Office of Inspector General
Department of Veterans Affairs

Semiannual Report to Congress
April 1, 2006 - September 30, 2006

Message from the Inspector General

This Semiannual Report to Congress focuses on the Office of Inspector General's (OIG) accomplishments for the period of April 1, 2006, through September 30, 2006. Issued in accordance with the *Inspector General Act of 1978*, as amended, it presents results based on OIG strategic goals, which cover the areas of health care delivery, benefits processing, financial management, procurement practices, and information management.

During this reporting period, OIG issued 114 reports on VA programs and operations. We recommended systemic improvements and efficiencies in quality of care, accuracy of benefits, budget processes, improved information technology security, and economy in procurement. OIG audits, investigations, and other reviews identified over $723.8 million in monetary benefits, for a return of $19 for every dollar expended on OIG oversight. Our criminal investigators closed 652 investigations and made 333 arrests. OIG investigative work also resulted in 540 administrative sanctions.

OIG also issued a summary report to provide information on 296 Combined Assessment Program (CAP) facility review reports. The summary report provides information on recurring and systemic issues identified during OIG CAP reviews from January 1999 to August 2006, including issues that impact patient care; benefits administration; and financial, management, and administrative controls. OIG is changing its approach for performing CAP reviews. OIG's Office of Audit (OA) participation in CAP reviews will end to concentrate on performing national audits. However, OA will continue to review the systemic issues reported in CAP reviews. OIG's Office of Healthcare Inspections will continue to perform cyclical CAP reviews, and the Office of Investigations will provide fraud and integrity training for VA employees at VA health care facilities nationwide.

In another area, the Office of Contract Review collaborates with VA's Office of Acquisition and Materiel Management on preaward and postaward reviews specifically designed to improve VA's procurement process. Those efforts resulted in savings and dollar recoveries of $26.9 million.

Of particular note this reporting period was the residential theft and recovery of a VA employee's personally-owned laptop computer and external hard drive containing sensitive and personal information for approximately 26 million veterans and military personnel. This has been characterized as the single largest data breach in the history of the Federal government. In response to this theft, we conducted a joint criminal investigation with the Federal Bureau of Investigation (FBI) and the Montgomery County, Maryland, Police Department, which resulted in the recovery of the computer and external hard drive and the apprehension of two individuals charged with the theft. Following the recovery, an FBI computer forensics analysis determined that there was no evidence that VA data had been compromised as a result of the theft. Concurrently, OIG conducted an administrative investigation and review to address several critical issues related to VA information security, including: (1) the circumstances surrounding the employee's access to the sensitive data stored on his personal laptop computer; (2) the sequence of events within VA once officials learned of the theft; (3) the existing VA-wide policies and procedures; and (4) whether VA had sufficiently addressed long-standing information security weaknesses previously reported by OIG.

As a result of OIG's oversight activities in connection with this incident, VA officials initiated a broad review and revision of departmental security directives, and implemented an intense all-employee training program focusing on security awareness and the protection of *Privacy Act* data. This issue was also the focus of several congressional hearings.

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

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Statistical Highlights

The following statistical data highlights OIG activities and accomplishments during the April 1, 2006, through September 30, 2006, reporting period. Fiscal year (FY) 2006 figures appear on the right.

	Reporting Period	FY 2006
DOLLAR IMPACT ($$$ in Millions)		
Better Use of Funds	$526.6	$549.5
Fines, Penalties, Restitutions, and Civil Judgments	$44.9	$48.4
Fugitive Felon Program	$122.2	$242.9
Savings and Cost Avoidance	$26.9	$53.0
Questioned Costs	$0	$.9
OIG Dollar Recoveries	$3.2	$5.6
Contract Review Savings and Dollar Recoveries	$26.9	$118.3
RETURN ON INVESTMENT		
Dollar Impact ($723.8)/Cost of OIG Operations ($38.8)	19:1	
Dollar Impact ($900.3)/Cost of OIG Operations ($72.5)		12:1
Dollar Impact ($26.9)/Cost of Office of Contract Review Operations ($1.6)	17:1	
Dollar Impact ($118.3)/Cost of Office of Contract Review Operations ($3.1)		38:1
OTHER IMPACT		
Arrests[1]	333	712
Indictments	157	344
Criminal Complaints	118	214
Convictions	166	316
Pretrial Diversions	13	36
Fugitive Felon Apprehensions by Other Agencies Using VA OIG Data	64	141
Administrative Sanctions	540	833
ACTIVITIES		
Reports Issued		
CAP Reviews	31	64
Joint Review	1	2
Audits	7	31
Healthcare Inspections	24	45
Administrative Investigations	6	8
Contract Reviews	45	85
Investigative Cases		
Opened	646	1,296
Closed	652	1,167
Healthcare Inspections Activities		
Clinical Consultations	0	3
Hotline Activities		
Contacts	10,344	17,808
Cases Opened	630	1,181
Cases Closed	605	1,160

[1] Includes the apprehension of 113 and 216 fugitive felons by OIG, respectively, for this period and FY 2006.

VA and OIG Mission, Organization, and Resources

The Department of Veterans Affairs

The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to the Nation. 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."

While most Americans recognize VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2006, VA had a $73 billion budget and almost 223,000 employees serving an estimated 24.4 million living veterans. To serve the Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

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.

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

VA Office of Inspector General

OIG was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, Public Law 95-452, the *Inspector General Act*, was enacted, establishing a statutory Inspector General (IG) in VA. 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 IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 485 allocated employees, is organized into three line elements: the Offices of Investigations, Audit, and Healthcare Inspections, plus a contract review office and a support element. FY 2006 funding for OIG operations provided $72.5 million from appropriations. The contract review office received $3.1 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. In addition to the Washington, DC, headquarters, OIG has field offices located in 23 cities throughout the country.

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

Health Care Delivery

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

OFFICE OF HEALTHCARE INSPECTIONS

OIG's Office of Healthcare Inspections (OHI) focused on quality of care issues in VHA and assessed VHA services in response to veterans and active duty service personnel returning from Afghanistan and Iraq. OHI published 29 cyclical CAP reviews to evaluate quality of care issues in VHA medical facilities, 21 hotline reports, and the 3 national reviews.

Traumatic Brain Injury Rehabilitation Needs Improvement

This review addressed the care of individuals who served in OEF/OIF and suffered a traumatic brain injury (TBI) either during their service in Southwest Asia or subsequent to such service while on active duty. The purpose of the review was to describe the status of these individuals following inpatient rehabilitation and to explore the functioning of VHA's network of care in support of them. OHI concluded that the 52 patients interviewed continued to suffer some degree of cognitive and behavioral impairment approximately 16 months after injury. VA TBI patients had very similar outcomes compared with a matched group of non-VA patients. Long-term case management efforts need improvement, and families need additional support in the care of TBI patients.

The Under Secretary for Health concurred with OHI's findings and took corrective actions, which included improving case management for veterans with complex and multiple injuries, including TBI, and revising VA's 2002 memorandum of agreement (MOA) with the Department of Defense (DoD) regarding referral of active duty military personnel who sustain spinal cord injury, TBI, or blindness to VA's medical facilities for health care and rehabilitative services. The MOA provides a comprehensive summary of the coordinated policy and procedures that ensure TBI patients receive the necessary continuing care regardless of their active duty status and amends the billing/reimbursement charges for services rendered. The revised MOA took effect in October 2006. VA will continue to stress the need for family support and to support families within the bounds of its authority. VA also developed VHA's *Handbook 1172.1* that identifies the processes to facilitate referral and transfer of clinical care of patients with TBI for rehabilitation. *(Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation)*

Veterans' Access to PTSD Treatment Needs Improvement

Inspectors reviewed allegations that a VHA facility denied eligible veterans access to post-traumatic stress disorder (PTSD) treatment. The purpose of this review was to determine the validity of allegations that: (1) the facility denied access to PTSD treatment to eligible patients if the patients were unable or unwilling to participate in research protocols, abusing substances, medically or psychiatrically unstable, or not of the appropriate age group; and (2) patients who were deemed unsuitable for the PTSD program had to opt for treatment at a VA Vet Center as a default.

OHI did not substantiate the allegation that patients were denied access to the PTSD program. However, OHI did substantiate that patients who were medically or psychiatrically unstable were excluded from the program, which is consistent with appropriate standards of care. OHI concluded that patients were not denied access to the PTSD program based on their willingness to participate in research protocols or their age. Also, OHI concluded that patients who were unable to participate in treatment provided in the PTSD program because of substance use/abuse or unstable medical and psychiatric conditions were appropriately excluded and referred to other treatment programs. Additionally, OHI did not substantiate that the patients not accepted into the PTSD program were referred only to the Vet Center. OHI further concluded that patients who were not

accepted into the PTSD program could access treatment in the outpatient department (OPD) and were not by default referred to the Vet Center.

OHI concluded that there was no policy that clearly defined admission and exclusion criteria for the PTSD program, and recommended that the facility director require a comprehensive policy governing the PTSD program's admission and exclusion criteria be developed, implemented, and followed consistently by all clinicians in mental health services. OHI also recommended the facility director ensure VA/DoD-recommended treatment modalities are available to clinically appropriate patients with PTSD regardless of whether they obtain their treatment through the PTSD program or OPD clinic. The facility director agreed with OHI's findings and recommendations and provided acceptable improvement plans. *(Access to Post-Traumatic Stress Disorder Treatment, James J. Peters VA Medical Center, Bronx, New York)*

Returning Veteran's Suicide Prompts Quality of Care Review

A U.S. Senator requested an investigation into the care that a young OEF/OIF veteran received at a VA medical center (VAMC). This reservist committed suicide. The Senator's request was made on behalf of the patient's parents who expressed concerns regarding the quality of care received by their son. In addition, the parents alleged that the VAMC refused to release all medical records related to their son's treatment. The purpose of this review was to determine the validity of the quality of care concerns and the alleged refusal to release all medical records pertaining to this patient's care. OHI concluded that:

- The patient's involuntary admission was appropriate. VAMC clinicians followed procedures during his involuntary hospitalization.
- The patient had the option to receive outpatient psychiatric treatment, but would not have satisfied usual criteria for admission to the specialized inpatient care.
- The patient was appropriately discharged although his family was not asked to attend a discharge planning meeting.
- The patient's behavior 4 days after discharge from the VAMC did not satisfy criteria to support an involuntary admission. The inpatient ward milieu may have influenced the patient's request for discharge and his unwillingness to be readmitted later. The patient declined follow-up at the VAMC mental health clinic.

OHI concluded that the facility did what it could for this patient under the circumstances. The VAMC provided the family with the patient's medical record and properly withheld internal quality assurance documents. OHI also concluded that because the VAMC is a medical center that primarily offers psychiatric care, it would be advantageous for a psychiatrist to see patients on the acute inpatient unit on a daily basis including weekends and holidays.

The VAMC director concurred with OHI's findings and established a procedure whereby the psychiatrist on call will review all possible admissions. Mental health clinicians also redesigned the VAMC's PTSD program to increase access for recently diagnosed PTSD patients, concurrently treat substance abuse and PTSD, and create a PTSD clinical team to provide accessible outpatient treatment to patients to prevent hospitalizations. Further, clinicians developed a policy to address the need for new patients admitted to the inpatient psychiatry unit on a temporary involuntary hold to be evaluated by a psychiatrist on a daily basis, including weekends and holidays. *(Review of Quality of Care Involving a Patient Suicide)*

VHA Needs to Increase Veterans' Access to Non-Institutional Care

In response to a congressional request, OHI reviewed VHA's process to ensure that all eligible veterans who are enrolled and present a clinical need have adequate access to care. The objectives were to determine whether eligible veterans had access to non-institutional care, were enrolled and provided timely care if they wanted it, and received clinically indicated elective procedures within reasonable time frames. Inspectors concluded that VHA had established policies and performance measures to ensure that eligible veterans have the opportunity to receive their care in non-institutional settings when appropriate,

but opportunities exist for VHA to further increase veteran access to non-institutional care. The enrollment process at the five facilities visited complied with national enrollment policies and did not include any local barriers that prevented or discouraged veterans from enrolling. However, medical facilities needed to track new enrollees to ensure that those who want care receive care, and VHA needed to establish acceptable time standards and require medical facilities to measure the time veterans wait for elective procedures. OHI made three recommendations to improve veterans' access to care. The Under Secretary for Health concurred. *(Review of Access to Care in the Veterans Health Administration)*

AIG for Healthcare Inspections Testifies on Patient Safety Issues

On June 15, 2006, the Assistant Inspector General (AIG) for Healthcare Inspections testified before the Subcommittee on Oversight and Investigations of the Committee on Veterans Affairs, U.S. House of Representatives, on patient safety issues at the VA. This testimony centered on recent OHI reports on processing sterile materials for use in medical procedures and suggestions to improve current procedures.

CAP REVIEWS

VHA Environment of Care and Management Need Improvement

OHI inspectors conducting environment of care inspections during VHA medical facility CAP reviews from January 1999 through August 2006 identified 119 facilities where improvements were needed. The most frequent deficiencies were in the categories of safety, cleanliness/sanitation, and infection control. CAP review reports have also contained recurring findings that show pharmacy drug controls, including accountability for controlled substances and pharmacy physical security, needed improvement at 175 VHA medical facilities. OIG oversight of quality management (QM) in VHA facilities concluded that many have established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas.

Auditors participating in OIG CAP reviews at VHA facilities found that VHA financial and management controls for accounts receivable, agent cashier activities, contract award and administration, Government purchase cards, information security, and management of equipment and supply inventories were consistently reported as needing improvement. Auditors also focused on VHA controls over part-time physicians' time and attendance and reported that some part-time physicians are not fully meeting their VA employment obligations. These reviews found that VHA needs to strengthen controls to provide better assurance of success for its operations. VHA must institute comprehensive and rigorous oversight over these activities to realize improvements. *(Review of Recurring and Systemic Issues Identified During Combined Assessment Program Reviews at VA Facilities January 1999 through August 2006)*

OFFICE OF INVESTIGATIONS

OIG's Office of Investigations (OI) conducts criminal investigations into allegations of patient abuse, facilities security, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for health care benefits, and other frauds relating to the delivery of health care to millions of veterans. In the area of health care delivery, OIG opened 197 cases, made 127 arrests, and obtained $2,557,806 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies/cost avoidance, and recoveries.

Corporate Executives Guilty in Patient Safety Conspiracy

Two former top corporate executives were found guilty of multiple felony counts of conspiracy and fraud involving the manufacture, promotion, and sale of a system marketed to hospitals to sterilize medical instruments. A joint investigation with Food and Drug Administration (FDA) exposed the conspiracy to defraud the Government by selling more than 160 sterilizers to hospitals nationwide, including VAMCs, without FDA approval. At least six VA patients suffered severe eye injuries. One executive was sentenced to 10 years' imprisonment and 3 years' probation. The other executive was sentenced to 6 years' imprisonment and 3 years' probation. They were ordered to make joint restitution of $17,209,075.

Veteran Steals Identity to Gain Unwarranted Benefits

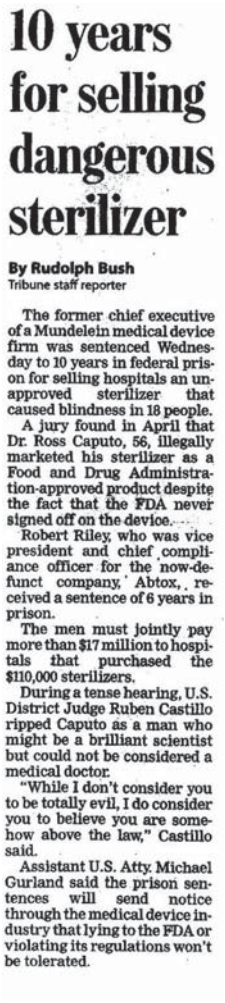
A veteran was arrested after a joint FBI, OIG, and VA police investigation disclosed that the veteran submitted an altered DD-214 military discharge record to a VAMC to obtain medical care and pharmaceuticals he was not entitled to receive. The DD-214 contained the Social Security number of another veteran. Because the defendant had been discharged from the military under less than honorable conditions, he was ineligible for certain VA benefits. As a result of the identity theft, the defendant received more than $100,000 in medical care, prescription medication, and medical devices from VA to which he was not entitled.

Nurse Steals Drugs From VA Intensive Care Patients

An allegation from the VA police resulted in an OIG investigation of a staff nurse in the intensive care unit (ICU) of a VAMC who diverted doses of Fentanyl, a Schedule II controlled substance intended for ICU patients, for 3 years. The nurse resigned and pled guilty to obtaining a controlled substance through fraud after admitting that she had replaced Fentanyl syringes with syringes containing saline solution. She was sentenced to 12 months' probation and fined $500.

Gang Member Convicted in Murder of VA Police Officer

A VA police officer who was shot three times while standing post at a VAMC died in the emergency room. A joint investigation with the FBI violent crimes task force disclosed that the officer was killed by members of a local street gang attempting to steal his Government-issued firearm. A jury trial resulted in the conviction of one defendant for murder, who awaits sentencing this fall.



10 years for selling dangerous sterilizer

By Rudolph Bush
Tribune staff reporter

The former chief executive of a Mundelein medical device firm was sentenced Wednesday to 10 years in federal prison for selling hospitals an unapproved sterilizer that caused blindness in 18 people.

A jury found in April that Dr. Ross Caputo, 56, illegally marketed his sterilizer as a Food and Drug Administration-approved product despite the fact that the FDA never signed off on the device.

Robert Riley, who was vice president and chief compliance officer for the now-defunct company, Abtox, received a sentence of 6 years in prison.

The men must jointly pay more than $17 million to hospitals that purchased the $110,000 sterilizers.

During a tense hearing, U.S. District Judge Ruben Castillo ripped Caputo as a man who might be a brilliant scientist but could not be considered a medical doctor.

"While I don't consider you to be totally evil, I do consider you to believe you are somehow above the law," Castillo said.

Assistant U.S. Atty. Michael Gurland said the prison sentences will send notice through the medical device industry that lying to the FDA or violating its regulations won't be tolerated.

Chicago Tribune, Chicago, IL
September 14, 2006

Benefits Processing

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

OFFICE OF AUDIT

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

Better Oversight Needed to Protect Incompetent Beneficiaries

VBA needs to provide more effective program oversight to reduce the increased risk of fraud, misuse, or theft of beneficiary funds for beneficiaries who have been determined to be incompetent. When a probate court or VA rating board determines a VA beneficiary is incompetent to care for his or her financial affairs, VBA personnel must assess the need for a fiduciary, appoint an appropriate person or entity to manage the beneficiary's funds, and monitor the management of those funds. As of May 2004, the fiduciary program was responsible for supervising the benefits of over 100,000 VA beneficiaries, including disabled veterans, widows, adult disabled children, and minors. The benefits paid to these beneficiaries total over $1 billion annually. The reported value of supervised estates comprised of both VA and non-VA income is over $2.8 billion. These beneficiaries and their funds are at increased risk for fraud.

Past audits have shown that beneficiary funds were not always adequately protected by surety bonds or bond values were inadequate. OIG concluded that VBA needed to better monitor fiduciaries required to submit periodic accountings of income and expenses, and to require documentation of reported fiduciary expenses because some fiduciaries and attorneys had charged excessive fees. In a recent audit, OIG estimated that $435 million in benefits payments and estates for just over 8,900 beneficiaries were at risk for misuse because of inadequate oversight. Additionally, approximately 2,100 incompetent beneficiary estates nationwide could be subject to fraud with an estimated impact of about $80.2 million, because VBA personnel did not follow up on questionable or incomplete data in fiduciary accountings and did not require documentation to support claimed expenses. This audit helped identify opportunities to ensure VBA adequately protects the incomes and estates of beneficiaries who cannot take care of their financial affairs from fraud, waste, and other abuses. *(Audit of Veterans Benefits Administration Fiduciary Program Operations)*

Systemic Deficiencies Continue To Threaten Benefits Services

OIG conducted CAP reviews at VBA facilities to ensure high-quality benefits services. Auditors examined a variety of risks and vulnerabilities in regional office operations, focusing on financial and management controls.

CAP reviews at VBA regional offices identified systemic deficiencies that were negatively impacting the efficiency of benefits administration activities. During these reviews auditors examined Government purchase card activities, information security, security of sensitive records, and management performance issues. In addition, OIG reviewed VBA program specific activities and controls for the compensation and pension program's (C&P) hospital adjustments, payments to incarcerated veterans, future medical examinations, fiduciary and field examination program activities, and controls for the vocational rehabilitation and employment program.

These reviews found that persistent systemic deficiencies continue to pose unnecessary risks to VBA operations. VBA needs to make additional efforts to strengthen controls to provide better assurance of success and to institute comprehensive and rigorous oversight of these activities to realize improvements. *(Review of Recurring and Systemic Issues*

Identified During Combined Assessment Program Reviews at VA Facilities January 1999 through August 2006)

OFFICE OF INVESTIGATIONS

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

C&P investigations routinely concentrate on payments being made to ineligible individuals. For example, a beneficiary may feign a medical disability to deliberately defraud the VA compensation program. The VA pension program, which is based on the beneficiary's income, is often defrauded by individuals who fail to report income in order to stay below the eligibility threshold for these benefits. OI's ongoing proactive income verification match identifies possible fraud in the pension program. OI's ongoing death match project identifies deceased beneficiaries of VA's C&P program whose benefits continue because VA was not notified of the death. In this reporting period, the death match project recovered $2 million, with another $1.2 million in anticipated recoveries. Generally, family members of the deceased are responsible for this type of fraud. In the area of benefits processing, OIG opened 307 cases, made 84 arrests, and had $31,288,711 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies/cost avoidance, and recoveries.

Over $1 Million Missing in Fiduciary Fraud

A VA fiduciary unit in Los Angeles, CA, alerted OIG that a VA fiduciary managing the financial affairs of more than 60 incompetent veterans had mismanaged their assets. OIG's investigation revealed that the fiduciary could not account for over $1 million entrusted to her. The investigation also disclosed an additional culpable subject, the fiduciary's lawyer. They were indicted on 15 counts, including conspiracy, perjury, forgery, submission of false evidence, grand theft, and embezzlement from an elder. The attorney pled guilty to multiple counts and was sentenced to 40 months' imprisonment and ordered to pay $740,187 in restitution. The fiduciary awaits trial.

Fugitive Felon Who Swindled Terminally Ill Veteran Arrested

A veteran wanted for financial elder abuse was arrested by OIG and the U.S. Marshals Service. A state prosecutor had requested OIG's assistance in locating and apprehending the fugitive, who together with an accomplice had defrauded a terminally ill veteran of $220,000. The two subjects befriended the veteran and used their friendship to swindle the veteran of his life savings. The subjects also used the same scam to defraud additional victims out of approximately $50,000. The second defendant was convicted and sentenced to substantial jail time. The fugitive felon is awaiting trial.

Joint Investigation Catches Equity Skimmer

OIG conducted a joint investigation with Department of Housing and Urban Development OIG after receiving an allegation from the U.S. Trustee's Office about a suspected bankruptcy fraud scheme commonly referred to as equity skimming. The investigation determined that an individual held foreclosure seminars leading people to believe that he could arrange for them to own their home, even if currently in foreclosure, in a short amount of time. Once employed, he filed bankruptcy proceedings on behalf of unwitting clients, allowing him to steal funds received from them for making mortgage payments in their behalf. A Federal grand jury charged the subject in an 11-count indictment that included bankruptcy, wire, and mail fraud violations. He awaits trial.

Couple Defraud VA to Collect for Daughters' College Costs

OIG investigated a husband and wife for benefits fraud. The investigation proved that the husband made false statements to VA to obtain an undeserved 100 percent disability rating and financial compensation from VA. As a result, each of his stepdaughters received

VA funds for their college education. The husband was charged with conspiracy to commit health care fraud, money laundering, and theft of public money. The wife was charged with misprision of felony. Both pled guilty. The husband was sentenced to 46 months' incarceration and 3 years' probation, and was ordered to pay restitution of $135,945. The wife was sentenced to 30 days' imprisonment and 1 year of probation, and was ordered to pay of $126,133.

VA Beneficiary Caught Trying to Get a Second Check

Alerted by a VBA employee about a retroactive $234,360 lump sum payment, OIG investigators determined that a VA beneficiary lied when he claimed that he neither received nor negotiated a $99,999 check that was part of the payment, resulting in a replacement check being issued for the same amount. The man was convicted of theft and awaits sentencing.

Two Fugitive Felons Apprehended in Separate Cases

A local police department requested OIG assistance in apprehending a veteran wanted on an outstanding felony warrant for sexual assault. The veteran was subsequently located at a VA facility and was taken into custody by the local police with the assistance of OIG and VA police. The veteran, who had an extensive criminal record, was also charged with drug possession for cocaine at the time of his arrest.

A veteran was arrested by OIG and local police on an outstanding warrant of parole violation based on a previous robbery conviction. In addition, the veteran was also wanted on a warrant for assault with bodily injury. The veteran was identified as a result of OIG's fugitive felon program.

Financial Management

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

OFFICE OF AUDIT

The Office of Audit performs audits of financial management operations, focusing on adequacy of VA financial management systems in providing managers information needed to efficiently and effectively manage and safeguard VA's assets and resources. OIG's oversight work satisfies the *Chief Financial Officer Act of 1990* and the *Government Performance Results Act of 1992* audit requirements for Federal financial statements and provides timely, independent, and constructive reviews of financial information, programs, and activities. OIG's reports provide VA with constructive recommendations needed to improve financial management and reporting throughout the Department.

Congressional Concerns Prompt OIG Recommendations to VHA

VA stakeholders remain concerned that the Department's facilities have adequate funds to serve veterans' health care needs. Two U.S. Senators requested that OIG determine whether VHA's capital budgets were being utilized or set aside for health care spending, possibly signifying VA is facing a budget shortfall. At the same time, the Florida media reported a senator received an anonymous complaint alleging Veterans Integrated Service Network (VISN) 8 was anticipating a $200 million shortfall and Bay Pines VA Health Care System had a budget shortfall of over $20 million. Auditors examined three VISNs and concluded they were deferring nonrecurring maintenance projects and equipment purchases as a means of establishing a reserve for needs arising at the end of the budget cycle and that VISNs were not deferring the spending of capital funds for major and minor construction, major leases, and information technology projects.

As a result of this work, VHA is finalizing a request to transfer funding from the medical services account to the medical administration account to eliminate the anticipated deficit. Based on current spending rates at the VISNs reviewed, medical services spending should not exceed appropriations. However, because one VISN was anticipating a budget shortfall of $163.1 million in FY 2006, OIG recommended VHA and VISN managers perform a joint assessment to determine whether that VISN's proposed actions will have a negative impact on patient care and safety. The review identified opportunities to strengthen budget processes, address potential shortfalls, and helped assess resource allocations VHA-wide. *(Report of Audit Congressional Concerns over Veterans Health Administration's Budget Execution)*

OFFICE OF HEALTHCARE INSPECTIONS

OIG Evaluates VHA's Homeless Grant and Per Diem Program

VA estimates that about one-third of the adult homeless population in the United States is comprised of veterans, with about 200,000 homeless veterans living on the streets or in shelters on any given night, and possibly as many as 400,000 veterans homeless at some time during the course of the year. OIG evaluated VHA's Homeless Grant and Per Diem (GPD) Program, which is authorized to establish alternative housing for homeless veterans through partnerships with non-profit or local Government agencies. The evaluation focused on determining whether the program's financial controls were effective and reviewed the administration of the program to determine whether per diem rates paid to providers were appropriate. In addition, OIG assessed whether financial reviews of grants and per diem payments were sufficient to prevent overpayments to grant providers. The review showed that GPD providers generally met requirements regarding accounting for program funds and allocations of costs, but VAMC monitoring and oversight of grant providers was

inadequate. OIG identified instances where per diem rates were overstated and noted that some overpayments went undetected because VA did not have adequate procedures in place, prior to March 2006, to conduct incurred cost reviews of grant providers. The review determined that 20 of the 32 programs reviewed were overpaid about $1.5 million, and it concluded financial oversight of GPD providers should be centralized to provide consistent oversight of grant providers. *(Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program)*

OFFICE OF INVESTIGATIONS

Former VA Nurse Pleads Guilty in Workers' Compensation Fraud

A former VA nurse pled guilty to fraudulently receiving more than $246,000 in worker's compensation benefits for an injury sustained 10 years ago at a VAMC. A joint investigation with Department of Labor OIG revealed that she submitted fraudulent paperwork stating that she was unable to hold gainful employment because of her disability, despite earning more than $100,000 while employed as an adult care giver.

Procurement Practices

VA spends over $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction, and services. In response to a May 2001 OIG report, the VA Secretary established a Procurement Reform Task Force. VA has implemented 60 of the 65 recommendations the Task Force made, as well as numerous other OIG recommendations for improvement. OIG contract audits focus on compliance with Federal and VA acquisition regulations and cost efficiencies. Preaward and postaward contract reviews have resulted in $26.9 million in monetary benefits during this reporting period.

OFFICE OF AUDIT

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

VHA Could Save $6.2 Million in Transcribing Medical Services

VA physicians and other health care providers record their medical assessments—such as admission and discharge summaries, operative reports, and consultations—through dictation that is then transcribed into documents that become part of the patient medical file. VA contracts out for most medical transcription work, although some is performed in-house by VA employees. This audit was initiated after an OIG hotline complaint disclosed that a contractor transcribing reports for several VHA facilities had submitted erroneous invoices. Auditors examined whether VHA had adequate controls to ensure patient health care information (PHI) was secure against unauthorized access once the information was in the possession of a contractor and assessed whether VHA transcription services were acquired economically, efficiently, and in compliance with applicable laws and regulations.

Results showed staff at VHA medical facilities did not adequately verify supporting information when approving invoices for payment, which resulted in overpayments to some contractors. In addition, facilities did not ensure PHI sent to transcription contractors was protected against unauthorized access or use. This review recommended using speech recognition technology to transcribe medical reports in-house as an alternative to outsourcing to resolve security concerns about PHI and reduce costs by as much as $6.2 million annually. OIG identified opportunities to help VHA ensure contractors safeguard patients' PHI and provided recommendations to strengthen management controls over patient privacy and invoice verification practices. *(Audit of the Veterans Health Administration's Acquisition of Medical Transcriptions Services)*

VA's Compliance with the *Economy Act* Could Be Improved

As Federal agencies increasingly use contracts and acquisition services offered by other agencies on a reimbursable fee basis, they often use existing interagency contracts to save time and administrative effort. Increased use of interagency contracts has come about as a result of various legislative reforms passed in the 1990s that allowed Federal agencies to streamline the acquisition process, operate more business-like, and offer increasing types of services to other agencies on a reimbursable basis. OIG audited VA acquisition for other Government agencies (OGAs) and found that two VHA contracting activities did not comply with *Economy Act* regulations when administering acquisitions for OGAs by charging the OGAs excessive service fees of about $8.1 million in FYs 2003 and 2004. Additionally, contracting officers made interagency acquisitions that often did not comply with Federal and VA acquisition regulations and violated VA policy by making 35 interagency acquisitions valued at about $15 million that were not within the scope of VA's mission.

VHA and VA's Office of Acquisition and Materiel Management (OA&MM) are addressing the recommendations to ensure compliance with the *Economy Act*, Federal Acquisition Regulations, and VA policy, as well as to centralize management of interagency acquisition programs under OA&MM. The Under Secretary for Health agreed to transfer management of interagency acquisitions under the *Economy Act* and the *VA-DoD Healthcare Resources and Emergency Operations Act of 1982* to OA&MM. *(Audit of VA Acquisitions for Other Government Agencies)*

OFFICE OF INVESTIGATIONS

OI investigates allegations of bribery and kickbacks, bid rigging and antitrust violations, false claims submitted by contractors, and other fraud relating to VA's procurement activities. In the area of procurement practices, OIG opened 14 cases, made 6 arrests, and had $41,067,525 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies/cost avoidance, and recoveries.

Pharmaceutical Company Fined Millions for Drug Promotion

A joint investigation found that a major pharmaceutical company had improperly promoted several of its drugs for uses that were not approved by the FDA and had offered or paid kickbacks to physicians to prescribe those drugs. The Department of Justice reached a $435 million global settlement with the company and its sales subsidiary to resolve criminal charges and civil liabilities. The sales subsidiary agreed to pay a $180 million criminal fine and another $255 million together with the parent pharmaceutical company to settle civil liabilities. The sales subsidiary also pled guilty to making false statements regarding its best price for certain drugs, and will be excluded permanently from participation in all Federal health care programs. VA's portion of the settlement is approximately $3 million.

Schering-Plough Agrees To Plead Guilty, Pay Fine

By Denise Lavoie
Associated Press

BOSTON, Aug. 29 — Schering-Plough Corp. on Tuesday agreed to pay $435 million and plead guilty to conspiracy to settle a federal investigation into marketing of its drugs for unapproved uses and overcharging Medicaid for certain drugs.

Schering-Plough, of Kenilworth, N.J., said it will pay $255 million to resolve civil aspects of the previously disclosed investigation. A subsidiary, Schering Sales Corp., will pay a criminal fine of $180 million and plead guilty to one count of conspiracy to make false statements to the government. The agreement is subject to court approval.

Schering-Plough said the settlement resolves an investigation by the Department of Justice and the U.S. attorney in Boston that began before a new management team took over in April 2003.

"With this agreement, we are putting issues from the past behind us," said Brent Saunders, senior vice president for compliance and business practices.

The agreement comes two years after Schering-Plough agreed to pay $345 million to settle charges that it paid a kickback to a big health insurer to protect the market for its allergy drug, Claritin.

U.S. Attorney Michael J. Sullivan, who announced the settlement, said health care corruption "erodes public confidence, compromises the patient-physician relationship and adds costs to important government programs."

"The American people, as both taxpayers and consumers, expect our health care system to be free from fraud and corruption," Sullivan said.

The investigation that led to the settlement began in 2001. Investigators found evidence that Schering-Plough marketed drugs for so-called "off-label" uses not approved by regulators, even though doctors can choose to prescribe drugs for those purposes.

One such drug was Temodar, which the Food & Drug Administration in 1999 approved to treat a type of brain tumor in patients who had not responded to other drug regimens. Sullivan said Schering promoted the drug to treat several other types of brain cancers and cancer that spread to the brain from elsewhere, uses the FDA had not approved. Temodar, Schering's No. 4 drug, had sales of $588 million last year.

Saunders said the company has agreed to plead guilty to making false statements in marketing Temodar related to promotion of the drug to doctors for uses other than the approved one.

Sullivan also said Schering-Plough provided misleading information to the government about the pricing of Claritin RediTabs to secure business from a major health maintenance organization. Prosecutors said Schering gave free Claritin RediTabs to the unnamed HMO to disguise a new lower price it was offering the HMO. Drugmakers are required to report their best price on drugs provided to commercial customers to the Health Care Financing Administration and to pay rebates to the Medicaid program to make sure Medicaid obtains the benefit of that low price.

Prosecutors said that from April 1998 through 1999, Schering Sales reported a false best price to HCFA to avoid paying millions of dollars in additional rebates to Medicaid.

As part of the settlement, Schering said it would add a section to an existing corporate integrity agreement it has with the Department of Health and Human Services. The agreement requires the company to monitor its sales, marketing and drug pricing, and to correct past abuses.

Schering-Plough shares rose 2.6 percent, to close at $20.94 on the New York Stock Exchange.

Washington Post, Washington, DC
August 29, 2006

VA Employee Accepts Bribes From Contractor

OIG, General Services Administration OIG, and VA police conducted a joint investigation into allegations of numerous billing irregularities by an auto repair shop for parts, labor, and other services related to the maintenance of VAMC vehicles. The investigation determined that a VA transportation program manager received bribes, including cash and checks, from a VA contractor to approve work on VA vehicles that was not needed, not done, and/or previously billed. This VA employee, who resigned early in the investigation and had previously pled guilty to bribery, was sentenced to 36 months' probation and ordered to pay a $3,000 fine. The owner of the auto repair shop and the corporation pled guilty to bribery and fraudulent acceptance of VA payments. The auto repair corporation was ordered to pay $150,000. The owner was sentenced to 6 months' home confinement and 12 months' probation, and was ordered to pay $27,747 in restitution.

OFFICE OF CONTRACT REVIEW

The Office of Contract Review (OCR) operates under a reimbursable agreement with OA&MM to provide preaward, postaward, and other requested reviews of vendors' proposals and contracts. In addition, OCR provides advisory services to OA&MM contracting activities. They completed 45 reports in this reporting period. The tables on the next page provide an overview of OCR performance.

Preaward reviews provide information to assist VA's contracting officers in ensuring the negotiation of fair and reasonable contract prices, and to identify monetary benefits. Preaward reviews identified $24,982,810 in potential cost savings during this reporting

period. Preaward reviews include FSS, cost-per-test, and the acquisition of health care provider services from VA affiliated medical schools.

CONTRACT PREAWARD REVIEWS

	April 1, 2006 – September 30, 2006	Summary FY 2006
Preaward Reports Issued	**23**	**50**
Potential Cost Savings	**$24,982,810**	**$98,754,797**

OCR conducted postaward reviews to ensure vendors' compliance with contract terms and conditions. These reviews resulted in the recovery of $1,906,327.

CONTRACT POSTAWARD REVIEWS

	April 1, 2006 – September 30, 2006	Summary FY 2006
Postaward Reports Issued	**21**	**34**
Dollar Recoveries	**$1,906,327**	**$19,526,903**

OTHER REPORTS ISSUED

	April 1, 2006 – September 30, 2006	Summary FY 2006
Special Report	**1**	**1**
Total Reports Issued	**45**	**85**

As a result of an OIG report based on OCR reports *(Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions)*, VA revised *VA Directive 1663—Health Care Resources Contracting—Buying* during this reporting period. Findings and recommendations in the OIG report were incorporated into the revised directive, and should result in improved contracting for health care resources.

Review of Ophthalmology Services Contract Identifies Deficiencies

A postaward review disclosed significant issues with the contract terms and conditions, including inconsistencies in the pricing schedule, the statement of work, and the invoicing. A review of timecards used for invoicing purposes showed that the VAMC did not receive the number of hours required under the contract. OCR identified nearly $740,000 in overcharges based on the level of services actually received.

Information Management

The loss of VA data on approximately 26 million veterans and military personnel highlights the challenges facing the VA in the area of information security. OIG conducted a criminal investigation, an administrative review, and a review of information technology (IT) security policies and procedures. Other investigations include theft of IT equipment or data, intrusions, identity theft, and child pornography. In the area of information management crimes, OIG opened 9 cases, made 3 arrests, and had $102,235 in fines, restitution, penalties, and civil judgments as well as savings, efficiencies/ cost avoidance, and recoveries.

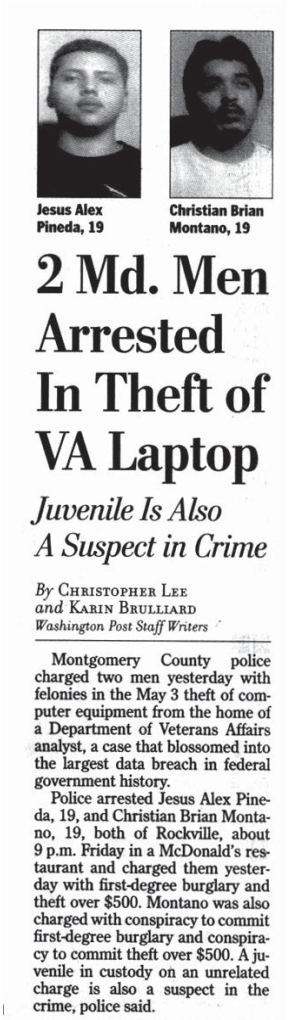
VA Data Loss Involves Identities of Millions of Veterans

The home of a VA employee was burglarized, resulting in the theft of a personally-owned laptop computer and external hard drive, which was reported to contain personal information on approximately 26 million veterans and U.S. military personnel. VA staff did not notify the Secretary of the breach for 14 days. OIG conducted a joint criminal investigation with the FBI and the Montgomery County, Maryland, Police Department to recover the stolen computer hardware, arrest the burglars, and establish whether the VA data had been compromised following the burglary. Investigators recovered the stolen computer equipment, and the FBI computer forensics analysis found no evidence to indicate that the missing VA data had been compromised. Two 19-year old males were charged with the burglary.

OIG conducted an administrative review into the loss of the data. Investigators found the employee was not authorized to take VA data home and did not encrypt or password protect the data. Senior officials failed to recognize the magnitude of the incident and did not identify it as a high priority item needing to be reported to the Secretary, and information security officials acted with indifference and little sense of urgency. OIG's review also found VA policies and procedures did not adequately protect personal or proprietary data. In addition, VA did not implement procedures for reporting and investigating incidents involving lost or stolen protected information as required by the *Federal Information Security Management Act of 2002* (FISMA), and did not implement the National Institute of Standards and Technology recommendations for security incident responses.

The Secretary agreed with the findings and recommendations. As a result of OIG's oversight activities in connection with this incident, VA officials initiated a broad review and revision of departmental security directives, and implemented an intense all-employee training program focusing on security awareness and the protection of *Privacy Act* data. VA has provided acceptable improvement plans based on OIG recommendations, and OIG will follow up on implementation. *(Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans)*

The data loss generated interest from both Congress and the public. Congress held a series of hearings at which OIG participated. The IG testified at a hearing of the House Committee on Veterans' Affairs and a joint hearing of the Senate Committee on Veterans' Affairs and the Senate Committee on Homeland Security and Governmental Affairs, on May 25, 2006. The IG also testified before the Senate Committee on Veterans' Affairs on July 20, 2006, on the results of OIG's review of the data loss.



Jesus Alex Pineda, 19

Christian Brian Montano, 19

2 Md. Men Arrested In Theft of VA Laptop

Juvenile Is Also A Suspect in Crime

By Christopher Lee and Karin Brulliard
Washington Post Staff Writers

Montgomery County police charged two men yesterday with felonies in the May 3 theft of computer equipment from the home of a Department of Veterans Affairs analyst, a case that blossomed into the largest data breach in federal government history.

Police arrested Jesus Alex Pineda, 19, and Christian Brian Montano, 19, both of Rockville, about 9 p.m. Friday in a McDonald's restaurant and charged them yesterday with first-degree burglary and theft over $500. Montano was also charged with conspiracy to commit first-degree burglary and conspiracy to commit theft over $500. A juvenile in custody on an unrelated charge is also a suspect in the crime, police said.

OIG Review Finds IT Security Deficiencies Remain Unresolved

Annually, OIG is required to review VA's compliance with FISMA. These reviews and work conducted during the CFS audit have led OIG to report information security and security of data and data systems as a major management challenge for the VA since FY 2000. The 2005 FISMA assessment again identified numerous unresolved recommendations from prior OIG reports that need to be fully addressed in order to mitigate information security weaknesses. VA leadership needs to take actions to implement a centralized IT program to ensure consistent administration and control of information and data; apply appropriate resources; establish, modify, and clarify IT policies and procedures; and implement and enforce security controls. *(FY 2005 Audit of VA Information Security Program)*

The AIG for Auditing testified twice on the results of recent OIG work related to information security weaknesses in VA and its implementation of previous OIG recommendations. On June 14, 2006, the AIG testified at the House Committee on Veterans' Affairs; and on June 20, 2006, the AIG testified at a joint hearing of the Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Economic Opportunity.

Stolen UNISYS Computer Recovered Without Data Compromise

A computer with VA data was stolen from Unisys Corporation, which provides software support to the Pittsburgh and Philadelphia VAMCs. The computer contained insurance claim data, including names, addresses, and personal identifiers, for approximately 16,000 patients treated in these two facilities or their community clinics. OIG and the FBI immediately opened a joint investigation. Investigators recovered the computer and arrested a contract employee at Unisys. Forensic analysis conducted by the FBI has not been completed.

VA Employee Arrested Watching Child Pornography at Work

A joint investigation by OIG, FBI, VA police, and local police revealed that a VAMC employee accessed child pornography websites on a Government computer during duty hours. The investigation determined that the employee had used a VAMC computer in a conference room that did not require him to use a logon or password, which creates accountablity problems in misuse cases. The employee was arrested at work while viewing child pornography.

Veteran Makes False Threats Against VA's Network

VHA received an e-mail from a hacker who claimed to have illegally accessed VA's network resources and threatened to expose network vulnerabilities. A joint investigation with the Secret Service located the hacker, who admitted to sending the e-mail and similar e-mails under the influence of alcohol and mental disorder medications. He had been previously visited by the FBI because of another e-mail incident and admitted a previous arrest for executing a virus that caused problems with the computer system at the college he attended. He denied compromising VA systems, hacking into any part of the systems, or any other similar activities. No intrusion or compromised systems were identified by VA IT staff.

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				
06-00008-130 4/17/06	Combined Assessment Program Review of the James E. Van Zandt VA Medical Center Altoona, PA	$33,810	$33,810	
06-00511-131 4/17/06	Combined Assessment Program Review of the VA Medical Center Tomah, WI	$12,211	$12,211	
05-01606-134 4/27/06	Combined Assessment Program Review of the Northampton VA Medical Center Leeds, MA	$101,974	$101,974	
05-03096-137 5/2/06	Combined Assessment Program Review of the VA Western New York Healthcare System Buffalo, NY	$1,060,142	$1,060,142	
06-00372-142 5/12/06	Combined Assessment Program Review of the VA San Diego Healthcare System San Diego, CA	$1,303,897	$1,303,897	
05-02925-144 5/15/06	Combined Assessment Program Review of the VA Medical Center Birmingham, AL	$43,911	$43,911	
06-00010-146 5/22/06	Combined Assessment Program Review of the VA Regional Office Waco, TX	$162,206	$162,206	
05-03281-168 7/17/06	Combined Assessment Program Review of the VA Medical Center Huntington, WV	$48,294	$48,294	
05-01232-174 7/24/06	Combined Assessment Program Review of the VA Medical Center Coatesville, PA	$95,269	$95,269	
06-00661-175 7/24/06	Combined Assessment Program Review of the West Texas VA Health Care System Big Spring, TX	$29,454	$29,454	
06-01218-176 7/26/06	Combined Assessment Program Review of the Syracuse VA Medical Center Syracuse, New York	$224,529	$224,529	
06-00510-192 8/17/06	Combined Assessment Program Review of the Iron Mountain VA Medical Center Iron Mountain, MI			
06-01136-193 8/18/06	Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, NY			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Management	Questioned Costs
05-01230-195 8/21/06	Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, MO	$27,296	$27,296	
06-01287-196 8/24/06	Combined Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, CA	$669,021	$669,021	
06-01128-201 9/11/06	Combined Assessment Program Review of the VA New Jersey Health Care System East Orange, NJ			
06-01831-202 9/11/06	Combined Assessment Program Review of the VA Maryland Healthcare System Baltimore, MD			
06-02301-210 9/13/06	Combined Assessment Program Review of the James H. Quillen VA Medical Center Mountain Home, TN			
06-01706-209 9/14/06	Combined Assessment Program Review of the Salem VA Medical Center Salem, VA			
06-01520-211 9/15/06	Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, MS			
06-00896-212 9/18/06	Combined Assessment Program Review of the Muskogee VA Medical Center Muskogee, OK			
06-01602-219 9/25/06	Combined Assessment Program Review of the VA Iowa City Health Care System Iowa City, IA			
06-02245-220 9/25/06	Combined Assessment Program Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, NC			
06-02003-225 9/26/06	Combined Assessment Program Review of the VA Pacific Islands Health Care System Honolulu, HI			
06-01521-229 9/28/06	Combined Assessment Program Review of the Alexandria VA Medical Center Pineville, LA			
06-01949-230 9/28/06	Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, WV			
06-01571-231 9/29/06	Combined Assessment Program Review of the Atlanta VA Medical Center Atlanta, GA			
06-00627-232 9/29/06	Combined Assessment Program Review of the Washington VA Medical Center, Washington, DC			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
06-02002-233 9/29/06	Combined Assessment Program Review of the VA Boise Medical Center Boise, ID			
06-00635-234 9/29/06	Combined Assessment Program Review of the VA Black Hills Health Care System, South Dakota	$22,501	$22,501	
06-03441-227 9/25/06	Review of Recurring and Systematic Issues identified During Combined Assessment Program Reviews at VA Facilities January 1999 through August 2006			
JOINT REVIEWS				
05-01978-226 9/27/06	Review of Selected Financial and Administrative Operations at VISN 1 Medical Facilities			
INTERNAL AUDITS				
04-03178-139 5/5/06	Audit of VA Acquisitions for Other Government Agencies			
04-00018-155 6/14/06	Audit of the Veterans Health Administration's Acquisition of Medical Transcription Services	$6,000,000		
05-01931-158 6/27/06	Audit of Veterans Benefits Administration Fiduciary Program Operations	$515,245,948	$515,245,948	
06-01414-160 6/30/06	Report of Audit Congressional Concerns over Veterans Health Administration's Budget Execution			
06-00116-177 7/26/06	Audit of Allegations at the Health Administration Center Denver, CO			
05-00055-216 9/20/06	FY 2005 Audit of VA Information Security Program			
OTHER OFFICE OF AUDIT REVIEWS				
05-00043-129 4/17/06	Evaluation of the Possible Mismanagement of Non-Appropriated Research Funds at the VA Central California Health Care System	$1,289,568	$1,289,568	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS				
05-02562-124 4/7/06	Review of Quality of Care Involving a Patient Suicide			
06-01642-126 4/10/06	Health Care Inspection Quality of Care in Cranial Implant Surgeries at James A. Haley VA Medical Center Tampa, FL			
05-02986-125 4/12/06	Healthcare Inspection Review of a Surgical Technician's Duties John D. Dingell VA Medical Center Detroit, MI			
06-00046-132 4/21/06	Coronary Artery Disease Treatment Issues, Sioux Falls Veterans Affairs Medical Center Sioux Falls, SD			
06-00460-133 4/21/06	Healthcare Inspection Nursing Home Care Unit and Homemaker Assistance Program Issues, Marion VA Medical Center Marion, IL			
05-03084-135 4/28/06	Healthcare Inspection Resident Supervision Issues in the Operating Room William Jennings Bryan Dorn VA Medical Center Columbia, SC			
05-03028-145 5/17/06	Review of Access to Care in the Veterans Health Administration			
06-00703-147 5/22/06	Healthcare Inspection Credentialing and Privileging Irregularities at the South Texas Veterans Health Care System San Antonio, TX			
06-00140-148 5/23/06	Healthcare Inspection Alleged Patient Care and Communication Issues VA Medical Center Fayetteville, NC			
06-01217-154 6/12/06	Healthcare Inspection Follow-Up Evaluation of Clinical and Administrative Issues Bay Pines Health Care System Bay Pines, FL			
06-00207-159 6/30/06	Healthcare Inspection Delay in Care and Discourteous Employees at the Michael E. DeBakey VA Medical Center Houston, TX			
05-00641-166 7/12/06	Healthcare Inspection Follow-Up Review of the Quality of Care at the James A. Haley VA Medical Center Tampa, FL			
05-01818-165 7/12/06	Healthcare Inspection Health Status of and Services for Operation Enduring Freedom/ Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation			
05-03287-169 7/17/06	Healthcare Inspection Patient Care Issues VA Medical Center Lexington, KY			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
06-00741-173 7/21/06	Healthcare Inspection Quality of Medical Management and Nursing Care, VA Boston Healthcare System Boston, MA			
05-01624-184 8/7/06	Healthcare Inspection Patient Care and Staffing Issues Physical Medicine and Rehabilitation Service Kansas City VA Medical Center Kansas City, MO			
05-03501-186 8/11/06	Healthcare Inspection Alleged Hostile Work Environment and Quality of Care Issues Evansville Outpatient Clinic Evansville, IN			
05-03571-187 8/11/06	Healthcare Inspection Access to Post-Traumatic Stress Disorder Treatment James J. Peters VA Medical Center, Bronx New York Bronx, NY			
06-01458-194 8/18/06	Healthcare Inspection Quality of Care in the Operating Room at the Overton Brooks VA Medical Center Shreveport, LA			
06-02010-197 8/22/06	Healthcare Inspection Alleged Denial of Care and Lapse in Courtesy, Louis Stokes VA Medical Center Cleveland, OH			
05-02408-208 9/14/06	Healthcare Inspection Review of Patient Transfer between Mental Health Providers, Huntington VA Medical Center Huntington, WV			
04-00888-215 9/20/06	Evaluation of the Veterans Health Administration Homeless Grant and Per Diem Program			
06-00437-218 9/22/06	Healthcare Inspection Review of Quality of Care John D. Dingell VA Medical Center Detroit, MI			
06-00008-237 9/29/06	Healthcare Inspection Review of Alleged Institutional Mistreatment/Mismanagement of Geriatrics and Extended Care Patients VA Medical Center Coatesville, PA			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS				
04-02900-127 4/11/06	Administrative Investigation Misuse of Position, VA Greater Los Angeles Healthcare System West Los Angeles, CA			
06-01748-141 5/10/06	Administrative Investigation, Misuse of Position and Resources, and Inaccurate Medical Records Bay Pines VA Healthcare System Bay Pines, FL			
06-02238-163 7/11/06	Review of Issues Related to the Loss of VA Information Involving the Identity of Millions of Veterans			
05-01545-178 7/27/06	Administrative Investigation, Misuse of Official Time by a Physician VA Medical Center Oklahoma City, OK			
05-03080-179 7/27/06	Administrative Investigation, Improper Tuition Reimbursements Veterans Integrated Service Network 15 Kansas City, MO			
05-00041-198 8/23/06	Administrative Investigation, Travel Irregularities and Misuse of Funds, Veterans Integrated Service Network 7 Atlanta, GA			
TOTAL:	69 Reports	$526,370,031	$520,370,031	$0

APPENDIX B

STATUS OF OIG REPORTS UNIMPLEMENTED FOR OVER 1 YEAR

The *Federal Acquisition Streamlining Act of 1994* requires Federal agencies to complete final action on each OIG report recommendation within 12 months after the report is finalized. The OIG is required to identify unimplemented recommendations in its Semiannual Report to Congress until the final action is completed. This appendix summarizes the status of OIG unimplemented reports and recommendations. The following chart lists the total number of unimplemented OIG reports and recommendations by organization. It also provides the total number of unimplemented reports and recommendations issued over 1 year ago (September 30, 2005, and earlier). One report on the following chart has actions at 3 offices.

Unimplemented OIG Reports and Recommendations				
VA Office	**Total**		**Issued 9/30/05 and Earlier**	
	Reports	Recommendations	Reports	Recommendations
VHA	84	460	16	51
OA&MM	106	216	0	0
VBA	3	7	2	6
OI&T	9	58	1	8
OM	4	19	3	12

Office of Information and Technology (OI&T)
Office of Management (OM)

Reports Unimplemented for Over 1 Year				
Report Number	Date of Issue	Title	Responsible Organization(s)	Open Recommendations
02-00972-44	12/31/02	Healthcare Inspection, Evaluation of VHA's Contract Community Nursing Home (CNH) Program	VHA	1 of 11
02-01339-85	4/23/03	Audit of VHA's Part-Time Physician Time and Attendance	VHA	9 of 17
02-00124-48	12/18/03	Healthcare Inspection, Evaluation of VHA Homemaker and Home Health Aide Program	VHA	2 of 4
03-00391-138	5/3/04	Healthcare Inspection, VHA's Community Residential Care (CRC) Program	VHA	4 of 11
04-01371-177	8/11/04	Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)	OI&T OM VHA	8 of 67 3 of 67 1 of 67
03-00079-183	8/13/04	Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities	VHA	11 of 15
03-00940-38	12/1/04	Evaluation of Selected Medical Care Collections Fund First Party Billings and Collections	VHA	2 of 4
04-01805-55	12/27/04	Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado	VHA	1 of 40
04-01271-74	2/1/05	Evaluation of Veterans Benefits Administration Vocational Rehabilitation and Employment (VR&E) Contracts	VBA	2 of 7
05-00290-78	2/8/05	Healthcare Inspection, Emergency Decontamination Preparedness, VA Salt Lake City Health Care System, Salt Lake City, Utah	VHA	1 of 2
05-01318-85	2/16/05	Evaluation of Sole-Source Contracts with Medical Schools and Other Affiliated Institutions	VHA	1 of 35
02-00986-101	3/9/05	Evaluation of VA Compliance with Federal Energy Management Policies	OM	5 of 12
04-03403-133	5/5/05	Combined Assessment Program Review of the Central Texas Veterans Healthcare System, Temple, TX	VHA	1 of 14
05-00765-137	5/19/05	Review of State Variances in VA Disability Compensation Payments	VBA	4 of 8

Reports Unimplemented for Over 1 Year				
Report Number	Date of Issue	Title	Responsible Organization(s)	Open Recommendations
05-01248-170	7/8/05	Combined Assessment Program Review of the VA Salt Lake Healthcare System, Salt Lake City, UT	VHA	1 of 15
05-00502-171	7/8/05	Combined Assessment Program Review of the VA Medical System, Miami, FL	VHA	1 of 19
04-00235-180	8/4/05	Healthcare Inspection, Inspection of Veterans Health Administration Patient Transportation Services	VHA	9 of 9
04-00616-203	9/19/05	Administrative Investigation, Appearance of Preferential Treatment, VA Medical Center, Fayetteville, NC	VHA	3 of 5
04-02330-212	9/30/05	Audit of VA Acquisition Practices for the National Vietnam Veterans Longitudinal Study	OM	4 of 6
05-02007-219	9/30/05	Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, AZ	VHA	3 of 19

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	Status
Section 4 (a) (2)	Review of legislation and regulations	Commented on 6 items
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	See pages 5-18
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	See pages 5-18
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	See page 29
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	See pages 5-18
Section 5 (a) (5)	Summary of instances where information was refused	none
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	See pages 19-24
Section 5 (a) (7)	Summary of each particularly significant report	See pages 5-18
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	See page 29
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	See page 29
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	See page 29
Section 5 (a) (11)	Significant revised management decisions	none
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	none
Section 5 (a) (13)	Information described under section 5(b) of the *Federal Financial Management Improvement Act of 1996* (Public Law 104-208)	VA has met its September milestones

Table 1: Resolution Status of Reports With Questioned Costs

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 3/31/06	0	$0
Issued during reporting period	0	$0
Total inventory this period	**0**	$0
Management decisions during the reporting period		
Disallowed costs (agreed to by management)	0	$0
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Reporting Period	**0**	$0
Total Carried Over To Next Period	**0**	$0

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

RESOLUTION STATUS	Number	Dollar Value (In Millions)
No management decision by 3/31/06	58	$1,099.7
Issued during reporting period	17	$526.4
Total inventory this period	**75**	**$1,626.1**
Management decisions during the reporting period		
Agreed to by management	16	$84.2
Not agreed to by management	0	$0
Total Management Decisions This Reporting Period	**16**	**$84.2**
Total Carried Over To Next Period	**59**	**1,541.9**

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

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