted false stressor information to VA about his military service. Based on his submission and his wife's false statements, VA awarded 100 percent PTSD compensation benefits, and SSA awarded disability benefits. The VA loss was $171,082 and the loss to SSA was $111,300. The veteran and his wife were convicted of wire fraud, social security fraud, false statements, and theft of Government funds.

OIG HOTLINE

The OIG Hotline receives numerous allegations of fraud against VA veteran financial benefits programs. Many of these contacts result in investigations of criminal conduct that recover significant sums of money or provide veterans help they need.

Review Saves $439,317 in Payments to Cancer-free Veteran

A VBA review determined a veteran continued to receive VA compensation at the 100 percent rate for cancer, although he had been cancer-free for over 10 years. The VARO failed to conduct follow-up examinations following the initial award. After an expedited physical examination, the VARO reduced the veteran's disability level and adjusted his benefits, resulting in a lifetime savings to the Government of $439,317.

Review Speeds Delayed Processing of Examination for Veteran

A VBA review concluded that a VARO delayed for nearly a year processing the results of a veteran's mental health examination, which found him competent to manage his VA benefits. As a result, VARO staff processed the change and terminated the guardianship appointment.

Veteran Given New Guardian After Being Left at VAMC by Son

A VBA review determined that a veteran's son, who served as the veteran's fiduciary, left the veteran in a VA hospital and contacted the VARO to request he be relieved of his custodial responsibilities for his father's benefits. The VARO ordered a field examination and appointed a new guardian.

Financial Management

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

OFFICE OF AUDIT

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

VA Receives Unqualified FY 2006 Audit Opinion with Material Weaknesses

OIG contracted with the independent public accounting firm, Deloitte & Touche LLP, to audit the VA FY 2006 CFS. The report provided an unqualified opinion on the VA FY 2006 CFS. However, the report on internal controls identified three material weaknesses in IT security controls, lack of an integrated financial management system, and operational oversight. All three material weaknesses are repeated from FY 2005. The report also referred to two reportable conditions identified by management as a result of an internal control assessment pursuant to Office of Management and Budget Circular A-123, Management's Responsibility for Internal Control. These reportable conditions were identified as "Transactions rejected by Financial Management System" and "Intergovernmental Transactions." The report continued to show that VA was not in substantial compliance with requirements of the *Federal Financial Management Improvement Act of 1996* because of the three material weaknesses described above. OIG will follow up and evaluate the implementation of corrective actions during the audit of the VA FY 2007 CFS. *(Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2006 and 2005)*

$13.7 Million Incorrectly Accounted for as Disaster Relief Costs

An OIG audit of internal controls associated with the recovery from Hurricane Katrina found that while VHA employees successfully oversaw the evacuation of 166 patients in Mississippi and Louisiana, VHA did not have sufficient internal controls in place to effectively account for costs resulting from relief activities. VHA needed to improve tracking and reporting, ensure routine costs are not reported as disaster relief costs, establish fund control points, and develop more comprehensive policies and procedures. OIG recommended the Acting Under Secretary for Health establish controls or mechanisms to correct the accounts and prevent recurrence of the errors. *(Audit of Veterans Health Administration's Accounting and Oversight of Hurricane Katrina Costs)*

Audit Finds Four Facilities Overpaid Medical Schools $635,340

OIG performed an audit to assess the effectiveness of VHA oversight of resident disbursement agreements and to evaluate how effectively health care systems and VAMCs managed disbursement agreements for senior residents. Auditors performed onsite reviews of 70 residency training programs at 4 VAMCs and telephone surveys at 113 VAMCs. OIG found that VHA's Office of Academic Affiliations (OAA) properly approved payment rates, and resident salaries and benefits were generally accurate and well supported by medical school financial and personnel records. However, VAMCs did not comply with operational and oversight requirements, and OAA did not provide sufficient policy guidance to VAMCs. As a result, VA has no assurance that it received a proportionate share of senior resident full-time equivalent employees or that VAMC disbursement agreement programs were effectively managed. For academic year 2004–2005, OIG estimated 4 VAMCs overpaid medical schools $635,340 due to inadequate timekeeping procedures in 19 programs reviewed. In addition, OIG estimated the 4 VAMCs

underpaid medical schools $44,324 because of inadequate fiscal procedures. *(Audit of VA Disbursement Agreements for Senior Residents)*

Audit Identifies Opportunities to Improve VBA Internal Controls

OIG audited the VBA Administrative and Loan Accounting Center (ALAC) to determine whether the facility was operating in accordance with applicable laws, regulations, and policies and to assess internal controls. The review concluded that the ALAC was generally operating in accordance with applicable laws, regulations, and policies. However, auditors identified four opportunities to improve internal controls that amounted to nearly $400,000 in funds that could have been put to better use. OIG recommended the VBA Chief Financial Officer, in coordination with the Director, Loan Guaranty Service, take action to strengthen accountability for transactions included in ALAC accounting records that are not initiated by ALAC employees, ensure that employees' duties are segregated whenever practicable, and implement procedures to identify and provide additional oversight of transactions processed by any employees whose duties are not segregated. OIG also recommended that the ALAC Director develop and implement procedures to detect and recover duplicate and other erroneous payments, and improve management of accounts receivable. The Under Secretary for Benefits provided acceptable implementation plans. *(Audit of the Administrative and Loan Accounting Center, Austin, Texas)*

OFFICE OF INVESTIGATIONS

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

Employee Charged with Embezzling $163,000 for Over 4 Years

A VA employee was charged with theft of Government funds after a VA Fiscal Service review and OIG investigation revealed that for over 4 years the employee embezzled approximately $163,000 from a VA agent cashier's office in Anchorage, Alaska.

OIG HOTLINE

The OIG Hotline receives and processes allegations of inefficient or ineffective financial management. Such contacts can result in improved management and cost savings for VA.

Hotline Contact Prompts Review of Payment Delays

A VHA review confirmed that a VAMC did not process payments for services provided through the fee-basis program in a timely manner. The delays resulted in part from a shortage of staff during a period when workload increased substantially. As a result, management began employing a variety of strategies to handle the workload, including utilizing staff from other areas and authorizing overtime. Division management reviewed and processed all invoices presented by the complainant, releasing payments totalling $37,344.

Procurement Practices

VA spends over $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology (IT), construction, and services. OIG contract audits focus on compliance with Federal and VA acquisition regulations and cost efficiencies, which resulted in recommendations for improvement. Preaward and postaward contract reviews have resulted in $74,810,471 in monetary benefits during this reporting period.

OFFICE OF AUDIT

To improve VA acquisition programs and activities, OIG identifies opportunities to achieve economy, efficiency, and effectiveness for VA national and local acquisitions and supply chain management. In addition, OIG examines how well major acquisitions are achieving objectives and desired outcomes. The OIG efforts focus on determining whether the Department is taking advantage of its full purchasing power when it acquires goods and services. Auditors examine how well VA is managing and safeguarding resources and inventories, obtaining economies of scale, and identifying opportunities to employ best practices.

Report Finds Incident Response Contract Became an Open Checkbook

OIG evaluated the planning, award, and administration of the Central Incident Response Capability contract, valued at $102.7 million. When the contract was allowed to expire because of lack of funding, VA had spent approximately $91.8 million (89.4 percent) of the total contract value. Cost overruns resulted from changing some requirements from fixed to indefinite prices, making the contract an open checkbook. Of the 22 non-competitive task orders valued at approximately $48.6 million, 17 were out of scope and thus prohibited cardinal changes. OIG also found deficiencies in the planning, solicitation, award processes, and contract administration. VA spent over $35 million to purchase equipment and supplies under the contract and does not know what equipment it has or where it may be located, and may have been overcharged $8.5 million in duplicate billing and payments without deliverables. *(Review of VA Central Incident Response Capability Contract Planning, Award, and Administration)*

OFFICE OF INVESTIGATIONS

OIG investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA procurement activities. In the area of procurement practices, OIG opened 17 cases, made 2 arrests, and had $3,004,798 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Contract Process Shows Lack of Continuity, Communication

An OIG review of the contracting process for a contract with Unisys for the Patient Financial Services System found deficiencies in the administration of the contract by VHA, Office of Acquisition and Materiel Management (OA&MM), and Office of General Counsel. There was a lack of continuity of personnel in the program office and a lack of communication among all VA entities involved in the contract. Unisys continually failed to meet contractual deadlines, resulting in significant project delays. Prior to August 2005, project delays were related to problems caused by VA and Unisys. A contract modification in August 2005 redefined the deliverables and established new delivery dates to resolve these issues. Unisys continued to miss deadlines, and VA terminated the contract. *(Patient Financial Services System Contract Planning, Award, and Administration Review, VA Central Office)*

VA Takes Administrative Action Against Two Officials

An OIG administrative investigation substantiated that officials in VA Central Office and the Austin Automation Center (AAC) did not properly plan for or compete a task order. A former senior official in VA Central Office knew for over a year that a contract would reach its financial cap in early 2006 and a new contract would therefore be required. However, he did not request options for a new contract until December 2005. As a result

of his poor planning, AAC acquisition officials were unnecessarily pressured to make an immediate award, which contributed to an improperly competed task order. The responsible contracting officer, with her supervisor's knowledge, failed to comply with requirements mandating competition. Additionally, a staff attorney did not adequately research acquisition regulations before providing legal advice. VA officials agreed to take appropriate administrative action against the contracting officer and her supervisor. *(Administrative Investigation, Improper Selection of a Contractor Austin Automation Center Austin, TX)*

VHA Manager Sentenced for Receiving Kickbacks

A consolidated mail out pharmacy (CMOP) manager, who pled guilty to conflict of interest charges for negotiating for employment with a private company at the same time she was involved in her official capacity in the establishment of a business relationship with that company, was sentenced to 46 months' incarceration, fined $10,000, and placed on 3 years' probation. The court found she personally received more than $115,000 in kickbacks from a company that was selling security tape to the VA at inflated prices, contributing to more than $400,000 in total losses to the VA. Another former CMOP employee pled guilty to conflict of interest charges after OIG investigators determined he had been involved in a fraudulent scheme with the CMOP manager. The former CMOP employee was sentenced to serve 24 months' supervised probation and was fined $5,000. The vendor involved with the kickbacks was sentenced to 3 years' probation and was ordered to make $263,620 in restitution to VA.

Joint Investigation Results in $3.25 Million Settlement for False Claims

A joint OIG-Government Accountability Office investigation in response to a *qui tam* complaint determined that an optical supply company submitted false claims and false statements regarding their products sold to VA and veterans. The investigation found the company routinely submitted claims that were fraudulent due to the inclusion of false certifications, non-prescribed add-ons, non-rendered services including ultraviolet and scratch coating, product substitution, and the involvement of unlicensed dispensers. The company agreed to a $3.25 million settlement with the Federal government.

Funeral Director and VA Employee Sentenced in Bribery Scheme

Following an OIG investigation, a former VA employee was sentenced to 1 year of probation and ordered to make $173,000 in restitution to VA after pleading guilty to receiving bribes. A funeral director, who bribed the VA employee and received $361,500 from VA for burial services not rendered, was sentenced to 13 months' incarceration and 3 years' probation, and was also ordered to pay $173,000 in restitution to VA.

$63,000 Kickback Scheme Inflates Cost of VAMC Spinal Cord Injury Unit

A joint investigation with the FBI determined that a subcontractor employee paid a $63,000 kickback to the prime contractor's project manager to secure work on a spinal cord injury unit at the James A. Haley VAMC. The subcontractor employee increased the price of the proposed subcontract by essentially the amount of the kickback and passed the inflated costs on to VA through a fraudulent change order to the prime contract. The project manager pled guilty to conspiracy charges and making false statements. The subcontractor corporation and the president were subsequently convicted of conspiracy and kickback charges.

Employees Accept Gift, Money from Medical Products Company

A part-time physician improperly accepted a gift from a prohibited source, allowing a medical products company doing business with VA to pay for expenses associated with a trip he took to another VA facility to conduct official business. An administrative investigation substantiated that the physician also improperly accepted an honorarium from the company for a presentation he made to VA employees. Investigators found that other VA employees also improperly accepted reimbursement of travel expenses and/or meals from the prohibited source. The investigation also determined that the physician misused his official VA time to perform professional remunerated services for the company. VHA agreed to take appropriate administrative action against the physician and the service chiefs at both VA facilities who allowed staff to accept gifts, ensure that the physician returns the value of the gift and honorarium, require other staff to return the value of gifts they received, and ensure that the physician takes annual leave for the time he misused.

OIG HOTLINE

The OIG Hotline receives and processes allegations of bribery, kickbacks, bid rigging, and other fraud relating to VA's procurement. Many such contacts result in criminal investigations and cost savings for VA.

Hotline Contact Results in Terminating Contract Services

A VHA review substantiated the complainant's report that a contractor did not fulfill his contractual obligations, failed to meet expected performance standards and, in some cases, failed to complete projects. VHA also substantiated the complainant's charge of being coerced by a contractor's representative to change a negative report on work performed. Management terminated the services of the contractor.

OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) operates under a reimbursable agreement with OA&MM to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OCR provides advisory services to OA&MM contracting activities. OCR has a staff of 25, and completed 42 reports in this reporting period. The tables that follow provide an overview of OCR 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. Preaward reviews identified $70,013,528 in potential cost savings during this reporting period. In addition to Federal Supply Schedule proposals, preaward reviews during this reporting period included 11 health care provider proposals—accounting for $17,893,161 of the identified potential savings—and 6 direct delivery equipment proposals accounting for $20,495,537. Reports resolved through negotiations by contracting officers continue to sustain a high percentage of recommended savings. For 11 reports, the sustained savings rate was 67 percent.

	October 1, 2006– March 31, 2007
Preaward Reports Issued	**28**
Potential Cost Savings	**$70,013,528**

Recruiting for Health Care Resources Part of $1.4M in Potential Savings

As a result of OCR preaward reviews on two proposals from an affiliated medical school for scarce medical specialist services, a VAMC cancelled the solicitations in favor of recruiting and hiring the needed physicians. OCR reports identifying significant unsupported costs contained recommended potential savings of over $1.4 million. The action by the VAMC complies with VA Directive 1663, *Health Care Resources Contracting–Buying*, which stipulates the VA facility must first attempt a good faith effort to recruit or clearly demonstrate why VA cannot recruit and hire the needed clinicians.

POSTAWARD REVIEWS

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with Public Law 102-585, the *Veterans Health Care Act of 1992*, for pharmaceutical products. OCR reviews resulted in VA recovering contract overcharges totaling $4,796,943, including nearly $4 million related to *Veterans Health Care Act* compliance with pricing requirements, recalculation of Federal ceiling prices, and appropriate status of pharmaceutical products. Postaward reviews also highlight the continuing success of the VA informal voluntary disclosure program. Of the 14 postaward

reviews performed, 9 involved voluntary disclosures. In 6 of the 9 reviews, OCR identified additional funds due.

	October 1, 2006–March 31, 2007
Postaward Reports Issued	**14**
Dollar Recoveries	**$4,796,943**

Information Management

IT plays a critical role in all VA operations. OIG oversight work in the IT area includes audits, criminal investigations, and reviews of IT security policies and procedures. The loss in May 2006 of VA data on approximately 26 million veterans and military personnel highlighted challenges facing VA information security. Since then, VA has shown increased awareness of IT security concerns and has initiated a number of efforts aimed at improvement. OIG has particularly noted VA commitment to centralizing IT functions, funding, and staff under the direction of the Department's Chief Information Officer. Serious problems remain, however, and OIG will continue close oversight of extensive VA IT activity.

OFFICE OF INVESTIGATIONS

OI investigates theft of IT equipment or data, network intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened 6 cases, made 14 arrests, and had $59,621 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies, cost avoidance, and recoveries.

Data Theft Case Defendants Plead Guilty after Joint Investigation

The May 3, 2006, theft of a VA employee's laptop computer and an external hard drive that stored the personal information of millions of veterans and active duty service members caused widespread concern over information security issues and possible identity theft. Both defendants pled guilty to first degree burglary as the result of a joint investigation by OIG, FBI, and Montgomery County police and were sentenced to 5 years' incarceration with all but 6 months suspended, 3 years' probation, and 60 hours' community service.

VAMC Employee Arrested and Fired for Possession of Child Pornography

After the discovery of child pornography in a hospital closet used by a Milwaukee VAMC employee, a joint OIG investigation with VA and local police resulted in a search of the employee's residence and personal computer. Investigators discovered over 800 sexually graphic images of children. The employee was arrested, charged with possession of child pornography, and subsequently terminated from VA employment.

Other Significant OIG Activities

CONGRESSIONAL TESTIMONY

Inspector General Testifies on Challenges in Oversight of VA Programs

Inspector General Opfer testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on February 15, 2007. He discussed the challenges OIG faces in providing oversight of VA to ensure it effectively serves America's veterans, and the impact OIG has on VA operations and programs. "In the 6-year period FY 2001–2006," Mr. Opfer said, "OIG delivered a return on investment of $31 for every dollar invested in OIG operations." He outlined key challenges facing VA in need of additional oversight, including health care and benefits for returning OEF/OIF veterans, research, protection of VA data, IT, and procurement.

OIG Reports Long-standing IT Risks and Vulnerabilities Still Remain

In testimony on February 28, 2007, senior OIG officials told the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations that major risks and vulnerabilities in VA information and information systems previously identified in OIG work still remain. OIG reported that VA recognizes the need to move ahead on implementing the 23 recommendations contained in two major 2006 OIG reports, but only one of those recommendations has been closed. However, OIG testimony noted that VA has initiated positive steps focused on policies, awareness, and training, and has taken initial steps toward implementing a more centralized Department-wide IT security program.

PEER REVIEW

Office of Audit Receives Top Marks in External Peer Review

According to Generally Accepted Government Auditing Standards, OIG auditing practices must be independently reviewed at least once every 3 years. The Department of Justice (DOJ) OIG reviewed the system of quality control in effect for the year ending September 30, 2006, for OIG's Office of Audit. The DOJ review provided an "unmodified opinion," meaning that the quality control system met the established requirements and provided reasonable assurance that OIG met applicable auditing standards, policies, and procedures intended to ensure that auditors maintain competence, integrity, objectivity, and independence in planning, conducting, and reporting their work. An "unmodified" opinion is the highest level of opinion that a Federal audit organization can achieve for its system of quality control.

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
REPORTS

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
06-03479-07 10/19/2006	Combined Assessment Program Review of the VA Medical Center, Beckley, WV			
06-02004-14 10/25/2006	Combined Assessment Program Review of the James A. Haley VA Medical Center, Tampa, FL			
06-01134-20 11/6/2006	Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, NY			
06-01721-32 11/27/2006	Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, TX			
06-02815-37 12/8/2006	Combined Assessment Program Review of the VA Health Care System, Amarillo, TX			
06-01133-39 12/8/2006	Combined Assessment Program Review of the Hudson Valley Health Care System, Montrose, NY			
06-02817-42 12/13/2006	Combined Assessment Program Review of the VA Roseburg Health Care System, Roseburg, OR			
06-02107-43 12/15/2006	Combined Assessment Program Review of the Augusta VA Medical Center, Augusta, GA			
06-00636-44 12/15/2006	Combined Assessment Program Review of the Sheridan VA Medical Center, Sheridan, WY			
06-02822-45 12/15/2006	Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, AL			
07-00127-52 1/2/2007	Combined Assessment Program Review of the Bath VA Medical Center, Bath, NY			
06-03480-54 01/5/07	Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, MI			
06-03710-76 02/5/07	Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, OH			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
06-01519-78 02/6/07	Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, WY			
06-02822-79 02/8/07	Combined Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, LA			
06-00507-83 02/12/07	Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, MI			
06-03482-86 02/26/07	Combined Assessment Program Review of the VA North Texas Healthcare System, Dallas, TX			
06-03484-96 03/14/07	Combined Assessment Program Review of the VA Sierra Nevada Healthcare System, Reno, NV			
07-00157-97 03/14/07	Combined Assessment Program Review of the Tuscaloosa VA Medical Center, Tuscaloosa, AL			
07-00795-99 03/14/07	Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, GA			
06-02818-100 03/14/07	Combined Assessment Program Review of the St. Louis VA Medical Center, St. Louis, MO			
06-00637-104 03/21/07	Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, CO			
07-00268-110 3/29/07	Combined Assessment Program Review of the Louis Stokes VA Medical Center, Cleveland, OH			

HEALTHCARE INSPECTIONS

05-01658-03 10/6/2006	Healthcare Inspection, Evaluation of Radiology and Laboratory Service Timeliness in Veterans Health Administration Facilities			
06-02149-04 10/6/2006	Healthcare Inspection, Quality of Care Issues, Community Based Outpatient Clinic, Hilo, HI			
06-00464-06 10/18/2006	Healthcare Inspection, Quality of Care Issues Jesse Brown VA Medical Center, Chicago, IL			
06-01361-15 10/25/2006	Healthcare Inspection, Management of the Operating Room and Quality of Care Issues, James A. Haley VA Medical Center, Tampa, FL			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
05-02939-19 11/3/2006	Healthcare Inspection, Radiology Issues VA Medical Center, West Palm Beach, FL			
06-01673-22 11/3/2006	Healthcare Inspection, Alleged Poor Psychiatric Care and Delay in Diagnosis and Treatment Salem VA Medical Center, Salem, VA			
06-02548-21 11/6/2006	Healthcare Inspection, Quality of Care and Environmental Conditions Northport VA Medical Center, Northport, NY			
06-03124-27 11/22/2006	Healthcare Inspection, Discharge, Shelter Environment, and Staff Support Issues at the VA Greater Los Angeles Health Care System, Los Angeles, CA			
06-02181-29 11/24/2006	Healthcare Inspection, Clinical and Administrative Issues Ralph H. Johnson VA Medical Center, Charleston, SC			
06-02365-30 11/24/2006	Healthcare Inspection, Patient Safety, Infection Control, and Mismanagement Tennessee Valley Health Care System, Nashville, TN			
05-00081-36 12/8/2006	Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Years 2004 and 2005			
06-00687-38 12/8/2006	Healthcare Inspection, Alleged Inappropriate Treatment Oklahoma City VA Medical Center, Oklahoma City, OK			
06-02021-46 12/13/2006	Healthcare Inspection, Credentialing, Privileging, and Pay Irregularities VA Medical Center, Oklahoma City, OK			
06-01674-47 12/21/2006	Healthcare Inspection, Alleged Delay in Colorectal Cancer Diagnosis and Treatment Kansas City VA Medical Center, Kansas City, MO			
06-02682-53 1/2/2007	Healthcare Inspection, Research Irregularities VA Medical Center, Durham, NC			
05-01223-56 01/8/07	Review of Resident Supervision Documentation and Billing Practices in Veterans Health Administration Facilities			
06-01961-57 01/8/07	Healthcare Inspection, Alleged Conflict of Interest and Breach of Confidentiality in VHA's Merit Review Process			
06-02429-62 01/23/07	Healthcare Inspection, Quality of Care Issues at the Amarillo VA Health Care System, Amarillo, TX			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
06-01952-63 01/23/07	Alleged Documentation Irregularities and Human Subjects Protection Violations at Bay Pines VA Healthcare System, Bay Pines, FL			
06-03158-64 01/23/07	Healthcare Inspection, Quality of Care Issues Claremore Veterans Center, Claremore, OK			
06-02470-66 01/30/07	Healthcare Inspection, Quality of Care Issues VA Medical Center, Lexington, KY			
05-00379-91 02/28/07	Review of Patient Safety in the Operating Room in Veterans Health Administration Facilities			
06-02265-106 3/23/07	Healthcare Inspection, Community Residential Care Program Review, Maryland Health Care System, Baltimore, MD			
06-00014-108 3/28/07	Healthcare Inspection, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006			
INTERNAL AUDITS				
06-01279-24 11/14/2006	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2006 and 2005			
05-01234-25 11/15/2006	Audit of VA Disbursement Agreements for Senior Residents	$591,016	$591,016	
05-01399-41 12/11/2006	Audit of the Administrative and Loan Accounting Center, Austin, TX	$398,766	$398,766	
05-01143-71 02/1/07	Audit of Adjustments of Hospitalized Veterans' Compensation and Pension Benefits	$10,203,975	$10,203,975	
06-00595-101 03/15/07	Audit of Veterans Health Administration's Accounting and Oversight of Hurricane Katrina Costs	$13,700,000	$13,700,000	
07-00753-102 3/15/07	Independent Review of VA's Fiscal Year 2006 Detailed Accounting Submission to the Office of National Drug Control Policy			
05-03180-111 3/29/07	Audit of Veterans Benefits Administration's Pension Maintenance Program Administered by the Pension Maintenance Centers			$5,400,000
OTHER OFFICE OF AUDIT REVIEWS				
05-00877-17 11/1/2006	Review of VA Medical Facility Compliance with Controls over Prescription Drugs			
04-03100-90 02/26/07	Review of VA Central Incident Response Capability Contract Planning, Award, and Administration			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS				
05-02958-28 11/24/2006	Administrative Investigation, Improper Acceptance of a Gift and Honorarium, and Misuse of Time, VA San Diego Health Care System			
06-00797-34 11/29/2006	Administrative Investigation, Improper Contracting Procedures Acquisition Operations Service, VA Central Office, Washington, DC			
06-01447-49 12/23/2006	Administrative Investigation, Misuse of Resources and Position VA Medical Center, Northport, NY			
06-03285-73 01/31/07	Patient Financial Services System Contract Planning, Award, and Administration Review, VA Central Office			
06-01219-70 02/1/07	Administrative Investigation, Improper Selection of a Contractor Austin Automation Center Austin, TX			
06-02238-84 02/12/07	Administrative Investigation, Contract Award and Administration Irregularities, Offices of Information & Technology and Acquisition & Materiel Management VA Central Office			
06-01135-103 03/20/07	Administrative Investigation, Improper Recruitment Bonus VA Nebraska-Western Iowa Healthcare System, Omaha, NE			
06-00089-107 3/28/07	Administrative Investigation, Improper Payments to Physicians VA Medical Center, Tampa, FL			
06-00518-109 3/29/07	Administrative Investigation, Misuse of Official Time by Physician, VA Greater Los Angeles Health Care System			
JOINT REVIEWS				
07-00641-40 12/6/2006	Major Management Challenges, Fiscal Year 2006			
TOTAL:	66 Reports	$24,893,757	$24,893,757	$5,400,000

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The *Federal Acquisition Streamlining Act of 1994* requires Federal agencies to complete final action on each OIG report recommendation within 12 months after the report is finalized. OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (March 31, 2006, and earlier). One report on the following chart has actions at 2 offices.

Unimplemented OIG Reports and Recommendations				
VA Office	**Total**		**Issued 3/31/06 and Earlier**	
	Reports	Recommendations	Reports	Recommendations
VHA	69	368	10	34
VBA	2	6	0	0
OI&T[1]	3	24	1	17
OM[2]	2	10	1	2

[1] Office of Information and Technology (OI&T)
[2] Office of Management (OM)

Reports Unimplemented for Over 1 Year					
Report Number	Date of Issue	Title	Responsible Organization(s)	Open Recommendations	Monetary Impact
02-01339-85	4/23/2003	Audit of VHA's Part-Time Physician Time and Attendance	VHA	3 of 17	
03-00391-138	5/3/2004	Healthcare Inspection, VHA's Community Residential Care (CRC) Program	VHA	1 of 11	
04-01371-177	8/11/2004	Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)	VHA	1 of 67	
03-00079-183	8/13/2004	Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities	VHA	11 of 15	$42,000,000
03-00940-38	12/1/2004	Evaluation of Selected Medical Care Collections Fund First Party Billings and Collections	VHA	1 of 4	
04-01805-55	12/27/2004	Combined Assessment Program Review of the VA Eastern Colorado Healthcare System, Denver CO	VHA	1 of 40	
02-00986-101	3/9/2005	Evaluation of VA Compliance with Federal Energy Management Policies	OM	2 of 12	$12,880,320
04-02887-169	7/8/2005	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures	VHA	5 of 8	
04-00235-180	8/4/2005	Healthcare Inspection, Inspection of Veterans Health Administration Patient Transportation Services	VHA	9 of 9	
04-02330-212	9/30/2005	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	VHA	1 of 3	
05-03037-107	3/21/2006	Audit of Allegations Regarding Payments for Fee Basis Care in Veterans Integrated Service Network 2, Albany, NY	VHA	1 of 1	
05-00055-216	9/20/2006	FY 2005 Audit of VA Information Security Program[1]	OI&T	17 of 17	
TOTALS				**53**	**$54,880,320**

[1] Although this FY 2005 FISMA audit is not yet over 1 year old, it contains OIG recommendations from earlier FISMA audits, which is the basis for including it in this presentation.

APPENDIX C

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS

The table below cross-references the specific pages in this Semiannual Report to the reporting requirements where they are prescribed by the *Inspector General Act of 1978* (Public Law 95-452), as amended by the *Inspector General Act Amendments of 1988* (Public Law 100-504), and the *Omnibus Consolidated Appropriations Act of 1997* (Public Law 104-208).

The *Federal Financial Management Improvement Act of 1996* (Public Law 104-208) requires OIG to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with the Act. VA reported that it met its milestones through the first quarter of FY 2007.

IG Act References	Reporting Requirements	Status
Section 4 (a) (2)	Review of legislative, regulatory, and administrative proposals	Commented on 295 items
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 5–18
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 5–18
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See pages 25–26
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 5–18
Section 5 (a) (5)	Summary of instances where information was refused	None
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	See pages 20–24
Section 5 (a) (7)	Summary of each particularly significant report	See pages 5–18
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 28
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	See page 28
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	See page 28
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 5(b) of the *Federal Financial Management Improvement Act of 1996* (Public Law 104-208)	See top of this page

Table 1: Resolution Status of Reports with Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/06	0	$0
Issued during reporting period	1	$5.4
Total inventory this period	**1**	**$5.4**
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	1	$5.4
Allowed costs (not agreed to by management)	0	$0
Total management decisions this reporting period	**1**	**$5.4**
Total carried over to next period	**0**	**$0**

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

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/06	0	$0
Issued during reporting period	4	$24.9
Total inventory this period	**4**	**$24.9**
Management decisions during the reporting period		
Agreed to by management	4	$24.9
Not agreed to by management	0	$0
Total management decisions this reporting period	**4**	**$24.9**
Total carried over to next period	**0**	**$0**

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

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

The report is also available on our website:

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

For further information regarding VA OIG, you may call 202-565-8620.

Cover photo of Medal of Honor flags courtesy Department of Defense

Help VA's Secretary ensure the integrity of departmental operations by reporting suspected criminal activity, waste, or abuse in VA programs or operations to the Inspector General Hotline.

(CALLER CAN REMAIN ANONYMOUS)

To Telephone:	**(800) 488-8244** **(800) 488-VAIG**
To FAX:	**(202) 565-7936**
To Send Correspondence:	**Department of Veterans Affairs** **Inspector General Hotline (53E)** **P.O. Box 50410** **Washington, DC 20091-0410**
Internet Homepage:	**http://www.va.gov/oig/contacts/hotline.asp**
E-mail Address:	**vaoighotline@va.gov**

Department of Veterans Affairs
Office of Inspector General
Semiannual Report to Congress

October 1, 2006 - March 31, 2007