Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
October 1, 2005 - March 31, 2006

Message from the Inspector General

This Semiannual Report to Congress focuses on the Department of Veterans Affairs (VA) Office of Inspector General (OIG) accomplishments for the period of October 1, 2005, through March 31, 2006. This report is issued in accordance with the *Inspector General Act of 1978*, as amended.

A new format is being introduced in this report based on the following OIG strategic goals:

- Health care delivery
- Benefits processing
- Financial management
- Procurement practices
- Information management

Presenting accomplishments by strategic goal demonstrates how OIG components work together in addressing the complexities of each issue. It also provides OIG customers with a broader perspective of all OIG oversight efforts on the key issues facing VA.

During this reporting period, 121 OIG reports on VA programs and operations resulted in systemic improvements and increased efficiencies in quality of care, accuracy of benefits, improved information technology security, and economy in procurement. OIG audits, investigations, and other reviews identified over $176 million in monetary benefits, for a return of $5 for every dollar expended. Our criminal investigators closed 515 investigations that led to 835 arrests, indictments, criminal complaints, convictions, and pretrial diversions. OIG provided investigative leads to other law enforcement agencies that directly resulted in 77 fugitive felon arrests nationwide. Also, the work of criminal and administrative investigations and the Hotline resulted in 293 administrative sanctions.

The Office of Contract Review collaborates with VA's Office of Acquisition and Materiel Management on special work to benefit the VA procurement process; those efforts recovered $17.6 million, for a return of $12 for every dollar expended.

OIG's ongoing Combined Assessment Program (CAP) reviews the quality, efficiency, and effectiveness of VA facilities. Auditors, investigators, and health care inspectors collaborate to assess key operations at VA medical and benefit facilities on a cyclical basis. The 31 CAP reviews we completed this period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention.

We appreciate the support we receive from VA's Secretary, Deputy Secretary, and senior management. We will continue to partner with them and Congress to maximize VA's effectiveness in providing benefits to our Nation's veterans.

George J. Opfer

GEORGE J. OPFER
Inspector General

TABLE OF CONTENTS

Statistical Highlights

The following statistical data highlights OIG activities and accomplishments during the October 1, 2005–March 31, 2006 reporting period.

DOLLAR IMPACT (Dollars in Millions)

- Better Use of Funds $22.9
- Fines, Penalties, Restitutions, and Civil Judgments $3.5
- Fugitive Felon Program $120.7
- Savings and Cost Avoidance $26.1
- Questioned Costs ..... $.9
- OIG Dollar Recoveries $2.4
- Contract Review Dollar Recoveries $17.6

RETURN ON INVESTMENT

- Dollar Impact ($176.5)/Cost of OIG Operations ($33.7) 5:1
- Dollar Impact ($17.6)/Cost of Contract Review Operations ($1.5). 12:1

OTHER IMPACT

- Arrests 379
- Indictments 187
- Criminal Complaints 96
- Convictions 150
- Pretrial Diversions 23
- Fugitive Felon Apprehensions 77
- Administrative Sanctions 293

ACTIVITIES

Reports Issued

- Combined Assessment Program (CAP) Reviews 31
- CAP Summary Reviews 2
- Joint Reviews 1
- Audits 24
- Contract Reviews 40
- Healthcare Inspections 21
- Administrative Investigations 2

Investigative Cases

- Opened 650
- Closed 515

Healthcare Inspections Activities

- Clinical Consultations 3

Hotline Activities

- Contacts 7,464
- Cases Opened 551
- Cases Closed 555

VA and OIG Mission, Organization, and Resources

The Department of Veterans Affairs

Background

In one form or another, American governments have provided veterans benefits since before the Revolutionary War. VA's historic predecessor agencies demonstrate the Nation's long commitment to veterans. The Veterans Administration was founded in 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers. The Department of Veterans Affairs was established on March 15, 1989, by Public Law 100-527, which elevated the Veterans Administration, an independent agency, to Cabinet-level status.

VA Central Office
810 Vermont Avenue, NW
Washington, DC

Mission

VA's 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." These words are inscribed on large plaques on the front of the VA Central Office building on Vermont Avenue in Washington, DC.

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.

Organization

The 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 (NCA) provides interment and memorial benefits.

Resources

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For fiscal year (FY) 2006, VA has a $72 billion budget and approximately 223,000 employees serving an estimated 24.3 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.

Approximately 201,000 of VA's employees work in VHA. Health care is funded at over $31 billion in FY 2006, approximately 43 percent of VA's budget. VHA provides care to an average of 60,000 inpatients daily. During FY 2006, there will be over 58 million episodes of care for outpatients. There are 156 health care systems, 135 nursing home units, 207 veterans centers, 43 domiciliary residential rehabilitation treatment programs, and 935 outpatient clinics (including hospital clinics). In addition, VHA is funded at over $1.1 billion for capital projects and the state extended care grant program.

Veterans benefits are funded at $36.7 billion in FY 2006, about 51 percent of VA's budget. Almost 13,000 VBA employees at 57 VA Regional Offices (VAROs) provide benefits to veterans and their families. Over 3 million veterans and their beneficiaries receive compensation benefits valued at $31.3 billion. Also, $3.5 billion in pension benefits are provided to approximately 533,000 veterans and survivors. VA life insurance programs insure 7.2 million lives, with policies totaling $1.1 trillion. Approximately 230,000 home loans will be guaranteed in FY 2006, with a value of approximately $36.1 billion.

With the opening of Great Lakes National Cemetery and Georgia National Cemetery, NCA operates and maintains 123 national cemeteries and 33 related installations. VA plans to begin interments at Sacramento Valley National Cemetery by the end of FY 2006. NCA operations, capital funding, and all of VA's burial benefits account for approximately $347 million of VA's budget. Interments in VA cemeteries will rise to about 101,800 by FY 2006 and approximately 352,900 headstones and markers will be furnished for veterans and their eligible dependents in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General

Background

The 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* (*IG Act*), was enacted, establishing a statutory Inspector General (IG) in VA.

Role and Authority

The *IG Act* 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 *Inspector General Act Amendments of 1988* provided the IG with a separate appropriation account, and revised and expanded procedures for reporting semiannual workload to Congress. 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. The inquiries may be in the form of audits, investigations, inspections, or other special reviews.

Organization

The OIG is organized into three line elements; the Offices of Investigations, Audit, and Healthcare Inspections, plus a contract review office and a support element. In addition to the Washington, DC, headquarters, OIG has offices located in 23 cities throughout the country. The organizational chart on page 8 lists the locations. For more information, please visit OIG's Internet home page at www.va.gov/oig.

Office of Investigations

The Office of Investigations (OI) conducts criminal and administrative investigations of wrongdoing in VA programs and operations in an independent and objective manner. OI seeks prosecution, administrative action, and/or monetary recoveries where appropriate as it strives to establish an environment in VA that is safe and free from criminal activity and management abuse.

Office of Audit

The Office of Audit (OA) contributes to the improvement and management of VA programs and activities by providing customers with timely, balanced, credible, and independent financial and performance audits that address the economy, efficiency, and effectiveness of VA operations. OA identifies constructive solutions and opportunities for improvement.

Office of Healthcare Inspections

The Office of Healthcare Inspections (OHI) conducts oversight, monitoring, and evaluation of VHA quality assurance programs and the activities of the VHA Office of the Medical Inspector. OHI reviews specialized VA treatment programs, patient care, quality assurance issues, and hotline allegations involving medical care issues to strengthen VA's health care programs for veterans and their families.

Office of Management and Administration

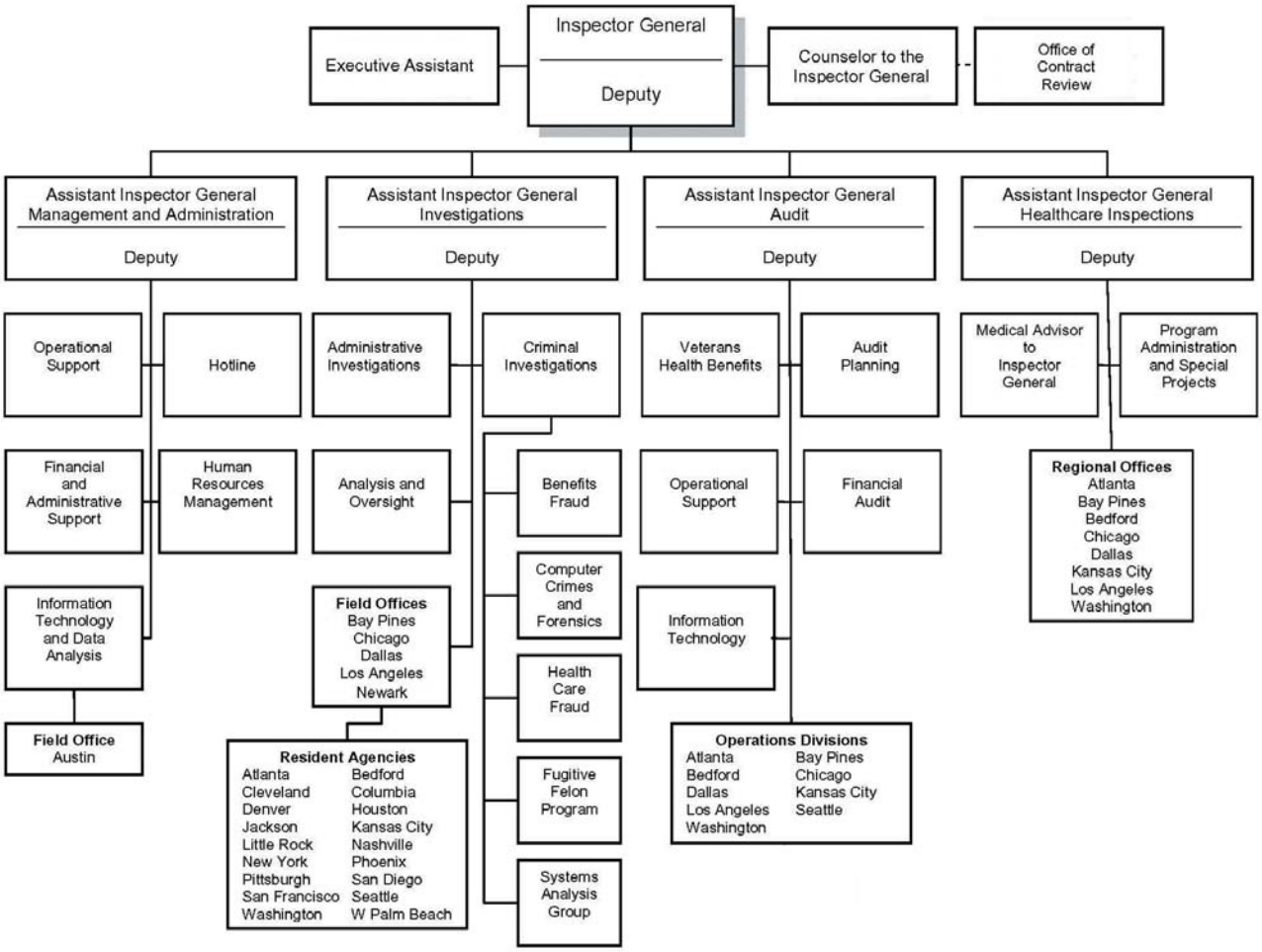
The Office of Management and Administration contributes to OIG results by providing management, planning, and support services to OIG employees nationwide, across every OIG operational element. Support services include operational support, hotline, budget and finance, administrative services, information technology, and human resources management.

Resources

The FY 2006 funding for OIG operations provides $69.1 million from appropriations. OIG allocated 485 full-time equivalent (FTE) employees from appropriations for the FY 2006 staffing plan to perform all OIG mandated, reactive, and proactive work.

In addition, OIG receives $3.3 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 (FSS) contracts. An additional 26 FTE are reimbursed through this agreement.

OIG Organizational Chart



OIG Mission Statement

OIG is dedicated to helping VA ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country. OIG strives to help VA achieve its vision of becoming the best-managed service delivery organization in Government. OIG continues to be responsive to the needs of its customers by working with the VA management team to identify and address issues that are important to them and the veterans served.

In performing its mandated oversight function, OIG conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter criminal activity, waste, abuse, and mismanagement. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer driven and results oriented.

OIG 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.

Strategic Challenges Facing VA

OIG has identified five strategic areas among VA's programs and services for America's veterans that continue to present significant management challenges for the Department:

1. Health Care Delivery
2. Benefits Processing
3. Financial Management
4. Procurement Practices
5. Information Management

This semiannual report highlights OIG accomplishments according to these five strategic goals. It discusses the key issues of each goal, and describes key OIG team efforts and successes in addressing them.

Health Care Delivery

OIG STRATEGIC GOAL #1: Improve veterans' access to high-quality health care by identifying opportunities to improve the management and efficiency of VA's health care delivery systems, and by detecting, investigating, and deterring fraud and other criminal activity.

The primary mission of VHA is to serve the health care needs of eligible veterans by providing quality inpatient, outpatient, and long-term health care services. Quality of care remains the primary health care focus of both VHA and OIG. Veterans should receive medical care that meets the highest standards. Improvements in the measurement and effective use of medical outcomes data will provide opportunities for VHA to improve the health care provided to veterans. VHA will continue to develop and implement appropriate medical outcome measures consistent with industry and Government standards that demonstrate the level of health care VA provides, and OIG will evaluate those measures. Fiscal constraints will require that VHA continue to improve the efficiency of health care delivery without sacrificing the quality of medical care provided to veterans.

Veterans' health care must meet the highest standards.

The OIG has helped VA improve health care delivery through 23 CAP reviews at VHA facilities and numerous audit, investigative, and inspection efforts during this reporting period. OIG recommendations resulted in managers issuing new and revised procedures, improving services, improving quality of patient care and access to care, and making environmental and safety improvements. Here are several examples of improvement from OIG oversight work.

INSPECTION: Feeding and Swallowing Problems Widespread

OIG evaluated whether VHA medical facilities were appropriately managing the feeding of patients with a swallowing disorder and those requiring feeding assistance at meals. The review found considerable variability in practice, including lapses in care and inadequate communication between disciplines. Discharge diet orders were frequently incorrect and follow-up was uneven. Patients were often given thickened liquids and restrictive, less palatable diets. The Under Secretary for Health concurred with OIG's findings and recommendations and provided acceptable improvement plans. VHA will establish a multi-disciplinary task force to make recommendations on a consistent standard of care and the need for national policy. The first task force meeting will take place by June 30, 2006, and a draft policy will be disseminated for review by September 30, 2007.

INSPECTION: Colorectal Cancer Detection Can Be Timelier

An OIG health care inspection evaluating VHA care for colorectal cancer (CRC) found patients were appropriately screened, clinicians appropriately responded to requests for evaluations, and the length of time from diagnosis to earliest treatment was acceptable. Treatment planning appeared to be coordinated across disciplines. However, OIG found the length of time from presentation to diagnosis was excessive, and patients were not consistently notified of their CRC diagnoses within a reasonable amount of time. The Under Secretary for Health concurred with OIG's findings and recommendations and provided acceptable improvement plans.

INSPECTION: Moderate Sedation Needs Improvement

An OIG health care inspection at 30 facilities, to assess whether patients who received moderate (conscious) sedation during invasive procedures performed outside the operating room (OR) received a commensurate level of care as patients who had their procedures performed in the OR, identified areas for improvement at 20 facilities. The Under Secretary for Health agreed with OIG's recommendations and provided acceptable improvement plans

INSPECTION: Emergency Preparedness Needs Improvement

OIG's health care inspection staff found VHA had properly addressed emergency preparedness at the national level, and many facilities were generally compliant with regulatory guidelines, but emergency preparedness education and training were not consistently provided to employees at the facility level. Facility hazard vulnerability analyses did not consistently reflect actual risks to the facility. Some high-risk laboratory safety recommendations from OIG's 2002 report had not yet been implemented. Without adequate disaster or emergency preparation, VHA facilities could be vulnerable to increased facility damages and increased injuries or death to employees and patients. OIG made five recommendations; the Under Secretary for Health agreed and provided acceptable improvement plans.

INVESTIGATION: VA Employee Guilty in Negligent Homicide

At least one VAMC patient died as a result of false and forged medical records to pharmaceutical companies that allowed otherwise ineligible patients to be included in oncology studies. As a result of an OIG investigation, a former program specialist at the VAMC pleaded guilty to criminally negligent homicide, making false statements, and mail fraud. He was sentenced to 71 months' incarceration, 36 months' supervised release, and ordered to pay $638,775 in restitution.

INVESTIGATION: Impersonator Steals VA Medical Services

A joint OIG and VA police investigation revealed that a man had fraudulently obtained health care services from a VAMC by using the identity of his deceased brother. The defendant pleaded guilty to theft of services and was sentenced to 206 days' incarceration.

INVESTIGATION: Identity Thief Uses VA Health Benefits

A joint OIG and Social Security Administration (SSA) OIG investigation revealed that, after stealing the identity of a veteran with whom he previously resided, a non-veteran fraudulently received $62,961 in VA health benefits and more than $31,000 in social security disability benefits. The non-veteran pled guilty to theft and making false statements.

INVESTIGATION: Operation Clean-Up Fugitive Sentenced

Operation Clean-Up was an award-winning joint investigation of illegal drug distribution impacting a VAMC, a local college, and the surrounding community. Conducted by OIG, the Drug Enforcement Administration (DEA), the Bureau of Alcohol, Tobacco, Firearms and Explosives, and a local drug task force, it concerned the sale of crack/cocaine, pharmaceuticals, and firearms in and around the VAMC. The last fugitive subject of the Operation Clean-Up investigation surrendered, pleaded guilty to distributing a Schedule II controlled substance, and was sentenced to 10 years' incarceration, with 9 years and 5 months suspended, and an indefinite term of probation. Operation Clean-Up resulted in 52 arrests. The four main subjects were sentenced to a combined total of 70

years' imprisonment and 18 years' probation. Fifty subjects have been convicted on various drug charges, and the remaining two await trial.

INVESTIGATION: Pharmacist Caught Stealing Drugs

A joint investigation by OIG and VA police determined that a VA pharmacist was diverting controlled substances and medical supplies. He was sentenced to 3 years' probation, ordered to repay VA $5,444, fined $1,000, and ordered to perform 15 hours a week of community services for 3 years.

INVESTIGATION: Thirteen Arrested for Drug Diversion

A joint investigation conducted by OIG, DEA, Health and Human Services OIG, U.S. Secret Service, and several local police departments found that pharmaceuticals diverted from a VAMC and other area medical facilities were being sold and purchased, in some cases, with counterfeit currency. Investigators arrested thirteen subjects in Buffalo and the surrounding area on charges of illegal distribution of a controlled substance and conspiracy to distribute a controlled substance.

AUDIT: Oxygen Supply Management Needs Improvement

In 2004, the San Juan VAMC's liquid oxygen supply became depleted, precipitating emergency deployment of reserve oxygen. Following the incident, the VAMC and VHA initiated several corrective actions. To help prevent similar occurrences, VHA issued a national Patient Safety Alert and strengthened contract administration requirements for new national oxygen contracts. Following the audit of oxygen supply management practices at the VAMC, OIG recommended the Under Secretary for Health continue to provide oversight of the VAMC's oxygen supply management and ensure the VAMC updates its oxygen control policy, administers contract requirements effectively, monitors the oxygen supply continuously, periodically reevaluates usage requirements, and addresses system maintenance issues consistently and promptly. The Under Secretary for Health agreed and provided acceptable implementation plans.

AUDIT: Access to Long-Term Nursing Home Care Uneven

The OIG evaluated veterans' access to long-term nursing home care. The evaluation showed VA is ensuring mandatory care veterans have access, but non-mandatory admissions varied significantly. VHA could improve the patient assessment process by using the results of minimum data set (MDS) assessments to ensure that only patients continuing to need such care are residing in VA or contracted facilities. The Under Secretary for Health agreed with report recommendations to address the uneven access of non-mandatory veterans and ensure that MDS assessments are routinely and timely completed and used to identify veterans who should be considered for discharge or placement in more appropriate care settings.

AUDIT: Survey Finds Special Disabilities Capacity Adequate

For years, VA met a statutory mandate to provide an annual Special Disabilities Capacity Report, which addressed VHA's ability to provide for the specialized treatment and rehabilitative needs of disabled veterans. VA's General Counsel determined the statutory reporting requirement expired after April 1, 2004, and that VA would provide the FY 2004 Capacity Report to Congress for informational purposes only. As a consequence, OIG discontinued work on the audit and provided the results of the completed survey work. The survey showed that, as reported in past years, data relating to spinal cord injury/disorders, blindness,

prosthetics and sensory aids, and traumatic brain injury were adequately supported. The survey also found that the data reported for specialized mental health programs (including staffing, numbers of programs, and expenditures) were adequately supported.

HOTLINE: Review Prompts Step to Address Nursing Shortage

Following a Hotline call, OIG arranged for a VHA review that confirmed a nursing shortage on the dementia units at a VA medical center. The facility had begun actively recruiting for additional nursing staff. To address the shortage until new staff can be hired, management shifted nurses to the dementia units. The review also determined the dementia units needed lift equipment to assist in transferring patients. Management requested an emergency purchase of the necessary equipment.

CAP REVIEW: Problems Persist at VHA Facilities

During the period October 2005 through March 2006, OIG issued 23 reports of CAP reviews on the evaluation of facility operations focusing on patient care, quality management, and financial and management controls at selected VA health care systems and Veterans Affairs Medical Center (VAMCs). Deficiencies identified during prior CAP reviews relating to management of veterans health care programs were discussed in OIG's *Summary Report of CAP Reviews at VHA Medical Facilities October 2004 through September 2005,* issued March 31, 2006, as summarized below. During this reporting period, OIG identified similar problems at the medical facilities.

Pulse Point	Number of instances	Number inspected
Management of Supply Inventories	44	47
Medical Care Collections Fund	39	42
Information Security	35	46
Contract Award & Administration	33	47
Environment of Care	28	48
Pharmacy Controlled Substances Accountability	27	48
Quality Management	22	48
Government Purchase Cards	21	45
Bulk Oxygen Management	15	19
Management of Equipment Inventories	15	19
Accounts Receivable	13	21
Moderate Sedation	12	19
Pharmacy Security	9	19
Pressure Ulcer Management	9	20
Part-Time Physician Time & Attendance	9	30
Emergency Preparedness	7	16
Colorectal Cancer Management	5	9
Unliquidated Obligations	4	10
Agent Cashier	3	8

Benefits Processing

STRATEGIC GOAL #2: Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing, and reduce criminal activity in the delivery of benefits through proactive and targeted audit and investigative efforts.

VA provides veterans and their dependents a broad array of benefit programs primarily designed to aid in the transition from military service, compensate for injury or death, and honor veterans' service. Benefit programs covering compensation and pension (C&P), education, loan guaranty, vocational rehabilitation and employment, and life insurance deliver about $36.7 billion in annual monetary benefits. VA administers these benefit programs through the VBA's network of regional offices, benefit offices, and at DoD sites where service personnel get discharged.

Veterans deserve timely, accurate benefits delivery.

During this reporting period, OIG efforts to help improve VA benefits processing while deterring and detecting fraud, waste, and abuse combined numerous audit, investigative, and inspection efforts and eight CAP reviews. Here are several examples of the accomplishments during this reporting period.

INVESTIGATIVE PROJECT: Fugitive Felon Program

The OIG Office of Investigations' Fugitive Felon Program identifies VA benefits recipients who are fugitives from justice. The program evolved after Congress enacted Public Law 107-103, the Veterans Education and Expansion Act of 2001, prohibiting veterans who are fugitive felons or their dependents from receiving specified benefits. The program matches fugitive felon files of law enforcement organizations against more than 11 million records contained in VA benefit system files. Once a veteran is identified as a fugitive, information on the individual is provided to the law enforcement organization responsible for serving the warrant to assist in the apprehension, and given to the Department so that, subsequent to the provision of the requisite due process, benefits may be suspended and overpayments recovered.

OIG has negotiated Memoranda of Understanding/Agreements with the U.S. Marshals Service (USMS), the National Crime Information Center, and 12 states, and is pursuing additional agreements. The program has led to additional cooperative efforts involving OIG, VBA, and VHA.

Investigative leads provided to law enforcement agencies since the inception of the program have led to the arrest of fugitives wanted for murder, manslaughter, sexual assault, robbery, drug offenses, and other serious felonies. The apprehension of these subjects has made VA facilities safer for veterans, employees, and the general public. In this reporting period:

- The Federal Bureau of Investigation (FBI) sought OIG assistance locating a veteran wanted for possession and distribution of child pornography, who subsequently admitted to sexually molesting his own son for 10 years. Agents from OIG and the FBI arrested the veteran.

- Agents from OIG, VA police, and the USMS arrested a veteran classified as a violent offender who was wanted for violating conditions of probation on charges of aggravated sexual assault of a child.
- A USMS task force sought OIG assistance finding a fugitive wanted for distribution of narcotics in a school zone pursuant to a felony probation violation warrant. The fugitive was located and arrested.

The following table identifies the statistics relating to the Fugitive Felon Program.

Fugitive Felon Program	This Reporting Period	Total Since Beginning
Felony Warrants Received from Participating Agencies	2.1M	11.3M
Matched Records	3,388	53,301
Referred to Law Enforcement Agency Which Holds the Warrant	2,945	23,723
Arrests Made by Law Enforcement Agency Which Holds the Warrant	77	633
Arrests Made by OIG	103	577
Referrals to VA for Benefits Suspension	4,851*	23,836
Estimated Identified Overpayments	$55.7M	$273.9M
Estimated Cost Avoidance	$65M	$302.3M

* Referrals include matched records from periods prior to this report.

INVESTIGATION: Death Match Pinpoints Suspicious Payees

The Office of Investigations conducts an ongoing proactive project in coordination with OIG's Information Technology and Data Analysis section. The death match project identifies individuals who may be defrauding VA by receiving benefits intended for veterans who have died. When indicators of fraud are discovered, the matching results are transmitted to OIG investigative field offices for appropriate action. In this reporting period, OIG reviewed 177 new leads and developed 140 criminal and administrative cases, resulting in 32 arrests. Investigations have recovered $2.2 million, with another $700,000 in anticipated recoveries. The 5-year projected cost avoidance to VA is estimated at $7.1 million. To date, the match has identified in excess of 10,401 possible investigative leads. Over 8,481 leads have been reviewed, resulting in the development of 1,088 criminal and administrative cases. Investigations have resulted in the actual recovery of $18.6 million, with an additional $8.3 million in anticipated recoveries. In addition to these recoveries, the 5-year projected

cost avoidance to VA is estimated at $44.7 million. To date, there have been 177 arrests in these cases with several additional cases awaiting judicial actions.

INVESTIGATION: Veteran Jailed For Pension Benefits Fraud

As a result of a OIG investigation, a veteran who admitted to providing false statements to VA to fraudulently receive pension benefits was sentenced to 180 days' imprisonment, 3 years' probation, and ordered to make restitution of $48,298.

INVESTIGATION: Veteran Sentenced for False Claims

A joint OIG and SSA OIG investigation determined that a veteran fraudulently claimed she was 100 percent disabled in order to collect disability benefits from VA and SSA. She pleaded guilty to mail fraud charges and was sentenced to 37 months' incarceration plus 36 months' probation and ordered to pay restitution of $144,225.

CAP REVIEW: OIG Notes Problems at VAROs

During the period October 2005 through March 2006, OIG conducted eight CAP reviews to evaluate benefits administration and financial and management controls at selected VAROs. Deficiencies identified during prior CAP reviews relating to management of veterans health care programs were discussed in OIG's *Summary Report of CAP Reviews at VBA Regional Offices October 2004 through September 2005*, issued March 31, 2006, as summarized below. During this reporting period, OIG identified similar problems at the medical facilities. OIG found:

Pulse Point	Number inspected	Number of instances
C&P Hospital Adjustments	17	17
Government Purchase Cards	10	15
Vocational Rehabilitation & Employment	9	13
Fiduciary & Field Examinations	8	13
Security of Sensitive Records	8	17
Information Security	7	15
Benefits Delivery Network Information Management Controls	6	17
C&P Payments to Incarcerated Veterans	5	15
Management Performance	3	3
Large Retroactive Payment Controls	3	17
C&P Future Examinations	2	2

INVESTIGATION: Fiduciary Caught Stealing Veterans' Funds

A VA-appointed custodian, who had fiduciary responsibility for 11 incompetent veterans, was sentenced to serve 12 months' and 1 day's incarceration, 3 years' probation, and ordered to pay $32,325 in restitution. An OIG investigation determined the fiduciary stole funds intended for veterans in her care.

Richmond Times-Dispatch
Richmond, VA
March 25, 2006

Woman gets prison term in fraud cases

A federal judge yesterday sentenced a woman to 27 months in prison for taking part in a scheme to defraud Medicaid of more than $1.3 million and other crimes.

Kim D. Beck, 41, was ordered to pay about $492,000 in restitution to the Virginia Department of Medicaid and two federal agencies. She pleaded guilty Dec. 21 to three charges — defrauding Medicaid, the Social Security Administration and the Department of Veterans Affairs.

From mid-summer 2002 until October 2004, Beck admitted, she took part in a scheme to bill Medicaid for fraudulent claims for in-home medical services for Medicaid patients. The U.S. attorney's office said she also failed to report that she remarried in 1995, thereby illegally receiving $42,250 in Social Security benefits and $100,887 in veteran's benefits.

Beck was originally indicted in September on 19 charges including health-care fraud, conspiracy, mail fraud and defrauding a federal program.

INVESTIGATION: Deceased Veteran's Spouse Jailed in Benefits Fraud Case

A joint OIG, FBI, and SSA investigation determined that a spouse of a deceased veteran failed to report her remarriage resulting in the overpayment of $100,887 in dependency and indemnity compensation. After pleading guilty to health care fraud (Medicaid) and defrauding VA and SSA, she was sentenced to 27 months' incarceration and 3 years' of supervised release, and was ordered to pay restitution in the amount of $492,000 ($100,887 to VA, $42,450 to SSA and $348,663 to the State).

HOTLINE: Tip Helps VBA Identify $36,262 Overpayment

A Hotline call prompted a VBA review of a veteran's claim folder that determined he had not returned eligibility verification reports since 2002. The regional office terminated his benefits, creating an overpayment of $36,262. An associated apportionment award was suspended from the date of the last payment.

HOTLINE: Terminated VA Benefits, Retirement Restored

A review determined that, through a mistake at the local regional office, a veteran's death was erroneously entered into his claim file and reported to DoD. As a result, the veteran's VA benefits and military retirement payments were terminated. All records have been corrected and VA compensation restored.

Financial Management

STRATEGIC GOAL #3: Assist VA in achieving its financial management mission of providing all VA activities with accurate, reliable, and timely information for sound oversight and decision making, and identify opportunities to improve the quality, management, and efficiency of VA's financial management systems.

VA's financial management organization exists to provide information for sound management decision making to aid in the delivery of high-quality services to veterans and their families. Over 3,000 employees serve in financial management positions throughout VA and have stewardship responsibilities for an annual budget of approximately $72 billion in 2006 and accountability for safeguarding assets totaling about $49 billion.

A $72 billion budget demands strong controls.

OIG will work to improve the effectiveness and efficiency of VA financial management with the goal of making VA operate in a more business-like manner. While addressing current and future financial management challenges, OIG will continue to identify best business practices aimed at helping VA achieve its financial management goals. Reviews of VA financial management during the reporting period include:

AUDIT: VA Gets "Clean" Audit Opinion for FY 2005 and 2004

OIG contracted with the independent public accounting firm Deloitte & Touche LLP to audit VA's FY 2005 Consolidated Financial Statement (CFS). The report provided an unqualified ("clean") opinion on VA's FY 2005 and FY 2004 CFS. However, the report on internal control identified the following three reportable conditions, all of which are material weaknesses:

- Information technology security controls.
- Integrated financial management system.
- Operational oversight.

During FY 2005, VA management took corrective action to eliminate the judgments and claims reportable condition from the FY 2004 audit. The report continues to show that VA is not in substantial compliance with requirements of the *Federal Financial Management Improvement Act of 1996* and Office of Management and Budget (OMB) Circular A-127, "Financial Management Systems." The Chief Management Officer agreed with the reported findings and recommendations. OIG will follow up and evaluate the implementation actions during its audit of the VA's FY 2006 CFS.

AUDIT: Homeless Veterans Project Should Repay $714,131

OIG audited the financial records of a non-profit corporation receiving VA grant and per diem funds to operate a homeless veterans transitional housing project. The audit showed the organization:

- Did not establish procedures to ensure proper disbursement and accounting for VA funds.
- Inappropriately converted the housing project to "for-profit" apartments.
- Received excess per diem payments.
- Submitted grossly inflated per diem budgets.

OIG determined $714,131 of the $806,731 received in grant and per diem payments should be repaid to VA. The report recommended the Director of VA's Homeless Providers Grant and Per Diem Program initiate action to recover $251,560 of grant funds, rehabilitate the housing project, and recover $462,571 of per diem overpayments. The Director agreed with the findings and recommendations and provided acceptable implementation plans.

AUDIT: Evaluation Finds Management Lapses at Cemetery

OIG evaluated selected areas of the VA Riverside National Cemetery's (RNC) business operations to determine if there were internal control weaknesses and potential financial mismanagement. Auditors found instances of financial mismanagement, but did not identify any illegal or fraudulent activities. Results also showed that, while RNC agreements provided the Government with a fair value, the agreements had not been established and administered in accordance with VA and Federal regulations and lacked adequate oversight. Because regulations related to the use of Government property and resources and the solicitation of donations were not followed, boundaries between the RNC and its non-profit support committee's operations were not adequately defined to ensure the support committee did not receive preferential treatment. OIG made recommendations to improve NCA and RNC management. The Under Secretary for Memorial Affairs agreed with the conclusions and recommendations and provided acceptable improvement plans.

AUDIT: Mismanagement of PCS Travel Program

Senator Charles Grassley, Chairman of the Senate Committee on Finance, requested an audit of VA's permanent change of station (PCS) travel program, based on allegations he received. OIG's audit substantiated 9 of the 13 allegations. VA needed to strengthen controls for obligating and advancing PCS travel funds. OIG identified concerns with Financial Services Center employees' knowledge of the Federal Travel Regulation, training, and experience. Also, the audit revealed inadequate support for the planned sole-source task order to outsource PCS services for VA employees affected by Hurricane Katrina. As a result of this audit, OIG calculated $521,591 (12 percent) of $4,455,933 in PCS travel funds could have been used for other VA activities. The Assistant Secretary for Management agreed with the findings and provided acceptable implementation plans.

Procurement Practices

STRATEGIC GOAL #4: Ensure that VA's acquisition programs support our Nation's veterans, other Government entities, and the taxpayer by providing its customers with quality products, services, and expertise delivered in a timely fashion, for a reasonable price, and to the right place.

With over $6 billion estimated for FY 2006 expenditures for supplies, services, construction, and equipment, VA is one of the largest procurement and supply entities in the country. VA's Office of Acquisition and Materiel Management (OA&MM) operates and maintains an extensive supply system for the Department and its external customers. OA&MM conducts national acquisition activities from VA Central Office, Washington, DC; and the National Acquisition Center (NAC), Hines, IL. In addition to procuring supplies and services for VA use, OA&MM awards and administers the FSS schedules for pharmaceuticals, medical/surgical supplies and equipment, and health care services for the entire Federal government and other entities authorized to use the schedules.

VA buys $6 billion in supplies and services each year.

The challenge for OIG is to develop and implement an effective plan to conduct oversight of VA's widespread and diverse acquisition activities and provide VA management with findings and recommendations that will improve the efficiency and effectiveness of the acquisition program. During this reporting period, OIG efforts to help improve VA procurement processes while deterring and detecting fraud, waste, and abuse involved audits, investigative efforts, and CAP reviews. Here are several examples of the accomplishments during this reporting period.

CAP REVIEW: OIG Notes Persistent Procurement Problems

CAP reviews at 14 of 23 VA facilities tested disclosed a need to improve contract award and administration practices. Management needed to strengthen controls to ensure staff follow preaward and postaward contract policies and procedures, monitor contract performance, review invoices before issuing contract payments, maintain required documentation, adequately document justification for contract renewals, and provide contracting officer technical representative training as required. In addition, management of supply inventories was deficient at 16 of the 23 facilities. Staff did not effectively monitor inventory levels using certain automated controls, reduce excess inventory as required by VA, and adequately update inventory records to accurately reflect inventory balances. Facilities needed to require staff to monitor, adjust, and excess stock levels as required. Management of equipment inventory at 8 of the 23 sites tested needed improvement. To properly account for all equipment, staff needed to perform physical inventories properly, accurately, and timely, and conduct follow up inventories when required.

INVESTIGATION: CEO, VA Officials Guilty in Bribery Scheme

An OIG investigation found that a company chief executive officer (CEO) doing business with a VAMC provided several airline and train tickets, a 2-night hotel stay, and $5,000 cash to the VAMC's chief of acquisition and materiel management. The CEO lied to OIG investigators about the bribery of a VA

employee, and subsequently pled guilty to making a false statement. He was sentenced to 12 months' probation and ordered to pay a $3,500 fine. The VAMC acquisition manager was sentenced to 8 months' imprisonment, to 36 months' probation, and to pay a $5,000 fine. Additionally, a VAMC contract specialist was charged with receiving an illegal gratuity for receiving resort hotel accommodations from the same vendor.

INVESTIGATION: Contractors Bribe Supervisor

An OIG investigation determined two contractors and a VA plumbing supervisor were engaged in a scheme to inflate and falsify purchase orders for emergency and routine plumbing repairs at a VAMC. Over a 3-year period, the contractors overcharged the VAMC more than $80,000 with the VA supervisor receiving at least this amount in kickbacks. One contractor was sentenced to 5 years' probation, ordered to make restitution to VA of $66,410, and fined $4,000 after his conviction for conspiracy to accept a bribe and bribery. The other was previously sentenced.

INVESTIGATION: CMOP Director Jailed in Extortion Attempt

The former director of a consolidated mail outpatient pharmacy (CMOP) pleaded guilty to conspiracy and bribery charges for conspiring to extort money from a company that had been awarded a $50 million contract for the CMOP. He was sentenced to 40 months' incarceration, 2 years' probation, and fined $7,500. The defendant had demanded partial ownership of the employee leasing company and one third of all revenue the company would derive from the CMOP contract.

INVESTIGATION: Arrests Follow $63,000 Kickback

An OIG investigation determined a subcontractor working on a $20 million VA construction project paid a $63,000 kickback to a prime contractor in order to secure work on a VAMC project and increased the price of the proposed subcontract by approximately the same amount. The subcontractor was sentenced to serve 2 years' probation, fined $2,000, and ordered to pay restitution to VA in the amount of $71,750. A second subcontractor on the project who submitted a fraudulent $41,000 pay request pled guilty to submitting false statements. The CEO and subcontractor corporation were indicted for conspiracy to defraud the United States, paying an illegal kickback, and making false statements. A project manager for the prime contractor was indicted for conspiracy to defraud the United States, accepting an illegal kickback, and falsifying a document to obstruct justice.

INVESTIGATION: VA Official, Contractors Plead Guilty

A VA official employed at a CMOP was arrested on public corruption charges stemming from kickbacks the official received from a vendor in exchange for awarding a "no bid" contract at an inflated price. The VA official pleaded guilty to a public corruption charge in connection with her duties at VA. Two Government contractors also pleaded guilty, one to conspiracy in connection with having paid the VA official more than $100,000 in kickbacks, and the other to acts affecting a personal financial interest. All three are awaiting sentencing.

INVESTIGATION: VA Contractor Guilty in False Claims Case

An OIG investigation revealed that a VAMC employee who was allowed to work during off-duty hours as a VA contractor providing medical transcription services overstated her medical transcription line counts on 25 fraudulent invoices, resulting in an overpayment of $46,356. After pleading guilty to making false

claims, she was sentenced to 5 years' probation, 6 months' home confinement with electronic monitoring, and ordered to pay $46,356 in restitution. The senior contracting officer, who approved the fraudulent invoices, resigned as a result of this investigation.

HOTLINE: Employees Not Always Obtaining Competitive Bids

A review determined prosthetics employees at a medical center had not been consistently obtaining competitive bids for health care equipment. The review further determined that a contractor was not returning health care equipment found to be beyond repair to the medical center. As a result, the chief of prosthetics will implement procedures to increase accountability for all equipment and to ensure its proper handling.

HOTLINE: Review Identifies $3 Million Contracting Deficiency

A Hotline call resulted in a VHA review that found deficiencies in the manner in which contracting officials at a medical center handled some major construction awards. The Acting Chief Logistics Officer recommended a range of procedural improvements and training to prevent recurrence of the problems.

Information Management

STRATEGIC GOAL #5: Assess information systems within VA to determine that they are adequately managed and protected to ensure information availability, integrity, authentication, and confidentiality; used in a lawful and ethical manner; are cost effective; and meet the needs of the user/customer. Investigate fraud and other computer related crimes against the VA.

Dependable information technology is central to VA's future.

Along with the entire Federal government and society at large, VA is becoming increasingly computer-based. The centrality of information technology (IT) in VA's future is clearly recognized in VA's *2003-2008 Strategic Plan*, which envisions the Internet as the primary communication vehicle VA has with its customers. Every month, more veterans receive VA benefits through electronic direct deposit rather than a paper check. Every day, veteran patient medical records and treatment information are accessed and entered electronically at thousands of networked computer terminals. VA maintains insurance, health, and burial records in millions of computer files. All VAMCs now provide patients with electronic access to their Department of Defense health care records. Annually, VA processes millions of transactions worth over $40 billion, and these figures will continue to increase. The cost and commitment to upgrade and integrate IT systems is a substantial part of the VA budget and will continue to rise rapidly in the years ahead.

OIG will continue close oversight of the extensive IT acquisition and implementation activity, as this area involves such monumental impact on overall VA performance and mission accomplishment. OIG reviews of VA IT management during the reporting period include:

CAP REVIEWS: OIG Finds IT Security Deficiences Persistent

Information security controls were deficient at 14 of the 23 medical facilities tested. The CAP reviews found a wide range of vulnerabilities in medical facilities systems existed, which could lead to unauthorized access, disclosure, modification, destruction, and misuse of automated information systems resources. In order to safeguard resources, OIG reported facilities needed to improve controls over computer access, contingency planning, risk assessments, security awareness training, background investigations, and physical security to computer rooms and communication closets. OIG identified similar deficiencies in CAP reviews conducted between October 2004 through September 2005.

AUDIT: Compliance Reviews Show Progress, Flaws

OIG prepared Federal Information Security Management Act (FISMA) compliance audits on information systems used VA-wide, information security controls, and security management at eight selected VA facilities during this reporting period. The electronic security review involved conducting scans of wired and wireless networks and reviewing electronic patient health information controls. OIG determined that each facility had made progress in the areas of information security. However, all eight facilities needed to improve physical, personnel, and electronic security controls. OIG also found weaknesses in backup tape storage, background investigations, verification of prescriptions submitted by VAMCs to the CMOPs for accuracy, background investigations, and periodic reinvestigation at specified intervals.

AUDIT: Penetration Testing Reveals VBA Vulnerabilities

OIG used a contractor to perform penetration testing in October 2005, using best business practices for information security. The resulting management letter and contractor's report are restricted because they contain confidential information exposing vulnerabilities of the VBA Benefits Delivery Network. The contractor was able to create a fictitious user who generated and approved an award, and the contractor was able to read sensitive data. The contractor made recommendations for improvement and OIG is awaiting an implementation plan.

AUDIT: Study Finds IT Equipment Mismanagement

OIG evaluated anonymous allegations concerning missing and unaccounted-for IT equipment, and possible unauthorized disclosure of sensitive patient and employee information in violation of the *Privacy Act of 1974*. OIG substantiated some allegations, but a wall-to-wall inventory and spot check did not substantiate that significant amounts of IT equipment were missing. OIG could not evaluate the allegation regarding the unauthorized disclosure of sensitive information and violations of the Privacy Act due to insufficient records. To improve operations, OIG made eight recommendations with which the Healthcare System Director agreed, providing acceptable improvement plans.

HOTLINE: Veteran's Missing Files Retrieved Electronically

Following a Hotline call, OIG arranged for a VHA review that determined a veteran's files were lost in transit between two medical centers. Current records are electronic and available through the VA's computerized records system. The sending facility issued a nationwide alert to locate the records. In response to the alert, several other facilities that had treated the veteran located files related to his care. All these records were assembled at the veteran's new medical center.

Office of Contract Review

The Office of Contract Review (OCR) operates under an agreement with VA's Office of Acquisition and Materiel Management to conduct contract preaward and postaward reviews. OCR's services are requested and paid for by VA.

The preaward reviews provide information to VA's contracting officers to assist in price negotiations to ensure fair and reasonable contract prices, and identify monetary benefits that protect VA's valuable resources. Preaward reviews identified $73,771,987 in potential cost savings during this reporting period. Thirteen preaward reviews of FSS and cost-per-test offers conducted at the request of the National Acquisition Center recommended that contracting officers negotiate $69,819,428 in lower contract prices for FSS users because the vendors were not offering their most favored customer prices to Government customers. Another 14 preaward reviews, of proposals from VA affiliated medical schools involving the acquisition of health care provider services were made at the request of VHA contracting officers. OCR recommended they negotiate reductions of $3,952,118 to proposed contract costs to achieve fair and reasonable contract prices.

OCR conducted postaward reviews to ensure compliance with contract terms and conditions. These reviews resulted in VA recovering contract overcharges in this reporting period totaling $17,620,576. Below are several examples of preaward and postaward reviews from this reporting period.

REVIEW: Pharmaceutical Firm Repays $11.8 Million

OCR performed a review of a pharmaceutical manufacturer's voluntary disclosure and refund offer of overcharges on its FSS contract. OIG recommended that the NAC contracting officer issue a bill of collection to the manufacturer for $11.8 million for contract overcharges. The overcharges are the result of the manufacturer's non-compliance with the price reduction clause in its FSS contract and the failure to implement the requirements of Public Law 102-585, section 603. The manufacturer concurred in the overcharges and remitted $11.8 million to VA's Supply Fund.

REVIEW: Contract Saves Nearly $2.4 Million, Improves Care

An OCR review of an affiliate's proposal to provide ophthalmology services identified potential savings of nearly $2.4 million. The affiliate refused to negotiate lower prices so the contracting officer issued a competitive solicitation for the services. Subsequently, the contracting officer awarded a contract to a local practice consisting of two Vietnam veterans who were well known and respected locally for their expertise. The local practice bid 80 percent of the Medicare rate versus the 105 percent bid by the affiliate. The difference resulted in the $2.4 million in cost savings.

REVIEW: Pharmaceutical Manufacturer Repays $1.8 Million

OCR performed a review of corrected Federal Ceiling Prices (FCPs) resulting in the collection of $1.8 million. Although the manufacturer voluntarily disclosed the error which caused the overcharges, they failed to disclose any monetary impact of the errant pricing. Subsequently, the company agreed to re-state the pricing and calculated overcharges of $1,805,536. The review determined that the revised methodology was correct, but that the overcharges should be $1,826,916.

The manufacturer concurred with this assessment and agreed to accept a bill of collection to resolve the amount due. The contracting officer issued a bill of collection and the manufacturer remitted $1.8 million to VA's Supply Fund.

REVIEW: VA to Receive $1.9 Million in False Claims Act Case

King Pharmaceuticals of Bristol, Tennessee, agreed to pay $124 million to settle a case filed under the *qui tam* provisions of the False Claims Act alleging noncompliance with statutory mandates that establish Government pricing for covered drugs. Based on a postaward review by OCR, VA will receive $1,921,875 from the settlement amount. This is in addition to the $953,626 reported in the last semiannual report that King Pharmaceuticals paid VA in an administrative settlement.

REVIEW: Pharmaceutical Manufacturer to Pay $921,161

OCR's review of a pharmaceutical manufacturer's voluntary disclosure and refund offer of $598,730 in price reductions on its FSS contract disclosed that the appropriate price reduction amount should be $594,377 with an additional $326,784 for FCP overcharges. Based on the review, the manufacturer agreed to pay $921,161 to resolve FSS contract overcharges.

REVIEW: Contracting Officer Saves VHA $756,546

In response to recommendations in a preaward review by OCR, a contracting officer in VHA was able to negotiate better pricing on a contract for urology services. The recognized savings of $756,546 represents 90 percent of the recommended savings in the preaward report.

CONTRACT PREAWARD REVIEWS

Report Number/ Issue Date	Report Title	Potential Cost Savings	Cost Savings Sustained Through Negotiations
05-01889-3 10/13/05	Review of Federal Supply Schedule Proposal Submitted by Hospira Worldwide, Inc., Under Solicitation Number M5-Q50A-03	$17,716,516	
05-03103-4 10/13/05	Review of Proposal Submitted by Indiana University, Under Solicitation Number 583-43-05, for Neurosurgery Services at the Richard L. Roudebush VA Medical Center	$949,207	
05-02044-6 10/19/05	Review of Federal Supply Schedule Proposal Submitted by Ortho Biotech Products, L.P., Under Solicitation Number M5-Q50A-03	$284,832	

Report Number/ Issue Date	Report Title	Potential Cost Savings	Cost Savings Sustained Through Negotiations
05-02809-10 10/24/05	Review of Proposal Submitted by University of Minnesota Physicians, Under Solicitation Number RFP 618-111-05, for Radiation Oncologist and Physicist Services at Minneapolis VA Medical Center	$231,164	
05-02597-12 11/2/05	Review of Proposal Submitted by University of California - Irvine, Under Solicitation Number 600-108-05, for Urology Services at the Long Beach VA Healthcare System	$838,180	$756,546
04-02718-23 11/3/05	Review of Federal Supply Schedule Proposal Submitted by TAP Pharmaceuticals, Incorporated, Under Solicitation Number M5-Q50A-03		
05-01908-24 11/3/05	Review of Proposal Submitted by University of Pennsylvania, Under Solicitation Number RFP 642-15-04, for Radiology Therapy Services at the VA Medical Center Philadelphia, PA	$185,550	
05-03048-28 11/16/05	Review of Proposal Submitted by University of Miami, Under Solicitation Number 546-48-05, for Anatomic and Clinical Pathology Services to VA Medical Center Miami		
05-02042-30 11/23/05	Review of Federal Supply Schedule Proposal Submitted by McKesson Automation Systems, Inc.	$4,030,734	
05-03404-38 12/5/05	Review of Proposal Submitted by Duke University Medical Center Under Solicitation Number RFP 246-05-01878 for Radiology Services at VA Medical Center Durham, NC	$289,049	
05-00277-43 12/14/05	Review of Federal Supply Schedule Proposal Submitted by 3M Medical Division Under Solicitation Number 797-FSS-99-0025-R4	$2,674,405	

Report Number/ Issue Date	Report Title	Potential Cost Savings	Cost Savings Sustained Through Negotiations
06-00175-46 12/21/05	Review of Proposal Submitted by the University of California - Los Angeles, Under Solicitation Number 600-013-05, for Cardiothoracic Surgery and Perfusionist Services at the VA Greater Los Angeles Healthcare System		
05-03169-48 12/27/05	Review of Proposal Submitted by Medical College of Wisconsin, Under Solicitation Number RFQ 69D-212-04, for Radiology Oncology Physician and Physicist Services for Clement J. Zablocki VA Medical Center Milwaukee, WI		
04-00457-44 12/29/05	Review of Federal Supply Schedule Proposal Submitted by Mallinckrodt, Inc., Division of Tyco International, Ltd., Under Solicitation Number M5-Q50A-03	$781,070	
05-03509-53 1/12/06	Review of Proposal Submitted by University of Minnesota Physicians, Under Solicitation Number 618-65-06, for Ophthalmologic Surgery and Retina Services for the Minneapolis VA Medical Center		
06-00529-54 1/12/06	Review of Proposal Submitted by Vanderbilt University, Under Solicitation Number RFP 626-30-04, for Urology Services at VA Medical Center Nashville, TN		
05-01810-56 1/13/06	Review of Federal Supply Schedule Proposal Submitted by C.R. Bard, Inc., Under Solicitation Number RFP-797-FSS-99-0025-R4	$5,768,220	
04-02751-59 1/18/06	Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Healthcare Systems, Inc., on Behalf of Ortho-McNeil Pharmaceutical, Inc., Under Solicitation Number M5-Q50A-03	$169,891	
05-01636-61 1/23/06	Review of Federal Supply Schedule Proposal Submitted by Beckman Coulter, Inc., Under Solicitation Number RFP-797-FSS-03-0001	$162,420	

Report Number/ Issue Date	Report Title	Potential Cost Savings	Cost Savings Sustained Through Negotiations
04-01684-63 1/27/06	Review of Federal Supply Schedule Proposal Submitted by Watson Pharma Inc., Under Solicitation Number M5-Q50A-03	$950,815	
05-02230-84 2/7/06	Review of Federal Supply Schedule Proposal Submitted by Abbott Laboratories Inc., Pharmaceutical Products Division, Under Solicitation Number M5-Q50A-03	$35,728,745	
06-00984-89 2/13/06	Review of Proposal Submitted by the Medical University of South Carolina, Under Solicitation Number 247-0244-04, for Vascular Surgery Services at the Ralph H. Johnson VA Medical Center		
06-01036-90 2/14/06	Review of Proposal Submitted by University Physicians Healthcare Under Solicitation Number 678-0107-05 for Vascular Surgery Services at Southern Arizona VA Health Care System		
06-00983-94 2/23/06	Review of Proposal Submitted by Medical University of South Carolina Under Solicitation Number RFP 247-0378-04 for Cardiothoracic Surgeon Services to the Ralph H. Johnson VA Medical Center		
05-02760-104 3/14/06	Review of Federal Supply Schedule Proposal Submitted by Biogen Idec US Corporation Under Solicitation Number M5-Q50A-03	$182,910	
05-02092-112 3/21/06	Review of Federal Supply Schedule Proposal Submitted by Permobil, Inc., Under Solicitation Number RFP-797-652F-03-0001	$1,368,870	
06-00530-115 3/27/06	Review of Proposal Submitted by Vanderbilt University, Under Solicitation Number 626-29-04, for Orthopedic Physician Services at VAMC Nashville	$1,459,409	
	TOTAL	$73,771,987	$756,546

POSTAWARD CONTRACT REVIEWS

Report Number/ Issue Date	Report Title	Recoveries
Postawards Requested by the NAC		
05-02132-5 10/13/05	Review of Schering Corporation's Addition of Rebetol Item to Federal Supply Schedule Contract Number V797P-5777x	
06-00963-116 3/28/06	Review of Schering Corporation's Modification to Add Products Under Federal Supply Schedule Contract Number V797P-5777x	
Contract Review Postawards in Response to Voluntary Disclosures and Civil Fraud Actions		
04-01284-7 10/25/05	Review of Sandoz Inc.'s Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5314x	$11,843,286
05-00259-27 11/16/05	Review of J&J Health Care Systems, Inc.'s Voluntary Disclosure and Refund Offer, on Behalf of Codman & Shurtleff, Inc., Concerning Federal Supply Schedule Contract V797P-4456a	$290,111
4-01258-36 12/2/05	Settlement Agreement King Pharmaceuticals	$1,921,875
99-00106-37 12/7/05	Public Law Pricing Review and Refund Offer by Schering-Plough Corporation Under Contract Number V797P-5368x	$749,997
05-01809-45 12/21/05	Review of Warrick Corporation's Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5653x	$781

Report Number/ Issue Date	Report Title	Recoveries
06-00570-52 1/12/06	Verification of Savient Pharmaceuticals, Inc.'s Contract Overcharges on Federal Supply Schedule Contract Number V797P-5787x	$291
05-03402-55 1/13/06	Review of Boehringer Ingleheim's Voluntary Disclosure Under Federal Supply Schedule Contract Numbers V797P-5429x and V797P-5705x	$1,826,916
05-02441-57 1/13/06	Review of Schering Corporation's Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5777x	$111
06-00366-62 1/24/06	Review of Ortho-McNeil Pharmaceutical, Inc.'s Self-Disclosed Price Reductions Under Federal Supply Schedule Contract Number V797P-5438x	$921,162
05-01316-83 2/7/06	Review of Philips Medical Systems' Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-4328a	$66,046
05-01327-111 3/21/06	Review of Reimbursement to Pfizer, Inc. for Alleged Overpayment of Credits to VA Facilities, Report Number 05-01327-111	
	TOTAL	$17,620,576

Other Significant Activities

George J. Opfer Confirmed as Inspector General

George J. Opfer was confirmed as Inspector General of the Department of Veterans Affairs on November 10, 2005, and appointed on November 17, 2005. Mr. Opfer served previously as Deputy Inspector General at the Department of Labor, where he was responsible for day-to-day operations aimed at reducing labor racketeering and corruption in employee benefit plans, labor-management relations, and internal union affairs. Prior to this appointment, he served for 8 years as Inspector General for the Federal Emergency Management Agency. He began his Federal career as a Special Agent in the U.S. Secret Service, serving for 25 years and holding several Senior Executive Service positions. He received his bachelor's degree in management from St. John's University.

Secretary Nicholson congratulates Inspector General Opfer

OIG Management Presentations

VHA's Financial Quality Assurance Managers

In January 2006, Audit staff made a presentation on financial audit issues at the first meeting of the VHA Networks' Financial Quality Assurance Managers.

VA Workers' Compensation Steering Committee

Audit staff made presentations at VA Workers' Compensation Steering Committee meetings that discussed past work and program findings. The committee was established to prepare a Workers' Compensation Program (WCP) strategic plan and coordinate implementation actions VA-wide in response to OIG-related WCP findings and recommendations for program improvement.

Veterans Health Administration Chief Logistics Officers and Network Managers Conference

In November 2005, Audit staff gave a presentation at the Indianapolis, IN, conference on OIG perspective on VA procurement issues, including the OIG's strategic planning goals pertaining to procurement and the results of recent audits and evaluations.

National Acquisition Center Industry Conference

Contract review staff made presentations on postaward reviews and voluntary disclosures and refund offers to industry representatives.

OIG Chicago Healthcare Inspections Director Named Associate Editor

The Director of OIG's Chicago Office of Healthcare Inspections was selected as Associate Editor for the American Association of Spinal Cord Injury Nurses' (AASCIN) Editorial Board, which publishes the official journal of AASCIN journal, *SCI Nursing*. The quarterly journal is distributed to AASCIN members, schools of nursing, VA medical libraries, and rehabilitation facilities.

Awards

President's Council on Integrity and Efficiency (PCIE) 2005 Awards

The Alexander Hamilton Award, PCIE's highest award: VBA state variance review.

PCIE Awards for Excellence – Audit:

- Review of VA implementation of the Zegato Electronic Travel Service.
- Follow-up Audit of the VA WCP Costs.
- Review of VHA management of outpatient scheduling procedures.

PCIE Awards for Excellence – Investigations:

- Investigative work leading to prosecution and conviction of a medical professional who harmed cancer victims by including ineligible patients in research studies.
- Identifying and prosecuting 52 members of drug trafficking group selling controlled substances to patients and employees of the VA Medical Center Hampton, Virginia.

PCIE Awards for Excellence – Multiple Disciplines:

- Efforts to improve the VA Core Financial and Logistics System (CoreFLS) and related patient care and administrative issues at VAMC Bay Pines.
- Benefit review of the VA Regional Office in San Juan, Puerto Rico, resulting in savings and cost avoidance of approximately $74 million.

PCIE Award for Excellence – Administrative Support:

- Succession planning and other human capital initiatives throughout the Inspector General community.

PCIE Award for Excellence – Employee Protections:

- Efforts to improve the safety of employees working in health care facilities as part of the VHA Management of Violent Patient Behavior Project.

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
REVIEWS BY OIG STAFF

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
05-00709-1 10/7/05	Combined Assessment Program Review of the VA Medical Center, San Juan, PR			
04-02331-17 11/2/05	Combined Assessment Program Review of the Northern Arizona VA Health Care System, Prescott, AZ	$548,361	$548,361	
05-02531-18 11/3/05	Combined Assessment Program Review of the VA Regional Office, Honolulu, HI	$5,906	$5,906	
05-02813-32 12/6/05	Combined Assessment Program Review of the VA Medical Center, West Palm Beach, FL	$10,087	$10,087	
05-02242-39 12/6/05	Combined Assessment Program Review of the VA Regional Office, San Juan, PR	$2,831,906	$2,831,906	
05-02813-40 12/12/05	Combined Assessment Program Review of the VA Medical Center, Fayetteville, NC			
06-00012-49 1/5/06	Combined Assessment Program Review of the VA Medical Center, Lexington, KY			
05-02361-50 1/6/06	Combined Assessment Program Review of the San Francisco VA Medical Center, San Francisco, CA	$103,443	$103,443	
05-02926-64 1/30/06	Combined Assessment Program Review of the VA Regional Office, Portland, OR	$111,618	$111,618	
05-02298-65 1/30/06	Combined Assessment Program Review of the VA Tennessee Valley Healthcare System, Nashville, TN	$1,028,385	$1,028,385	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
05-00734-67 1/31/06	Combined Assessment Program Review of the VA Boston Healthcare System, Boston, MA	$1,729,501	$1,729,501	$194,837
05-01607-68 1/31/06	Combined Assessment Program Review of the Providence VA Medical Center, Providence, RI	$1,035,337	$1,035,337	
05-01654-69 2/1/06	Combined Assessment Program Review of the VA Medical Center, Kansas City, MO	$1,017,355	$1,017,355	
05-03384-70 2/2/06	Combined Assessment Program Review of the VA Medical Center, Asheville, NC			
05-01229-71 2/2/06	Combined Assessment Program Review of the VA Regional Office, Philadelphia, PA	$1,933,577	$1,933,577	
05-01661-72 2/2/06	Combined Assessment Program Review of the Oklahoma City VA Medical Center, Oklahoma City, OK	$312,581	$312,581	
05-03389-82 2/8/06	Combined Assessment Program Review of the VA Regional Office, Roanoke, VA	$1,594,680	$1,594,680	
05-01608-85 2/8/06	Combined Assessment Program Review of the Togus VA Medical Center, Togus, ME	$1,307,466	$1,307,466	
06-00025-86 2/15/06	Combined Assessment Program Review of the Spokane VA Medical Center, Spokane, WA	$782,498	$782,498	
05-02924-87 2/15/06	Combined Assessment Program Review of the VA Regional Office, Oakland, CA	$4,223,712	$4,223,712	
05-03126-92 2/17/06	Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, AR			
05-03486-93 2/21/06	Combined Assessment Program Review of the VA Medical Center, Marion, IL	$132,776	$132,776	
05-01514-96 3/3/06	Combined Assessment Program Review of the VA Medical Center, White River Junction, VT	$158,027	$158,027	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
05-02502-99 3/7/06	Combined Assessment Program Review of the VA Medical Center, Lebanon, PA	$296,596	$296,596	
05-03219-103 3/14/06	Combined Assessment Program Review of the North Chicago VA Medical Center, North Chicago, IL			
06-00095-106 3/21/06	Combined Assessment Program Review of the VA Regional Office, Boston, MA	$1,139, 345	$1,139, 345	
05-03220-108 3/22/06	Combined Assessment Program Review of the VA Illiana Health Care System Danville, IL	$284,676	$284,676	
05-01508-114 3/27/06	Combined Assessment Program Review of the Edith Nourse Rogers Memorial Veterans Hospital Bedford, MA	$24,186	$24,186	
05-01941-117 3/29/06	Combined Assessment Program Review of the VA Medical Center, Butler, PA	$47,345	$47,345	
06-00026-119 3/31/06	Combined Assessment Program Review of the VA Regional Office, San Diego, CA	$349,703	$349,703	
05-03277-121 3/31/06	Combined Program Assessment Review of the Veterans Health Administration Activities at the Robert J. Dole VA Medical Center, Wichita, KS	$107,617	$107,617	
06-01753-122 3/31/06	Summary Report of Combined Assessment Program Reviews at Veterans Benefits Administration Regional Offices, October 2004 through September 2005			
06-01754-123 3/31/06	Summary Report of Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities, October 2004 through September 2005			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
JOINT REVIEWS				
06-00480-26 11/15/05	Major Management Challenges Fiscal Year 2005			
INTERNAL AUDITS				
05-00055-8 10/20/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Great Lakes Consolidated Mail Outpatient Pharmacy			
05-00055-9 10/20/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Veterans Benefits Administration Regional Office, Chicago, IL			
05-00055-11 10/24/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Philadelphia Information Technology Center			
05-00055-16 11/1/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Austin Automation Center (AAC)			
05-00055-20 11/2/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Financial Services Center (FSC)			
04-01901-19 11/3/05	Audit of Medical Oxygen Supply Management Practices VA Medical Center, San Juan, PR			
05-00055-22 11/3/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Tennessee Valley Healthcare System (TVHS)			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use		Questioned Costs
		OIG	Management	
05-01096-21 11/15/05	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2005 and 2004			
05-01096-29 11/18/05	Report of the Audit of the Department of Veterans Affairs Special Purpose Financial Statements for Fiscal Years 2005 and 2004			
05-01096-35 12/2/05	Department of Veterans Affairs Fiscal Year 2005 Agreed-Upon Procedures for Federal Intragovernmental Activity and Balances			
05-00055-33 12/5/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit of the Mid-South Consolidated Mail Outpatient Pharmacy (CMOP)			
05-00055-34 12/5/05	Management Letter, Fiscal Year 2005 Federal Information Security Management Act (FISMA) Audit Network Operations Center (NOC) and Security Operations Center (SOC)			
06-00763-66 1/26/06	Attestation of the Department of Veterans Affairs Fiscal Year 2005 Detailed Accounting Submission to the Office of National Drug Control Policy			
05-03177-95 3/1/06	Evaluation of Time and Attendance of a Part-Time Physician at the Malcolm Randall VA Medical Center, Gainesville, FL			
05-00123-97 3/6/06	Wireless Network Vulnerability Assessment at the VA Medical Center, Dallas, TX			
05-00123-98 3/6/06	Wireless Network Vulnerability Assessment at the VA Medical Center, San Antonio, TX			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
02-03372-101 3/8/06	Audit of the VA Homeless Veterans Transitional Housing Grant to Tampa-Hillsborough Action Plan, Inc., Tampa, FL			$714,131
05-00321-105 3/20/06	Evaluation of Veterans' Access to Long-Term Nursing Home Care, Washington, DC			
05-03037-107 3/21/06	Audit of Allegations Regarding Payments for Fee Basis Care in Veterans Integrated Service Network 2, Albany, NY			
05-03271-113 3/23/06	Evaluation of Time and Attendance of a Full-Time Physician at the John J. Pershing VA Medical Center, Poplar Bluff, MO			
06-00785-120 3/31/06	Audit of Alleged Mismanagement of VA's Permanent Change of Station Travel Program, Washington, DC	$521,591	$507,654	

OTHER OFFICE OF AUDIT REVIEWS

05-01542-2 10/11/05	Management Letter, Department of Veterans Affairs Fiscal Year 2004 Special Disabilities Capacity Report
04-00856-31 12/2/05	Evaluation of Alleged Information Technology Equipment Mismanagement and Privacy Act Violations at the VA Loma Linda Healthcare System
05-00017-91 2/17/06	Evaluation of Financial Management Activities at the VA Riverside National Cemetery

HEALTHCARE INSPECTIONS

05-02085-13 11/1/05	Healthcare Inspection, Clinical Laboratory Issues Cheyenne VA Medical Center, Cheyenne, WY

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
04-00330-15 11/1/05	Healthcare Inspection, Evaluation of Management of Moderate Sedation in Veterans Health Administration Facilities			
04-02321-14 11/2/05	Healthcare Inspection, Alleged Lack of Resident Supervision in Orthopedics Service Dallas VA Medical Center, Dallas, TX			
04-01646-25 11/3/05	Healthcare Inspection, Management of Bulk Oxygen Systems			
05-01838-41 12/7/05	Healthcare Inspection, Patient Care Issues in Mental Health William Jennings Bryan Dorn VA Medical Center, Columbia, SC			
05-02203-42 12/14/05	Healthcare Inspection, Quality of Care Issues, Bay Pines VA Medical Center, Bay Pines, FL			
05-02589-47 12/27/05	Healthcare Inspection, Quality of Care Issues in the Dialysis Unit, Bay Pines VA Medical Center, Bay Pines, FL			
04-03266-51 1/5/06	Emergency Preparedness in Veterans Health Administration Facilities			
04-03313-58 1/20/06	Healthcare Inspection, Review of Alleged Institutional Mistreatment, Department of Veterans Affairs Medical Centers, Iowa City and Knoxville, Iowa			
05-01372-60 1/25/06	Healthcare Inspection, Alleged Suspicious Death, Delay in Surgery, and Failure to Obtain Preoperative Cardiac Workup, Harry S. Truman Memorial Veterans' Hospital, Columbia, MO			
05-02418-75 2/2/06	Healthcare Inspection, Environmental, Safety, Patient Privacy, and Staffing Issues Edward Hines, Jr. VA Hospital Hines, IL			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
05-00784-76 2/2/06	Healthcare Inspection, Colorectal Cancer Detection and Management in Veterans Health Administration Facilities			
05-02023-73 2/3/06	Alleged Failure to Supervise Hand Surgery Fellows VA Boston Healthcare System, Boston, MA			
05-03053-77 2/3/06	Healthcare Inspection, Quality of Care Issues in the Traumatic Brain Injury Unit, James A. Haley VA Medical Center, Tampa, FL			
04-03402-81 2/6/06	Healthcare Inspection, Evaluation of Environment of Care in Veterans Health Administration Facilities			
04-01639-74 2/8/06	Healthcare Inspection, Quality of Care and Management Issues Kansas City VA Medical Center, Kansas City, MO			
05-03098-88 2/15/06	Healthcare Inspection, Alleged VistA System Malfunction Olin E. Teague Veterans Center, Temple, TX			
05-02925-100 3/7/06	Resident Supervision in the Operating Room, Birmingham VA Medical Center, Birmingham, AL			
05-01552-102 3/9/06	Healthcare Inspection, Operating Room Nurses Scope of Practice Issues Edward Hines, Jr. VA Hospital, Hines, IL			
05-00295-109 3/22/06	Healthcare Inspection, Management of Patients with Pressure Ulcers in Veterans Health Administration Facilities, Washington, DC			
03-00494-110 3/22/06	Healthcare Inspection, Evaluation of the Management of Patients with Feeding and Swallowing Problems in Veterans Health Administration Facilities, Washington, DC			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use: OIG	Funds Recommended for Better Use: Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS				
04-02823-79 2/6/06	Administrative Investigation Alleged Reprisal of a Contract Employee by the Contractor, Asheville, NC			
06-00209-80 2/6/06	Administrative Investigation, Financial Irregularities VA Medical Center, Washington, DC			
	TOTAL	$21,638,275	$21,624,338	$908,968

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED OVER 1 YEAR

The *Federal Acquisition Streamlining Act of 1994* provides guidance on prompt management decisions and implementation of OIG recommendations. It states a Federal agency shall complete final action on each recommendation in an OIG report within 12 months after the report is finalized. If the agency fails to complete final action within this period, OIG will identify the matter in its semiannual report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations.

OIG requires that management officials provide documentation showing the completion of corrective actions on OIG recommendations. In turn, OIG reviews status reports submitted by management officials to assess the adequacy and timeliness of agreed-upon implementation actions. When a status report adequately documents corrective actions, OIG closes the recommendation. If the actions do not implement the recommendation, OIG continues to monitor progress.

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, 2005, and earlier).

Unimplemented OIG Reports and Recommendations				
VA Office	**Total**		**Issued 3/31/05 and Earlier**	
	Reports	Recommendations	Reports	Recommendations
VHA	77	485	13	67
VBA	12	60	2	5
OI&T	3	25	2	24
OHRA	1	12	1	12
OM	6	27	2	9
OPPP	1	3	1	3
Totals	**100***	**612**	**21****	**120**

* There are 95 total unimplemented reports, but 2 reports have actions for two or more offices.

** There are 17 total unimplemented reports over 1-year old, but 1 report has action for four offices.

Office of Information and Technology (OI&T)
Office of Human Resources and Administration (OHRA)
Office of Management (OM)
Office of Policy, Planning, and Preparedness (OPPP)

OIG is particularly concerned with five reports on VHA operations (three issued in 2002 and two in 2003) with recommendations that still remain open. The following information provides a summary of reports over 1 year old with open recommendations.

Veterans Benefits Administration

Unimplemented Recommendations and Status

Report: *Evaluation of Veterans Benefits Administration Vocational Rehabilitation and Employment (VR&E) Contracts*, 04-01271-74, 2/1/05

OIG completed an evaluation of the award and administration of VBA VR&E contracts. OIG conducted the evaluation at the request of the VR&E Task Force, which was concerned about the adequacy of the contracting process and pricing information. The purposes of the evaluation were to determine the reasonableness of the prices paid, and to identify opportunities to enhance contract administration and better utilize VA resources.

Status: As of March 31, 2006, three of seven recommendations remain unimplemented. VBA continues to work on a process to ensure that adequate internal controls are in place to monitor the contract payment process and anticipates completion of required action early in FY 2007.

Veterans Health Administration

Unimplemented Recommendations and Status

Report: *Healthcare Inspection, Evaluation of VHA's Contract Community Nursing Home (CNH) Program*, 0200972-44, 12/31/02

At the request of Senator Christopher S. Bond, OIG conducted an inspection of the progress of VHA's efforts to strengthen oversight and control procedures, and to determine whether veterans residing in community nursing homes were vulnerable to abuse, neglect, or financial exploitation. OIG identified the need to strengthen CNH oversight and control practices as far back as January 1994, and reported that similar conditions and vulnerabilities continued to exist in a Combined Assessment Program Summary Report dated October 30, 2001.

Status: As of March 31, 2006, 1 of 11 recommendations remains unimplemented pending actions by the VHA Chief Consultant for Geriatrics and Extended Care (G&EC). That recommendation states that the Under Secretary for Health needs to ensure that VHA medical facility managers devote the necessary resources to adequately administer the CNH program. G&EC will analyze and submit findings of the web-based CNH Certification Report to the Deputy Under Secretary for Health for Operations and Management.

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Report: *Audit of VHA's Part-Time Physician Time and Attendance*, 02-01339-85, 4/23/03

At the request of the Secretary of Veterans Affairs, OIG audited VHA's management of part-time physician time and attendance, physician productivity in meeting employment obligations, and physician staffing requirements. The audit objectives were to determine if (1) timekeeping and other management controls were effective in ensuring that part-time physicians worked the hours required by their VA appointments; and (2) VHA used effective procedures to align physician staffing with workload requirements.

Status: As of March 31, 2006, 9 of 17 recommendations remain unimplemented pending actions by a number of VHA staff offices. VHA explored ways to create a time and attendance system that meets the needs of VA in providing patient care while at the same time allowing flexibility in scheduling for those part-time physicians who need such accommodations. All relevant parties agreed upon the concept of eliminating core hours for those part-time physicians on alternative work schedules. VA Handbooks relating to staffing, pay administration, and hours of duty and leave document the new policy. OIG expects release of the new handbooks shortly. Five medical centers are testing the new policies together with new supporting software changes to the Enhanced Time & Attendance System. Concurrently, the Employee Education System developed a training module to assist the field when national implementation of the new policies becomes mandatory.

VA developed a proposed policy to meet this staffing requirement. It relates staffing levels and staff mix to patient outcomes and other performance measures. This proposed policy requires all VHA facilities to develop written staffing plans for each distinct unit of patient care or health service. The directive's requirements are to be used in conjunction with the requirements of appropriate accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations. Currently, there are no information management systems capable of supporting nationwide standardized staffing plans for health care providers in varied care settings. VHA briefed OIG in February 2006 on the program points of its Decision Support System Physician Labor Mapping Directive, now in the concurrence phase, which will serve as the foundation for a national specialty physician database. VHA expects this database to ensure standardized labor mapping and improve accuracy of cost determination. It should be fully operational in calendar year 2006 (with completion in FY 2009), and support measuring productivity and staffing for the remaining physician specialties.

OIG continues to work with VHA to review VHA's proposed policy due to concerns over compliance with the intent of Public Law 107-135, *The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001*, particularly with respect to national standards for nurse staffing, the length of time VHA projects to establish a complete set of staffing standards, and questions over the need to develop new data systems versus using existing data resources in a consistent manner.

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Report: *Healthcare Inspection, Evaluation of VHA Homemaker and Home Health Aide Program*, 02-00124-48, 12/18/03

OIG conducted an evaluation of VHA's Homemaker and Home Health Aide (H/HHA) Program to determine whether H/HHA programs at VA medical facilities were in compliance with VHA policy and whether H/HHA services provided to patients were clinically appropriate, cost-effective, and met customer expectations.

Status: As of March 31, 2006, two of four recommendations remain unimplemented pending actions by VHA Chief G&EC. OIG will close both recommendations upon VHA finalizing the Home Health Care Program Administration handbook and implementing a Geriatrics and Extended Care referral form. The VHA program office has not provided a planned completion date to issue the handbook that was first drafted in January 2004, and the referral form is on hold at most sites.

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Report: *Healthcare Inspection, VHA's Community Residential Care (CRC) Program*, 03-00391-138, 5/3/04

OIG conducted an evaluation of VHA's Community Residential Care (CRC) Program. OIG conducted the evaluation to determine whether: VA medical facilities inspect their CRC homes in accordance with VA policy; veterans are appropriately assessed, placed, and followed up in CRC homes; CRC caregivers are qualified to meet veterans' needs; and incompetent veterans' care is coordinated with VBA.

Status: As of March 31, 2006, 4 of 11 recommendations remain unimplemented pending VHA actions. The Under Secretary for Health needs to assure that appropriate VAMC CRC program managers, inspection team members, or clinicians:

1. Conduct annual fire safety inspections of CRC homes.
2. Give CRC caregivers instructions for managing patient care needs at the time of placement, and after hospitalizations and clinic visits, and document these discussions in the medical records.
3. Document that patients and families sign statements of agreement when accepting referrals to CRC services and programs not approved by VA.
4. Conduct and document annual discussions with VBA field examination supervisors regarding incompetent CRC patients, and take actions as appropriate.

Three of the four recommendations required regulatory changes that are being drafted for Title 38, Code of Federal Regulations. VHA issued Handbook 1140.1 in March 2005, but did not address the last recommendation involving discussions with VBA. The next handbook revision will address all recommendations.

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Report: *Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities*, 03-00079-183, 8/13/04

OIG evaluated the efforts to manage nursing resources in VHA medical facilities in light of the national nursing shortage. The purposes of OIG's evaluation were to determine whether VHA facility managers: (1) effectively allocated and deployed nursing resources, (2) monitored the impact of staffing levels on the quality of care provided to patients, and (3) applied effective recruitment, retention, and deployment strategies to maintain a stable VHA nursing work force. OIG also solicited employee perceptions on other issues that may affect job satisfaction.

As of August 2003, VA employed more than 36,000 Registered Nurse FTE. In a 1989 report, OIG concluded that: (1) VHA managers needed to better monitor their nurse staffing needs, (2) staffing decisions were based on inaccurate data, (3) wide variations occurred among facilities, and (4) VHA did not have a standardized methodology to determine the appropriate number and mix of nursing personnel. Public Law 107-135, which became effective January 1, 2002, required the VA to establish a nationwide VHA staffing policy to ensure the provision of appropriate high-quality care and services. At the time of this review, VHA had not mandated the use of a national nurse staffing methodology.

Status: As of September 30, 2005, 11 of 14 recommendations remain unimplemented pending VHA actions. VHA actions that address the staffing issue in the above OIG *Audit of VHA's Part-Time Physician Time and Attendance*, 02-01339-85, 4/23/03, will also address

unimplemented recommendations in this report. In 2002, VHA approved funding for the VA Nursing Outcomes Database project to collect data related to nurse-sensitive indicators of quality and integrated it into a national database, with a planned completion date the end of 2009. The Office of Nursing Services created a task force in FY 2003 that includes an assessment and analysis of current trends and structures that define nursing performance. Drafts of four proposed career paths continue to be refined and a potential additional grade will need to be addressed legislatively.

A VA nurse outcomes report is being prepared that looks at the 5-year outcomes study of nurses who have participated in VHA Employee Incentive Scholarship Program/National Nurse Education Initiative programs. Scholarships and tuition reimbursement are strong recruitment and retention tools and this report is designed to analyze VHA outcomes. The final report is expected in 2006. VAMCs have been manually collecting overtime data for the third and fourth quarters of FY 2005. A final report will be prepared in FY 2006. The National Center for Organizational Development has analyzed data from the most recent VHA all-employee surveys to that of the all-employee survey results from the 10 facilities originally surveyed by OIG. Preliminary results indicate that there is no statistical significance difference between the 10 facilities and the universe surveyed. Action is held in abeyance pending review of the overtime data currently being manually collected.

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Report: *Evaluation of Selected Medical Care Collections Fund First Party Billings and Collections*, 03-00940-38, 12/1/04

The purpose of the evaluation was to determine the appropriateness of Medical Care Collections Fund (MCCF) first party billings and collections for certain veterans receiving C&P benefits. Current Federal law requires VA to collect fees (copayments) for medical care and medications provided certain veterans for nonservice-connected conditions. Veterans receiving compensation for service-connected disabilities rated 50 percent or higher or VA pensions based on being totally disabled with low income are generally exempt from copayments and should not be billed. OIG's evaluation focused on the appropriateness of debts, for veterans receiving compensation for service-connected disabilities rated 50 percent or higher or VA pensions, which VHA referred to the Debt Management Center, St. Paul, MN for collection.

Status: As of March 31, 2006, two of four recommendations remain unimplemented pending development of VETSNET.

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Report: *Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado*, 04-01805-55, 12/27/04

The OIG review evaluated selected operations, focusing on patient care administration, quality management, and financial and administrative controls. The CAP review covered 16 operational activities. The system complied with selected standards in four areas. The remaining 12 areas resulted in recommendations or suggestions for improvement.

Status: As of March 31, 2006, one of nine recommendations remains unimplemented. OIG recommended the Medical Center Director take action to ensure that infection control, safety, and cleanliness standards are maintained by assessing the system's vulnerability to aspergillus contamination and infection, continuing efforts to rigorously clean and maintain

the environment, determining the steps needed to prevent future aspergillus outbreaks, and diverting immunocompromised patients until clearance is received from the Under Secretary of Health.

The recommendation remains unimplemented pending installation of a forced air ducted ventilation system in the subbasement to exhaust air outside the facility; and pending additional dispensers being added to meet the requirements of VHA Directive 2005-002, "Required Hand Hygiene Practices," issued January 13, 2005.

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Report: *Evaluation of Sole-Source Contracts with Medical Schools and Other Affiliated Institutions*, 05-01318-85, 2/16/05

Since the beginning of FY 2000, OIG has been conducting preaward reviews of proposals for contracts to be awarded on a sole-source basis to VA affiliates. These reviews, combined with postaward reviews, CAP reviews, and interactions with VA personnel, identified numerous issues that need to be addressed. This report advised of OIG's collective findings and made recommendations for improvement in the procurement of health care resources in order to ensure quality health care is provided to veteran patients and to protect the interests of the Government.

Status: As of March 31, 2006, 32 of 35 recommendations remain unimplemented pending the publication of VHA Health Care Resources Contracting – Buying Directive.

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Report: *Healthcare Inspection, Emergency Decontamination Preparedness, VA Salt Lake City Health Care System, Salt Lake City, Utah*, 05-00290-78, 2/8/05

OIG reviewed emergency decontamination preparedness at the VA Salt Lake City Health Care System, Salt Lake City, Utah. Congressman Lane Evans requested that OIG review the decontamination program at the medical center, including conducting an inventory of decontamination equipment and determining whether training requirements had been established. He also requested a general review of decontamination capabilities at VA medical centers with decontamination programs.

Subsequent to the events of September 11, 2001, Public Law 107-188, dated June 12, 2002, *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*, and Public Law 107-287, dated November 7, 2002, *Department of Veterans Affairs Emergency Preparedness Act of 2002*, clarified VA's role in preventing, preparing for, and responding to bioterrorism and other public health emergencies. These laws require that VA provide decontamination and personal protection equipment at VHA medical centers and train employees in the use of such equipment.

Status: As of March 31, 2006, one of two recommendations remains unimplemented. The VISN Director needs to ensure that the Health Care System Director conducts and reports decontamination training and exercises to Central Office, as required, after receiving decontamination equipment. This recommendation is pending completion of decontamination training and exercises, and reporting the completion of this training to Central Office.

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Report: *Combined Assessment Program Review of the Minneapolis VA Medical Center, Minneapolis, Minnesota*, 04-03408-113, 3/25/05

OIG conducted a CAP review of the Minneapolis VA Medical Center, Minneapolis, Minnesota. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. This CAP review focused on 16 areas. There were no concerns identified in seven areas. The remaining nine areas resulted in recommendations for improvement.

Status: As of March 31, 2006, 2 of 25 recommendations remain unimplemented. OIG will close these recommendations upon receipt of documentation showing reduction of excess medical supply inventory to a 30-day turnaround supply and documentation of unannounced inspections.

Office of the Assistant Secretary for Management

Unimplemented Recommendations and Status

Report: *Evaluation of VA Compliance with Federal Energy Management Policies*, 02-00986-101, 3/9/05

OIG conducted an evaluation to determine whether VA complied with Federal energy management policies and to assess VA's effectiveness in reducing energy consumption and costs. OIG conducted the evaluation in accordance with the *Energy Policy Act of 1992*, which encourages OIGs to conduct periodic reviews of their agencies' compliance with the *National Energy Conservation Policy Act of 1978* and other laws relating to energy consumption.

Status: As of March 31, 2006, six of seven recommendations remain unimplemented. NCA and VBA will provide the names once VHA has identified the energy managers serving each VISN. VHA will incorporate the duties of Energy Manager into the position descriptions of selected facility managers. Energy management responsibilities are already incorporated into the capital asset manager position description. Once facility energy supervisors have been selected, VHA will conduct a survey to determine its training needs. VBA has four owned facilities and one direct leased facility that are eligible for energy audits. The VARO Phoenix is a new direct leased facility that was activated within the past year and does not require an audit. The audit for VARO Montgomery was completed June 3, 2005. VBA will conduct audits for the Jackson, Houston, and St. Petersburg VAROs during FY 2006.

Revisions to Handbook 3140 regarding procedures of the Management and Decision Support System were completed in November 2005, and a draft is currently being circulated for review within the NCA organization. Interim guidance has been provided to field personnel who are responsible for the input of energy data. VBA's local official is the field station Energy Liaison who, prior to input, reviews and approves data for the VSSC Energy Database. A member of VBA's Central Office Energy Team then reviews the VSSC automatic data validation checks report and forwards exceptions to the relevant local official for review and explanation/correction. Testing of the MADSS database has been completed. OIG will close the recommendation upon receipt of the 2005 energy and cost report.

Office of Human Resources and Administration

Unimplemented Recommendations and Status

Report: *Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program (WCP) Cost*, 02-03056-182, 8/13/04

OIG conducted a follow-up audit of the VA Workers' Compensation Program. A 1998 OIG audit identified opportunities for VA to strengthen WCP case management and reduce program costs by more effectively identifying employees who can be brought back to work or should be removed from the rolls. A 1999 OIG audit found that VHA was vulnerable to abuse, fraud, and unnecessary costs associated with WCP claims in certain high-risk areas reviewed. The objectives of the current audit were to:

1. Evaluate implementation of recommendations included in the 1998 and 1999 OIG WCP audits.
2. Identify opportunities to improve VA's case management associated with WCP claims and reduce program costs.
3. Identify the extent of potential fraud associated with WCP claims.

Status: As of September 30, 2005, 15 of 16 recommendations remain unimplemented pending VA actions. A Workers' Compensation Strategic Planning Committee was formed in October 2004, and a strategic plan was approved in February 2005 that consists of five strategic goals: case management; return to work; education; partnerships; and identify and reduce fraud, waste, and abuse. The Strategic Planning Committee meets monthly to review progress toward meeting the goals.

Managers from both OIG and the Office of Human Resources and Administration met on March 29, 2006, to discuss planned actions that could satisfy the intent of certain recommendations and lead to their closure. The representatives also agreed to meet on a regular basis to discuss any remaining issues, the progress that is being made on resolving those issues, and what still needs to be done to allow OIG to close them.

Multiple Office Action

Unimplemented Recommendations and Status

Report: *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*, 04-01371-177, 8/11/04

OIG conducted an evaluation of selected patient care and administrative issues at the Bay Pines VA Medical Center (BPVAMC), Bay Pines, Florida. The evaluation also included reviews of VA Central Office contract procedures and the deployment of CoreFLS.

The Secretary, Members of Congress, and other stakeholders requested that the OIG review reported delays in elective surgeries, major shortages of surgical supplies, and other allegations concerning BPVAMC activities; and whether the deployment of CoreFLS contributed to these reported problems. The Secretary also requested a private contractor to determine the viability of the CoreFLS software package to accomplish expected goals.

Status: As of September 30, 2005, 15 of 66 recommendations remain unimplemented pending actions by a number of VA staff offices. The Office of Management continues

to review expenditures made to the CoreFLS vendors and review all travel expenditures submitted by the vendor. The issue of discounts for Phase IV work and/or award fee will be considered within the context of OIG's continuing investigation of this matter.

Federal Information Processing Standards Publication 201 was issued in February 2005. It mandates that all departments be able to implement identity proofing and issuance process by October 2005, and begin issuing personal identification verification cards by October 2006. Furthermore, OMB has requested that a national rollout be completed by September 30, 2008. It is anticipated that VA's implementation of FIPS 201 requirements will correct concerns about background checks and contract employees as presented in the OIG report. However, this issue has not been finalized by OMB. Decisions on future CoreFLS activities are still pending.

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).

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	54
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	7-23
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	7-23
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	43
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	54
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	33-41
Section 5 (a) (7)	Summary of each particularly significant report	7-23
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	55
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	56
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	44-51
Section 5 (a) (11)	Significant revised management decisions	55
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	54
Section 5 (a) (13)	Information described under section 5(b) of the *Federal Financial Management Improvement Act of 1996* (Public Law 104-208)	54

INSPECTOR GENERAL ACT REPORTING REQUIREMENTS (CONT'D)

Prior Significant Recommendations Without Corrective Action and Significant Management Decisions

The IG Act requires identification of significant revised management decisions, and significant management decisions with which the OIG is in disagreement. During this 6-month period, there were no reportable instances under the Act.

Obtaining Required Information or Assistance

The IG Act requires the OIG to report instances where access to records or assistance requested was unreasonably refused, thus hindering the ability to conduct audits or investigations. During this 6-month period, there were no reportable instances under the Act.

Federal Financial Management Improvement Act of 1996 (Public Law 104-208)

The IG Act 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 requirements of Public Law 104-208. VA met its March 2006 milestones.

Review and Impact of Legislation and Regulations

The IG Act requires OIG to report on its reviews and comments on the impact of pending legislation and regulations. OIG coordinated concurrences on 20 legislative, 32 regulatory, and 75 administrative proposals from Congress, OMB, and VA. Of the 127 items, OIG commented or made recommendations concerning the impact of the legislation and regulations of 38 of them on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse.

Reports Issued Before this Reporting Period Without a Management Decision Made by the End of the Reporting Period

The IG Act requires a summary of audit reports issued before this reporting period for which no management decision was made by the end of the reporting period. There were no internal OIG reports unresolved for over 6 months.

Statistical Tables 1 and 2 Showing Number of Unresolved Reports

As required by the IG Act, Tables 1 and 2 provide statistical summaries of unresolved and resolved reports for this reporting period. Specifically, they provide summaries of the number of OIG reports with potential monetary benefits that were unresolved at the beginning of the period, the number of reports issued and resolved during the period with potential monetary benefits, and the number of reports with potential monetary benefits that remained unresolved at the end of the period.

Questioned Costs

For audit reports, it is the amounts paid by VA and unbilled amounts for which the OIG recommends VA pursue collection, including Government property, services or benefits provided to ineligible recipients; recommended collections of money inadvertently or erroneously paid out; and recommended collections or offsets for overcharges or ineligible costs claimed.

Table 1: Resolution Status Of Reports With Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 9/30/05	0	$0
Issued during reporting period	2	$.9
Total inventory this period	**2**	**$.9**
Management decisions during the reporting period.		
Disallowed costs (agreed to by management)	2	$.9
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Reporting Period	**2**	**$.9**
Total Carried Over To Next Period	**0**	**$0**

Disallowed Costs

Disallowed Costs are costs that contracting officers or management officials have determined should not be charged to the Government and which will be pursued for recovery; or on which management has agreed that VA should bill for property, services, benefits provided, monies erroneously paid out, overcharges, etc. Disallowed costs do not necessarily represent the actual amount of money that will be recovered by the Government due to unsuccessful collection actions, appeal decisions, or other similar actions.

Allowed Costs

Allowed Costs are amounts on which contracting officers or management officials have determined that VA will not pursue recovery of funds.

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 9/30/05	58*	$1,233.1*
Issued during reporting period	24	$21.6
Total inventory this period	**82**	**$1,254.7**
Management decisions during the reporting period.		
Agreed to by management	24	$155
Not agreed to by management	0	$0
Total Management Decisions This Reporting Period	**24**	**$155**
Total Carried Over To Next Period	**58**	**$1,099.7**

* These figures include contract review reports issued prior to 10/1/05. Contract review reports issued subsequent to 10/1/05 are not included and will not be included in future reports.

Recommended Better Use of Funds

For audit reports, it represents a quantification of funds that could be used more efficiently if management took actions to complete recommendations pertaining to deobligation of funds, costs not incurred by implementing recommended improvements, and other savings identified in audit reports.

Dollar Value of Recommendations Agreed to by Management

Dollar Value of Recommendations Agreed to by Management provides the OIG estimate of funds that will be used more efficiently based on management's agreement to implement actions, or the amount contracting officers disallowed in negotiations, including the amount associated with contracts that were not awarded as a result of audits.

Dollar Value of Recommendations Not Agreed to by Management

Dollar Value of Recommendations Not Agreed to by Management is the amount associated with recommendations that management decided will not be implemented, or the amount of questioned and/or unsupported costs that contracting officers decided to allow.

APPENDIX D

GLOSSARY

C&P	Compensation and Pension
CAP	Combined Assessment Program
CEO	Chief Executive Officer
CFS	Consolidated Financial Statement
CMOP	consolidated mail outpatient pharmacy
CoreFLS	Core Financial and Logistics System
CRC	Colorectal cancer
DEA	Drug Enforcement Administration
FBI	Federal Bureau of Investigation
FCP	Federal Ceiling Prices
FISMA	*Federal Information Security Management Act of 2002*
FSS	Federal Supply Schedule
FTE	Full-time Equivalent
FY	Fiscal Year
H/HHA	Homemaker and Home Health Aide
IG	Inspector General
IT	Information Technology
MCCF	Medical Care Collections Fund
MDS	Minimum Data Set
NCA	National Cemetery Administration
OA	Office of Audit
OA&MM	Office of Acquisition and Materiel Management
OCR	Office of Contract Review
OHI	Office of Healthcare Inspections
OI	Office of Investigations
OIG	Office of Inspector General
OMB	Office of Management and Budget
OR	Operating Room
PCIE	President's Council on Integrity and Efficiency
PCS	Permanent Change of Station
QM	Quality Management
SSA	Social Security Administration
USMS	U.S. Marshals Service
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VR&E	Vocational Rehabilitation and Employment
WCP	Workers' Compensation Program

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Office of Inspector General
Semiannual Report to Congress

October 1, 2005 - March 31, 2006