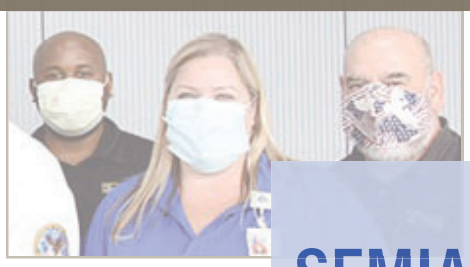
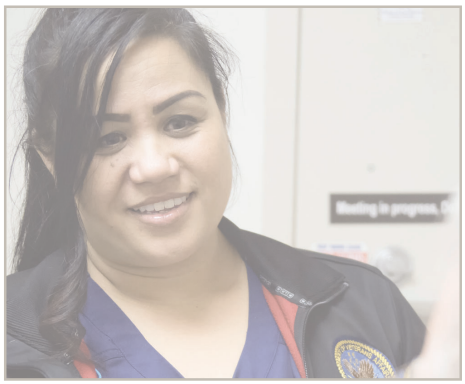


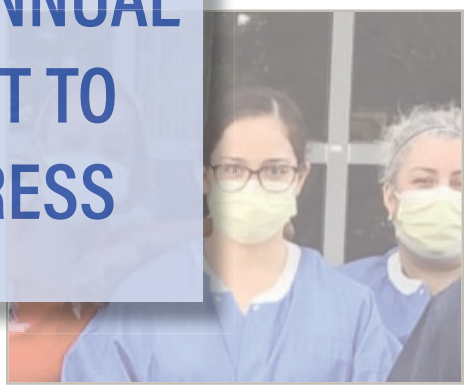
US DEPARTMENT OF VETERANS AFFAIRS

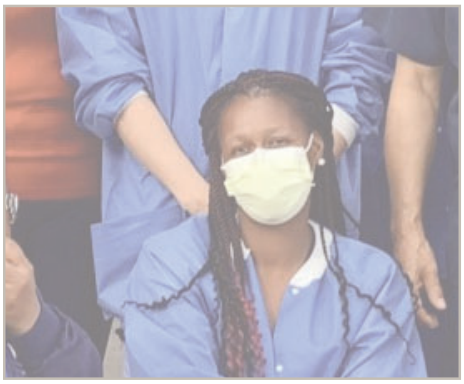
OFFICE OF INSPECTOR GENERAL




SEMIANNUAL REPORT TO CONGRESS





ISSUE 83

OCTOBER 1, 2019–MARCH 31, 2020

2020: THE YEAR OF THE NURSE
WITH SPECIAL THANKS TO ALL VA HEALTHCARE PROFESSIONALS

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

MISSION

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

VISION

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

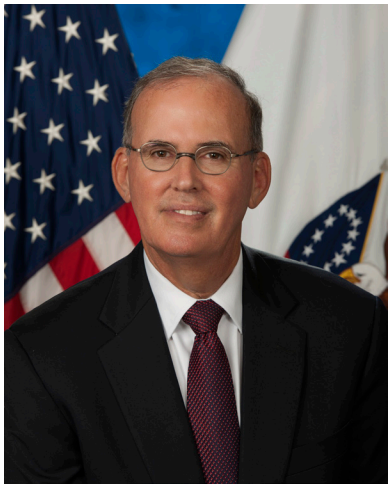
To achieve this vision, the Office of Inspector General (OIG) will

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

VALUES

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

A MESSAGE FROM THE INSPECTOR GENERAL



I am honored and privileged to submit this Semiannual Report (SAR) to Congress on the Department of Veterans Affairs (VA) Office of Inspector General (OIG) activities and accomplishments for October 1, 2019, through March 31, 2020. This report was prepared during the coronavirus disease (COVID-19) pandemic—one of the greatest challenges in recent history faced by VA. The work and commitment of VA personnel serving our veterans and engaging in its "fourth mission" to care for nonveterans during a national emergency—often at great personal cost and sacrifice—is recognized and appreciated. Dealing with the short- and long-term effects of this pandemic will continue to test us all.

The need for effective oversight during these trying times has never been greater. Planning has begun to examine VA's response to this crisis, as well as the impact on other VA functions that its personnel have needed to alter or pause as a result of the pandemic. This work will supplement our traditional oversight and should provide important lessons for VA leaders who can apply them to better prepare for future crises.

The current environment highlights two key attributes of the OIG: our ability to adapt quickly to changing conditions and our unwavering commitment to focus on issues with the greatest potential impact on veterans, their families and caregivers, VA personnel, and taxpayers. We conducted an inspection directly related to VA's COVID-19 response that was structured to require minimal attention from VA staff, while presenting near real-time information to them on risks and vulnerabilities. More than 50 OIG healthcare staff volunteered to observe and undergo screenings at the entrances of 237 Veterans Health Administration facilities from March 19–24, 2020, and to collect information on the pandemic readiness of the medical facilities. The OIG staff, nearly all with healthcare experience, self-screened for COVID-19 indicators before driving to these facilities and then immediately sharing on-site findings with facility leaders positioned to take corrective action. The resulting report, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, was publicly released with aggregate findings within a week of the site visits. We are performing other COVID-19-related work, including examining the quality of health care and allegations of potential criminal wrongdoing.

During this reporting period, there was other significant oversight work conducted unrelated to COVID-19 issues. OIG staff remained committed to working on projects to ensure veterans are receiving the routine benefits, services, and health care on which they depend. The OIG's oversight work is detailed in the 154 publications we issued for the first half of fiscal year 2020. It is important to note that some reports initially planned for release this reporting period will be disseminated at later dates so as not to draw undue attention away from VA's COVID-19-related care. Information has been shared with VA on matters that require immediate attention in the interim.

Other significant work focused on VA's multibillion-dollar electronic health record modernization efforts. The OIG has entered into a joint audit with the Department of Defense (DoD) that focuses on the interoperability between VA and DoD and with external healthcare providers. OIG audit and healthcare teams have engaged in efforts that are expected to result in released reports during the next

A MESSAGE FROM THE INSPECTOR GENERAL

SAR period. The OIG also has expanded its data collection, analysis, and modeling. This will allow us to work more effectively and rapidly when spikes, trends, or outlying incidents are spotted.

In this six-month period, the OIG identified nearly $866.8 million in monetary impact for a return of investment of $10 for every dollar spent on oversight. The OIG hotline received and triaged 14,747 contacts to help identify wrongdoing and concerns with VA programs and activities. Investigators opened 208 investigations and closed 239, with efforts leading to 142 arrests. Collectively, the OIG's work resulted in 834 administrative sanctions and corrective actions.

I am very proud to have worked alongside the outstanding and dedicated OIG staff during this SAR period. They give their best every day to make a real difference in the lives of veterans and their families. Their efforts will be even more critical in the months and years ahead as VA works through the aftermath of the COVID-19 pandemic. I would like to thank the members of Congress, VA staff, the veterans service organizations, and the veteran community for their continued support that is instrumental to our oversight efforts.

MICHAEL J. MISSAL

Inspector General

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ORGANIZATION PROFILE

THE DEPARTMENT OF VETERANS AFFAIRS

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

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

VA is the second-largest federal employer. For fiscal year (FY) 2020, VA is operating under a $220.6 billion budget, with over 408,000 employees serving an estimated 19 million veterans. VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands. It also operates the nation's largest integrated healthcare system. For more information, visit www.va.gov.

THE OFFICE OF INSPECTOR GENERAL

MISSION

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

HISTORY AND STATUTORY AUTHORITY

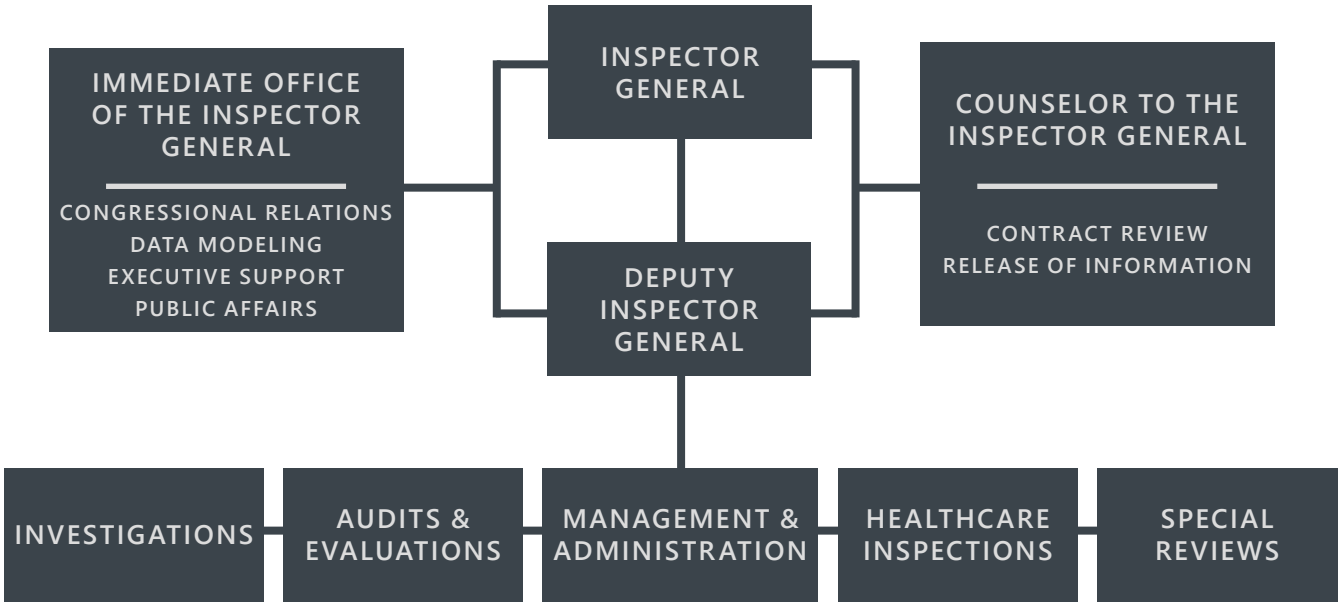
The VA OIG's role as an independent agency was formalized and clarified by the Inspector General Act of 1978 (IG Act) [Public Law (P.L.) 95-452, as amended]. This Act states that the Inspector General is responsible for (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action. The Inspector General has authority to review all VA programs and employee activities as well as the related actions of people and entities performing under grants, contracts, or other agreements with the Department. In addition, the Veterans Benefits and Services Act of 1988 (P.L. 100-322) charged the OIG with overseeing the quality of VA health care. Integral to every OIG effort is an emphasis on strong and effective leadership and quality management of VA operations that makes the best use of taxpayer dollars.

STRUCTURE, FUNDING, AND OFFICE LOCATIONS

The VA OIG has over 1,000 staff organized into six primary directorates: the Offices of Audits and Evaluations, Contract Review (which is overseen by the Office of the Counselor to the Inspector General), Healthcare Inspections, Investigations, Management and Administration (including the OIG hotline), and Special Reviews. The OIG also has an office for congressional relations, public affairs, data modeling, and executive support, as well as an Office of the Counselor to the Inspector General. The FY 2020 funding for OIG operations provided $210 million from ongoing appropriations.

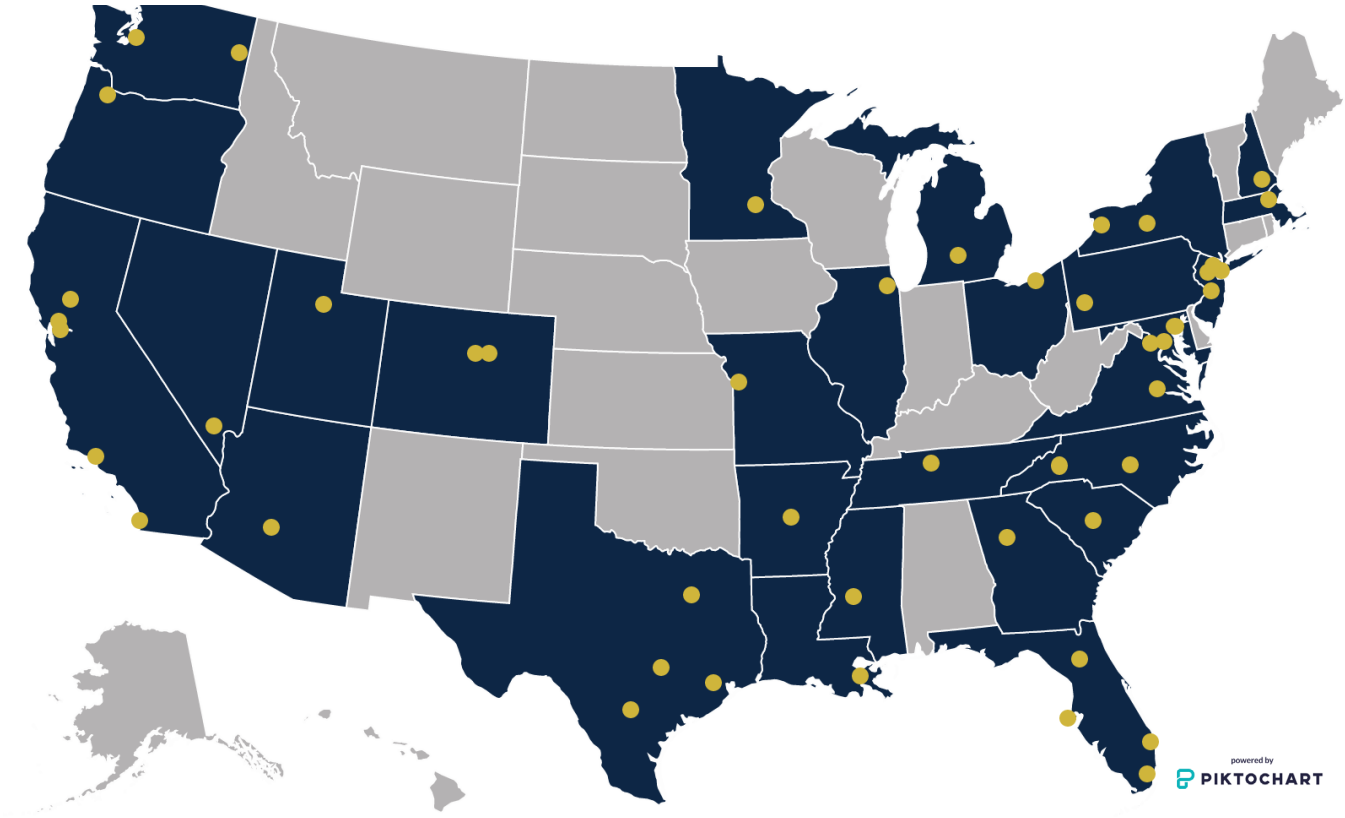
In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country. The OIG is committed to transparency and keeping the Secretary, Congress, and the public fully and currently informed about issues affecting VA programs and opportunities for improvement. OIG staff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

OIG ORGANIZATIONAL CHART



ORGANIZATION PROFILE

OIG FIELD OFFICES MAP



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

OFFICES OF THE INSPECTOR GENERAL

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

The office serves as the central coordination point for all executive correspondence, congressional testimony, media inquiries, data modeling, and stakeholder engagement. The Inspector General and Deputy Inspector General provide leadership and set the strategic direction for a nationwide staff of auditors, investigators, inspectors, attorneys, healthcare professionals, and support personnel who conduct independent oversight of the second-largest agency in the federal government. The office includes congressional relations and public affairs staff who ensure that information is accurately and promptly released and that requests from legislators and reporters are appropriately addressed, as well as a data modeling group that specializes advanced analytics, information integration, and data visualization. In addition, through report follow-up, the office helps to ensure that corrective actions taken by VA in response to OIG recommendations are effectively monitored and resolved.

THE OFFICE OF AUDITS AND EVALUATIONS

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

THE OFFICE OF CONTRACT REVIEW

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

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

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

THE OFFICE OF HEALTHCARE INSPECTIONS

Healthcare Inspections assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of individual medical facilities, systems, and networks. Field staff participate in Comprehensive Healthcare Inspection Program (CHIP) site visits focusing on leadership,

quality management, and adherence to requirements and standards for patient care provision and documentation. Facility results are aggregated into summary reports that identify national trends. This office also conducts statistically supported national reviews of topical issues and provides consultations to criminal investigators and audit staff as needed.

THE OFFICE OF INVESTIGATIONS

This office investigates crimes and other violations of law involving VA programs and operations by employees and nonemployees. Criminal and civil investigations focus on issues such as healthcare, benefits, education, and procurement fraud (including service-disabled veteran-owned small business fraud); embezzlement, extortion, and bribery; drug theft and diversion; theft of VA resources and data; identity theft; homicide, manslaughter, sexual assault, and rape; and threats against VA employees, patients, facilities, and computer systems.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

Staff provide comprehensive support services to the OIG. This office promotes organizational effectiveness and efficiency by providing reliable and timely financial, personnel, budgetary, information technology, and data services to the organization. The office also oversees the OIG hotline, which receives, screens, and refers all allegations and complaints for additional action. Cases are accepted on a select basis, prioritizing those having the most potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue of redress.

THE OFFICE OF SPECIAL REVIEWS

This office increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. Staffed with professionals possessing a broad array of expertise, this office undertakes projects assigned to it by the Inspector General and Deputy Inspector General and also works collaboratively with the other directorates to review topics of interest to multiple offices. This office also conducts administrative investigations.

HIGHLIGHTED ACTIVITIES AND FINDINGS

Pursuant to the Inspector General Act of 1978, this Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the reporting period October 1, 2019–March 31, 2020. Highlighted below are some of the activities conducted during this period by the VA OIG's offices and their impact, followed by statistical tables that summarize key performance measures. Subsequent sections of the report then feature examples of each office's high-impact publications and activities. This information is supplemented by appendixes that detail such information as titles of OIG publications released; the monetary impact of OIG products including savings, cost avoidance, and dollar recoveries; the status of VA's implementation of recommendations; and reporting requirements.

THE IMMEDIATE OFFICE OF THE INSPECTOR GENERAL

This office consists of the Inspector General and Deputy Inspector General's executive support staff, as well as congressional relations, data modeling, recommendation follow-up, and public affairs personnel.

CONGRESSIONAL RELATIONS

The VA OIG actively works with Congress on issues affecting VA programs and operations. During this reporting period, the OIG testified at eight hearings on topics that include the following:

- Operations at VA's Office of Accountability and Whistleblower Protection
- Management of the VA's credentialing and privileging process for medical professionals
- Care for veterans in crisis
- Health benefits and compensation benefits for military sexual trauma survivors
- VA's progress in implementing a new electronic health record system
- VA' cybersecurity challenges

Additionally, the OIG testified at a legislative hearing related to H.R. 5483, Strengthening Oversight for Veterans Act of 2020. If passed, this legislation would give the VA Inspector General the authority to require by subpoena the attendance and testimony of individuals no longer working at or contracting with VA when needed for the OIG to perform its authorized oversight functions.

It would give OIG personnel an important tool to conduct comprehensive and effective oversight of VA's activities. OIG staff must consider all available information from individuals with knowledge of serious misconduct, fraud, and inefficiencies that affect veterans and their families. Testimonial subpoena authority strengthens the OIG's ability to gather information in administrative investigations and other oversight projects identifying misconduct related to VA programs and activities—information

needed for VA to hold responsible individuals accountable. For a full listing of OIG testimony delivered this reporting period, see the Congressional Relations and Public Affairs section.

The Inspector General and OIG personnel had 66 briefings with congressional members and their staff during this period. These included prerelease briefings on OIG reports that addressed deficiencies in routine clinical evaluations in VA health facilities and VBA benefit claims processing. OIG congressional relations staff fielded 110 requests related to constituent casework for review or referral as well.

DATA MODELING

The Data Modeling Group was established in April 2019 and has deployed over 20 major projects—13 in this reporting period alone. The group consists of teams specialized in advanced analytics, information integration, and data visualization to support OIG's proactive oversight efforts.

The group has continued to develop the OIG's geospatial analysis platform, known as DRACO, which provides performance monitoring information to assist staff in benchmarking and identifying both best practices and improvement opportunities across VA programs and services. The group has implemented oversight and surveillance trigger systems that monitor data on mortality rates, OIG hotline contacts, electronic health record coding anomalies, and VHA organizational health. These trigger systems provide near real-time signals about events that deviate from expectations and allow OIG staff to intervene early when appropriate. The data modeling staff collaborate closely with every OIG directorate to develop analytic tools to support their operations. These collaborative efforts include models to evaluate the quality of care at VA and non-VA healthcare facilities and VHA medical center leadership. The models also help detect potential fraud, waste, and abuse in areas such as prosthetics; nonexpendable medical equipment; compensation and pensions; and pharmaceutical prescribing, dispensing, and purchasing.

In response to the COVID-19 pandemic, data modeling staff also have developed and implemented a COVID-19 Impact Report. This data surveillance system provides daily updated information regarding patient access to care in VHA and statistics on affected cases in VHA and in U.S. communities.

PUBLIC AFFAIRS

The OIG is committed to transparency and to providing accurate and timely information to veterans and their families, the media, veterans service organizations, VA staff and leaders, and the public. During this reporting period, the OIG restructured its public affairs office. This included creating and hiring a new Senior Leader position to serve as the Director of Communications. The position is charged with aligning all internal and external communications efforts by the OIG. This requires close collaboration with senior staff across the directorates, as well as with the OIG's many stakeholders, to ensure the complex activities of the OIG are clearly represented inside and outside the organization. Also, the Electronic Release Division was transferred from within the Office of Management and Administration to the public affairs office. This integrates report publishing and distribution with related communications efforts within the Immediate Office of the Inspector General.

Public affairs staff work with U.S. Attorneys' Offices and other partners on press releases and routinely respond to media requests for information on the OIG's investigations, inspections, reviews, and audits. The OIG's work was featured in hundreds of media accounts during the reporting period. Working with staff previously assigned to the Office of Management and Administration, the public affairs office continues to remain active in social and digital media. During this reporting period, the OIG's LinkedIn

page became the most followed page of any OIG with more than 21,000 followers. The page is also used as a recruiting tool to fill the OIG's ranks with the highest quality candidates. The OIG Twitter account continues to grow, with more than 5,200 followers and up to 150,000 impressions per month. The account is used to increase the office's transparency by pushing reports, releases, statements, and congressional testimony to the OIG's many stakeholders who are present on the social media platform, such as the media, congressional staff, and veteran service organizations, as well as business leaders and the public. It complements the email delivery system to more than 50,000 subscribers.

THE OFFICE OF AUDITS AND EVALUATIONS

Responsible for conducting audits and reviews of VA's programs and operations, this office independently evaluates the efficiency and effectiveness of a diverse range of issues. These include compliance with VA policies governing veterans' access to health care in the community; the oversight of claims processing and disability payments; and VA's administration of contracts for supplies and services for its many programs, projects, and facilities. During this reporting period, the office's 19 published reports identified nearly $590 million in potential monetary benefits. These reports continued to critically review the management and oversight of VA's acquisition and procurement operations—ensuring VA gets the best value for the goods and services it purchases. Staff also continued its scrutiny of benefits for compensation and pensions claims processing, including a report that indicated the use of public-use disability benefits questionnaires by some individuals and firms contributed to the abuse of the program. VA has since removed these questionnaires from its website.

Included in the legislatively required reports the OIG must issue is the oversight of VA's financial and information security management. The OIG examines the Department's adherence to its stated policies and other guidance. These internal controls are meant to help ensure VA programs meet their goals and are conducted in the best interest of veterans and taxpayers. In all reports, OIG audit staff disclose and detail program weaknesses and deficiencies to promote programmatic improvements throughout VA by recommending changes to internal controls or their implementation and monitoring for potential fraud.

THE OFFICE OF CONTRACT REVIEW

The Office of Contract Review is staffed by 33 employees divided among seven teams and two divisions. Under the supervision of the Counselor to the Inspector General, the Office of Contract Review provides preaward, postaward, and other pricing reviews of contracts related to the Federal Supply Schedule, construction, and healthcare providers' services. Preaward reviews provide VA

contracting officers with assistance and information needed to negotiate fair and reasonable prices, and to protect the interests of veterans and taxpayers. The 31 preaward reviews yielded potential cost savings of about $59 million. Postaward reviews assess compliance with contract terms and conditions and recovered $8.4 million in contract overcharges. The Office of Contract Review Special Projects team issued two reports during this review period, one of which identified $602 million in unnecessary expenditures by other government agencies because of restrictions placed on temporary price reductions for pharmaceuticals in contracts negotiated by VA contracting officers under Federal Supply Schedule contracts. The team's division director also briefed staff from VA's congressional oversight committees on the results of this report. The second report, which examined a company's contract for conducting medical disability examinations, concluded that the company adequately followed billing requirements for the contract and did not materially overbill VA for services rendered during the review period.

THE OFFICE OF COUNSELOR TO THE INSPECTOR GENERAL

The counselor's office continues to provide legal support to all components of the OIG and to look for new ways to serve the needs of the organization. During this reporting period, the counselor's office performed the following activities:

- Reviewed the OIG Office of Investigations' policies on Law Enforcement Availability Pay, use of force, and managing critical incidents; prepared case law updates and developed refresher training for investigators required by the Council of the Inspectors General on Integrity and Efficiency; and reviewed more than 114 subpoenas issued in criminal and civil investigations
- Provided substantial legal support for an audit team's examination of the VBA Records Management Center's disclosure of third-party personally identifiable Information, which found that information was being released without proper redaction or notification and led to VBA agreeing to revise its policy and resume redactions
- Supported the Office of Management and Administration by initiating a review and update of OIG policies; dedicated an attorney to help train new employee relations specialists; provided briefings to employees and managers on topics such as the legal authorities of inspectors general, government ethics, merit system processes, and Equal Employment Opportunity and whistleblower rights and responsibilities
- Advised the Office of Healthcare Inspections in its review of complaints involving nearly every aspect of healthcare delivery throughout VA including reports on cardiac research, quality management concerns, deficiencies in staffing and sterile processing services, and quality of care issues in community living centers and emergency departments
- Provided oversight and executive leadership to the Office of Contract Review, and supported its Special Project Team in its review of the Department's failure to ensure other agencies benefit from temporary price reductions on Federal Supply Schedule pharmaceutical contracts

- Assisted the Office of Special Reviews in evaluating the VA Office of Accountability and Whistleblower Protection by analyzing responsibilities assigned to the office under law and assisting with the resulting report

The Office of Information Release led the OIG's response to several litigation matters, including those involving the Privacy Act and Federal Tort Claims Act, working closely with various U.S. Attorneys' Offices representing the OIG in federal court proceedings. Staff also represented the OIG in establishing data use agreements with several other federal offices of inspector general to aid in ongoing criminal investigations. In addition, the office continued its core work reviewing all OIG reports before publication for compliance with the Privacy Act of 1974 (P.L. 93-579) and other disclosure laws, and reviewing more than 550 requests from the public and other government agencies for agency records.

THE OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) is committed to ensuring that veterans throughout the country have access to timely, high-quality health care provided by competent and appropriately trained staff who are sensitive to their distinct needs. In addition, such care must be provided in a setting that is safe and promotes recovery. In this SAR period, OHI reviewed a wide range of topics including staffing shortages, issues related to timely and quality emergent care, mental healthcare screening and management, sterile processing services, deficiencies in care coordination and quality rating systems for community living centers.

CHIP reviews assessed VHA's provision of care to veterans who experienced military sexual trauma and medication management of geriatric patients diagnosed with depression. OHI expanded the scope of leadership engagement and responsiveness to include reviews of Veterans Integrated Service Networks (VISNs). Recognizing the impact of supportive and engaged leaders, the VISN-level reviews provide an additional perspective into higher-level accountability, resource allocation, and other activities that VISN leaders are tasked with providing.

In response to VA's planned transition to a modern electronic healthcare record system, OHI reviewed the potential impact on patient access to care and safety. The review focused on VA's progress at the initially scheduled "go-live" date and the transition period at the Mann-Grandstaff VA Medical Center. The OHI team examined whether VHA's risk-mitigation strategies were sufficient to overcome gaps created by rolling out the new system with incomplete capabilities, potentially posing risks to patient safety and access to care. OHI will continue to review and report during this massive modernization effort—even as the rollout has been postponed during the COVID-19 crisis.

Ensuring that VHA provides timely access to high-quality mental health care for veterans remains one of OHI's top priorities. Most urgent is the need to mitigate the risk for veteran suicide. OHI identified deficiencies in care coordination and staff communication involving a high-risk veteran who ultimately

died by suicide. Without seamless coordination and information sharing among team members, patient care can be compromised, especially for veterans with complex mental healthcare needs in an environment of staffing shortages, expanding use of community services, and increasing efforts to identify and engage more veterans in need of these services.

Even in a predictable healthcare delivery climate, there are significant challenges to ensuring timely and quality care. The recent global pandemic highlights the need for all healthcare systems to anticipate demand and leverage resources on a scale that potentially overwhelms even the largest integrated healthcare systems. OHI is committed to continuing its meaningful oversight as VHA navigates its staff and veterans through this uncharted journey.

THE OFFICE OF INVESTIGATIONS

Office of Investigations (OI) staff investigate an extensive range of potential criminal activity—from drug offenses and various types of fraud to crimes of violence and threats to information systems and VA personnel. During the COVID crisis, investigators have been particularly vigilant to allegations of procurement fraud, theft, and other activities that put VA personnel, patients, and resources at risk. In this reporting period, investigators' efforts resulted in 142 arrests. Criminal and civil investigations yielded millions of dollars in recoveries for VA and resulted in significant judicial and administrative actions.

Investigators continue to focus on VA healthcare fraud and coordination between headquarters and field operations to identify, investigate, and work with other agencies and the U.S. Department of Justice in addressing criminal violations against VA programs. To support this effort, OI recently created a healthcare fraud unit that includes several new positions. OI also has provided support for hiring a Special Prosecutor with expertise in combating healthcare fraud involving VA to support the Department of Justice's Healthcare Fraud Task Force. Further, the Investigative Development Division continues to work closely with field Special Agents in Charge and external law enforcement partners to initiate and refer impactful investigations in high-value VA program areas.

OI personnel continued coordinating with internal and external data analytics specialists to identify patterns of fraud in education and procurement fields to detect vulnerabilities within these programs. In addition, OI assigned a desk officer to set up a nationwide fiduciary program, with plans to hire additional investigative analysts to support complex investigations nationwide. Personnel have also continued to use regional proactive working groups to help detect high-risk program areas that are susceptible to high-impact fraud. These working groups and the Investigative Development Division coordinate closely to ensure that emerging criminal enterprises and important investigations receive appropriate attention and resources. To support these efforts, OI's Forensic Audit Division program continues to provide nationwide support in significant agency investigations.

THE OFFICE OF MANAGEMENT AND ADMINISTRATION

The Office of Management and Administration (OMA) provides comprehensive, reliable, and timely administrative services to promote organizational effectiveness and efficiency, and to support the OIG's overall mission. In the last six months, OMA had major responsibilities for overseeing execution of the OIG's largest budget to date—$210 million—while also working to modernize and enhance support functions to address the needs of a growing agency. For example, OMA is implementing a paperless performance management system to streamline processes and ensure performance plans strategically align with agency-wide standards and the OIG mission. OMA also implemented processes and procedures to increase interactions and reduce processing times associated with the OIG hotline, allowing for a more timely review and response to contacts. Additionally, OMA is actively assessing aspects of the OIG's IT infrastructure to identify opportunities for modernization and to help ensure that stakeholder needs are met and to support the expanded use of data throughout the organization. OMA continues to focus on OIG-wide employee engagement, recruitment, and retention and has bolstered employee recognition, and activity on social media sites (see more in the Public Affairs highlights above).

OMA also has a central role in enhancing the OIG's Predictive Data Analytics and Modeling Program (PDAMP). It continues to facilitate close collaboration among OMA data analysts, cross-directorate subject matter experts, and data scientists to conduct thorough analyses of VA programs to identify fraud, waste, and abuse. Metrics of success include

- Generating new work such as two new audits involving VA care in the community and one involving veterans' educational benefits;
- Strengthening products by providing supplemental data and visualizations to support three ongoing procurement-related audits;
- Informing audit proposals under development by responding to requests for insights, data analysis, and visualizations; and
- Identifying potential criminal activity and generating numerous investigative leads involving construction companies.

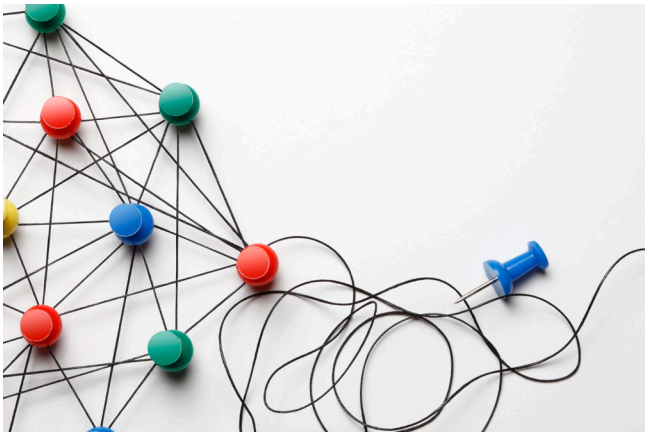
The cases and audits to which PDAMP contributes can result in monetary recoveries and changes in VA operations and programs in response to related OIG recommendations. The impacts may not be realized for months or even years after PDAMP contributions, as investigations and prosecutions unfold and oversight work is completed and implemented. The activities and achievements of the PDAMP are complementary to those of the data modeling group. The PDAMP leverages iterative, in-depth statistical analyses and collaboration with subject matter experts, often in response to specific requests, to generate actionable leads for oversight whereas the data modeling group discussed previously

focuses on models and systems that support a breadth of useful, just-in-time predictive analytics to OIG staff to inform project development and quick responses.

In addition, OMA is responsible for overseeing the OIG's hotline. OMA continues to expand the number of staff who support that function. The increased staffing allows the OIG to more quickly review and respond to the tens of thousands of complaints that are received annually—14,747 in this reporting period alone. OMA continues to look at ways to enhance the systems supporting the hotline function to help staff process complaints faster and to share information across the organization more effectively. Finally, OMA has hired a contractor to assist the OIG hotline with providing customized responses to complainants.

THE OFFICE OF SPECIAL REVIEWS

The Office of Special Reviews focuses on significant events and administrative investigations, particularly involving senior VA officials, and collaborates with other directorates to address complex issues. Staff continue to work on multiple review projects and administrative investigations pertaining to VA programs, operations, and staff. The office is implementing its staffing plan to build a more robust team of investigative attorneys, administrative investigators, criminal investigators, forensic auditors, and senior analysts. In FY 2020, the office published a report on *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, which received significant media attention and congressional interest. The report contained six findings and 22 recommendations, which will have significant impact across VA when implemented. The Office of Special Reviews during this reporting period has taken on projects assigned to it by the Inspector General and Deputy Inspector General and also has been working collaboratively with the other OIG directorates to review topics and issues of interest that span multiple offices or agencies.



STATISTICAL PERFORMANCE

AT A GLANCE: SELECTED METRICS FOR THE REPORTING PERIOD

154 PUBLICATIONS

142 ARRESTS

132 CONVICTIONS, PRETRIAL DIVERSIONS, AND DEFERRED PROSECUTIONS

8 CONGRESSIONAL TESTIMONIES

834* ADMINISTRATIVE SANCTIONS AND CORRECTIVE ACTIONS

14,747 HOTLINE CONTACTS

$10:1 RETURN ON INVESTMENT

777 RECOMMENDATIONS TO VA

$866,766,575 MONETARY IMPACT

8 PODCASTS

*Hotline and Investigations included

STATISTICAL PERFORMANCE

TABLE 1: MONETARY IMPACT AND RETURN ON INVESTMENT

TYPE	THIS PERIOD
Better Use of Funds	$484,740,219
Dollar Recoveries	$13,038,421
Fines, Penalties, Restitution, and Civil Judgments	$87,833,026
Fugitive Felon Program	$83,500,000
Savings and Cost Avoidance	$92,980,909
Questioned Costs	$104,674,000
Total Dollar Impact	**$866,766,575**
Cost of OIG Operations[1]	$83,201,589
Return on Investment[2]	**$10:1**

1. The six-month operating cost for OHI ($21.8 million), whose oversight mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

2. The return on investment is calculated by dividing total dollar impact by cost of OIG operations.

TABLE 2: REPORTS AND OTHER PUBLICATIONS

REPORT TYPE	THIS PERIOD
Administrative Investigations	1
Audits and Reviews	19
Claim Reviews	2
Comprehensive Healthcare Inspections	34
Hotline Healthcare Inspections	17
National Healthcare Reviews	3
Postaward Reviews	23
Preaward Reviews	31
Special Reviews	1
Subtotal	**131**
OTHER PUBLICATION TYPE	**THIS PERIOD**
Congressional Testimonies	8
Monthly Highlights	6
Podcasts	8
Press Releases	1
Subtotal	**23**
Total	**154**

TABLE 3: SELECTED OFFICE OF INVESTIGATIONS ACTIVITIES

TYPE[1]	THIS PERIOD
Arrests[2]	142
Fugitive Felon Arrests Made by Other Agencies with VA OIG Assistance	12
Indictments[3]	111
Indictments and Informations Resulting from Prior Referrals to Authorities	76
Criminal Complaints	28
Convictions	118
Pretrial Diversions and Deferred Prosecutions	14
Case Referrals to Department of Justice for Criminal Prosecution[4]	158
Cases Accepted	64
Cases Declined	70
Cases Pending	24
Case Referrals to State and Local Authorities for Criminal Prosecution[5]	29
Cases Accepted	15
Cases Declined	6
Cases Pending	8
Administrative Sanctions and Corrective Actions	303
Cases Opened	208
Cases Closed[6]	239

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

2. Total arrests include 10 apprehensions of fugitive felons by VA OIG agents. This total does not include fugitive felon arrests made by other agencies with VA OIG assistance.

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

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

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

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

STATISTICAL PERFORMANCE

TABLE 4: SELECTED OFFICE OF HEALTHCARE INSPECTIONS ACTIVITIES

TYPE	THIS PERIOD
Clinical Consultations to Other VA OIG Offices	6
Hotline Referrals Reviewed	2,101

TABLE 5: SELECTED HOTLINE ACTIVITIES

TYPE	THIS PERIOD
Contacts	14,747
Cases Opened	895
Cases Closed	686
Administrative Sanctions and Corrective Actions*	531
Substantiation of Allegations Percentage Rate	36%
Individuals Claiming Retaliation/Seeking Whistleblower Protection	15
Individuals Provided Office of Special Counsel Contact Information	38
Individuals Provided Merit Systems Protection Board Contact Information	48
Individuals Provided Office of Resolution Management Contact Information	93

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

RESULTS FROM THE OFFICE OF AUDITS AND EVALUATIONS

OVERVIEW

19
REPORTS

118
RECOMMENDATIONS

$589M
MONETARY BENEFITS

The Office of Audits and Evaluations (OAE) published 19 reports during this SAR reporting period. These focus on issues that have a meaningful impact on veterans' health and benefits, management of VA resources and taxpayer dollars, and the effective operations of VA programs and services. The list of all OAE report recommendations for corrective action made during the reporting period can be tracked on OIG's dashboard at www.va.gov/oig. Information is also available on the monetary impact and the implementation status of report recommendations published since October 2012.

FEATURED PUBLICATIONS

OAE conducts audits and reviews of VA's operations and programs that provide veterans with timely medical care and benefits to which they are entitled. OAE's efforts continue to focus on the oversight of specific, high-risk areas within VA. These include the oversight and administration of financial management, procurement and acquisition, and information security, all of which, if poorly accomplished, could cause ripple effects in access to VA health care and benefits delivery. Identifying VA's vulnerable areas helps improve program administration and ensures that taxpayer dollars are well spent. This reporting period, OAE identified issues in key areas challenging VA's oversight responsibilities, such as leaders in the Records Management Center not reassessing mailing practices and policies regarding the release of third-party veteran's personal information, inadequate staffing levels and processes to ensure medical centers had readily available medical and surgical supplies, and claims processors improperly using benefits questionnaires to make determinations without ensuring an in-person examination was conducted. During this reporting period, OAE identified an estimated $589.4 million in potential monetary benefits. The OAE reports also prompted policy and practice changes as well as congressional action during the review period. The three publications that follow provide examples of the type of work OAE conducts that focuses on identifying problems and making recommendations that can have a meaningful effect on VA and the veterans it serves.

RECORDS MANAGEMENT CENTER DISCLOSED THIRD-PARTY PERSONALLY IDENTIFIABLE INFORMATION TO PRIVACY ACT REQUESTERS

The OIG conducted this review to determine whether VBA's Records Management Center disclosed third-party information (including social security numbers of other service members and medical professionals) when responding to Privacy Act requests. The Act requires VBA to let beneficiaries review their claims files and have copies made. Many VBA records include third-party information, which had been redacted until a May 2016 policy change. VBA changed the policy that month because the redaction requirement was a major contributor to its massive requests backlog. Redaction also interfered with VBA's plans to give veterans online access to their records. The May 2016 policy change

did not require third parties to be notified when their information was released, meaning individuals at risk of identity theft might not be aware of that risk. VBA also did not communicate the policy change to veterans and service members. The OIG also found VBA put individuals at risk by not following procedures to encrypt sensitive information on discs mailed to veterans. The review of a random sample of 30 Privacy Act responses found 1,027 unrelated third-party names and social security numbers. The OIG determined those disclosures raised legal concerns and estimated that responses under the May 2016 policy put millions of people at risk of identity theft. VA's Office of General Counsel, however, had provided VBA with legal support for the policy change, despite the risk. The OIG asked the under secretary for benefits in a December 11, 2018, memo to immediately suspend VBA's release policy and reevaluate the Privacy Act request program. After initially rejecting the request, the under secretary responded on June 19, 2019, saying VBA concluded that a policy update was necessary, and redactions would resume by October 1, 2019. The report was subsequently released in November 2019.

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

INADEQUATE OVERSIGHT OF THE MEDICAL/SURGICAL PRIME VENDOR PROGRAM'S ORDER FULFILLMENT AND PERFORMANCE REPORTING FOR EASTERN AREA MEDICAL CENTERS

The OIG conducted this audit to determine if VA effectively monitored Medical/Surgical Prime Vendor-Next Generation Program (MSPV-NG) order fulfillment and vendor performance. This audit focused on VA medical centers serviced by American Medical Depot (AMD). The MSPV-NG is VA's national program for obtaining medical or surgical supplies across VHA. The audit team reviewed a sample of AMD's delivery orders and estimated that medical centers received incorrect orders about 60 percent of the time. Incorrect orders occurred when delivery orders and invoice pricing did not match approved costs, products were obtained from unapproved suppliers, or staff obligated funds without proper authority. When necessary supplies are unavailable or incorrect because of vendors' errors, veterans' quality of care could be at risk. Orders were incorrect because VHA's Healthcare Commodities Program Office and VA's Strategic Acquisition Center did not develop a formal process to validate prime vendor performance reporting and the algorithm used by AMD. In addition, contracting officer representative (COR) positions at four of eight VA medical centers were vacant. CORs are responsible for monitoring vendor accuracy and performance. As a result, VA did not verify AMD's self-reported compliance with performance measures. The audit team found that AMD did not use the calculations and methodologies required by its contract, which led to inaccurate reporting. AMD also used unapproved suppliers. In addition, deliveries and invoice pricing did not match approved product costs, causing improper payments. The audit team estimated that, without correction, VA would improperly pay AMD about $84 million over the next five years. The OIG made 11 recommendations to VA, including establishing measures to ensure vendor compliance with contract requirements and developing and implementing processes to validate vendor performance and reporting.

TELEHEALTH PUBLIC-USE QUESTIONNAIRES WERE USED IMPROPERLY TO DETERMINE DISABILITY BENEFITS

The OIG conducted this review in response to veterans' benefits claims identified and referred by VBA as being potentially fraudulent. It also addressed allegations to the OIG hotline that telehealth questionnaires (without in-person examinations) were being improperly used for benefits determinations. VBA prohibits the use of private provider telehealth examinations for benefit rating purposes. The OIG had previously found problems with the use of disability benefits questionnaires and recommended VBA improve controls on the use of publicly available forms that could be altered to support baseless or exaggerated disability claims. The OIG found claims processors improperly used questionnaires completed by private care providers to determine benefit entitlements without ensuring the examinations were done in person. For example, VBA made improper determinations in 41 of the 81 claims the OIG reviewed, amounting to about $613,000 in benefit payments. Many other claims were likely submitted with telehealth examinations. VBA cannot easily identify those examinations improperly used to provide benefits nor correct related claims. VBA did not provide consistent staff guidance, adequately monitor use of telehealth questionnaires, or modify forms to reflect prohibited uses. VBA's internal controls are inadequate to prevent the use of publicly available questionnaires, which contain an inherent risk of fraud, despite VBA's risk-mitigation efforts. The OIG recommended the under secretary for benefits consider whether to discontinue using publicly available questionnaires for supporting benefit claims. If use is continued, VBA should update procedures so claims processors know how to handle questionnaires they suspect were completed via telehealth. The OIG also recommended adding to questionnaires whether they were completed in person or through telehealth, and publicly noting that telehealth examinations are not acceptable for determining benefit entitlements.

PUBLICATIONS ON HEALTHCARE ACCESS AND ADMINISTRATION

OIG audits and evaluations focus on the effectiveness of VA programs providing healthcare delivery for veterans. Reports on these programs identify opportunities for VA leaders to improve the processes, procedures, and policies needed to better manage these operations. The constructive recommendations are meant to support patients' timely access to high-quality healthcare services.

VHA DID NOT EFFECTIVELY MANAGE APPEALS OF NON-VA CARE CLAIMS

The OIG conducted this audit to determine whether appeals of non-VA care claims decisions were effectively managed and processed. It also focused on the readiness of VHA to implement the appeals process set out in the Veterans Appeals Improvement and Modernization Act of 2017. The audit team found significant deficiencies with the management of appeals, including unprocessed and unaccounted-for appeals stored in file cabinets, boxes, and bins. Office of Community Care leaders lacked effective oversight of its appeals function, and the appeals manager's roles and responsibilities had not been clearly defined. Also, VHA did not effectively prepare for the new appeals process and faces significant challenges. The OIG made eight recommendations to improve appeals management, including identifying and processing existing appeals, ensuring incoming appeals go to facilities that will process them, providing staff clear policies and procedures, and ensuring appropriate access and use of the appeals system of record.

DELAYS AND DEFICIENCIES IN MANAGEMENT OF SELECTED RADIOLOGY AND NUCLEAR MEDICINE OUTPATIENT EXAMS

This review examined whether VHA completed radiology and nuclear medicine exam requests and follow-up care in a timely manner. The audit team also considered whether VHA managed canceled requests appropriately. The audit team estimated that 17 percent of routine exams and 25 percent of urgent exams were not completed within the time frames required by VHA policy. Reasons included staff and equipment shortages, issues with staff allocation, and insufficient monitoring of the scheduling process. Most follow-up care was completed appropriately, but facility staff did not consistently cancel obsolete exam requests correctly. The audit team also substantiated two hotline allegations of inappropriate exam cancellations at the James A. Haley and Iowa City VA medical centers. The OIG made several recommendations to the under secretary for health for improving radiology and nuclear medicine oversight at the facility and regional levels.

IMPROVEMENTS ARE NEEDED IN THE COMMUNITY CARE CONSULT PROCESS AT VISN 8 FACILITIES

The OIG conducted this audit to determine whether facilities in VISN 8 were appropriately staffed and structured to manage the community care needs of veterans. The audit team found that during FY 2018, patients experienced delays receiving community care in VISN 8 due to insufficient staffing and the consult-processing structure at community care departments. These departments review, authorize, and schedule requests from a VA facility service for a patient to receive care from a non-VA provider. The OIG made five recommendations to the VISN 8 director to improve the timeliness of community care consults and address staffing deficiencies. The recommendations included implementing a mechanism to identify and routinely exchange wait time data. This exchange would ensure patients understand potential wait times and would help staff monitor the timeliness of each processing stage.

PUBLICATIONS ON BENEFITS DELIVERY AND ADMINISTRATION

The OIG performs audits and evaluations of VA's veterans' benefits programs. Through published reports, the OIG identifies potential risks to benefit program operations and services. Staff examine the effectiveness, timeliness, and accuracy of benefits delivery to veterans, eligible family members, and caregivers.

LITTLE ROCK VA REGIONAL OFFICE EMPLOYEE INACCURATELY ESTABLISHED AND DECIDED CLAIMS

The OIG substantiated an anonymous allegation that an employee at the VA Regional Office in Little Rock, Arkansas, inaccurately established and decided claims for disability benefits. As a result, VBA made nearly $311,000 in improper beneficiary payments. The review team did not find the decisions benefited the employee financially. The allegation also noted a potential conflict of interest in the employee's website for his nonprofit organization, but the review team found the site was not used to assist veterans on claims the employee processed. The employee subsequently resigned from his VA position to work in a different field. The OIG recommended the Little Rock VA Regional Office director review and correct the employee's rating decisions. The director also was prompted to ensure that the

proper authority approves rating decisions that are intended to resolve errors, and that rating veterans service representatives cannot establish claims in VA's electronic system.

VETERANS RECEIVED INACCURATE DISABILITY BENEFIT PAYMENTS AFTER RESERVE OR NATIONAL GUARD DRILL PAY ADJUSTMENTS

The OIG examined whether disability benefit adjustments were calculated accurately for veterans who served in the Reserve or National Guard. These veterans may be eligible for military training pay, or "drill pay." However, they are not entitled to receive drill pay and disability benefits in the same fiscal year. VBA asks the veteran to choose between drill pay and disability benefits and adjusts payment accordingly. Furthermore, VBA must adjust the payment for any days the veteran was on active duty and ineligible for disability benefits. The review team found that VBA inaccurately processed about 11 percent of adjustments in FY 2016, resulting in an estimated $14.2 million in overpayments and underpayments to veterans. The OIG made four recommendations to VBA to review FY 2016 adjustments and take corrective action as needed, as well as provide training for staff who process drill pay adjustments.

PUBLICATIONS ON MANAGEMENT OF FINANCIAL OPERATIONS AND SYSTEMS

Audits and reviews of VA's administrative support functions and financial management operations focus on the adequacy of infrastructure to provide program managers and leaders with the information needed to be good stewards of the funds entrusted to them by efficiently and effectively overseeing and safeguarding VA assets and resources. OIG oversight work satisfies the Chief Financial Officers Act of 1990 (P.L. 101-576) audit requirements for federal financial statements and provides timely, independent, and constructive evaluations of financial information, programs, and activities.

FY 2019 AUDIT OF VA'S COMPLIANCE UNDER THE DATA ACT OF 2014

The independent public accounting firm CliftonLarsonAllen LLP (CLA), under contract to the OIG, audited VA's compliance with the Digital Accountability and Transparency Act of 2014 for the first quarter of FY 2019. CLA reported VA's financial management and related systems have limited functionality to fully meet the reporting standards and requirements, and that data management and reporting processes need improvement to ensure compliance. As a result, CLA determined VA did not fully meet the required reporting standards and attributes of completeness, timeliness, quality, and accuracy. The 16 recommendations from CLA are meant to improve compliance, including that VA continue system modernization efforts and improve internal controls over aspects of the data submission process. VA concurred with all recommendations and provided planned corrective actions. CLA is responsible for the report, including its conclusions and recommendations, and the OIG does not express an opinion on VA's compliance.

FINANCIAL CONTROLS AND PAYMENTS RELATED TO VA-AFFILIATED NONPROFIT CORPORATIONS: BOSTON VA RESEARCH INSTITUTE

The OIG conducted this audit in response to allegations that the Boston VA Healthcare System violated law and VA policy by making inappropriate payments to the Boston VA Research Institute,

a VA-affiliated nonprofit corporation. The OIG found lapses in oversight and weak internal controls allowed for inappropriate payments to the Boston VA Research Institute. VA Boston Healthcare System officials authorized about $1.6 million in inappropriate payments to the institute for administrative fees, reimbursing salaries and benefits of administrative positions, and duplicate retirement contributions because they did not follow VA policy. The healthcare system made an estimated $22.8 million in improper payments because employees did not verify services were performed before making payments, as VA policy requires. The OIG made seven recommendations, including that the under secretary for health confer with the VA Office of General Counsel and human resources officials about whether administrative actions should be taken against officials responsible for inappropriate payments.

FINANCIAL CONTROLS AND PAYMENTS RELATED TO VA-AFFILIATED NONPROFIT CORPORATIONS: CINCINNATI EDUCATION AND RESEARCH FOR VETERANS FOUNDATION

The OIG evaluated the merits of a 2018 hotline complaint alleging the executive director of the Cincinnati Education and Research for Veterans Foundation (CERV), a VA-affiliated nonprofit corporation, used the CERV credit card inappropriately for personal expenses. In addition, the OIG broadly examined whether there were adequate controls in place for ensuring proper expenditures and whether the CERV board of directors provided adequate oversight of expenditures. The audit team did not substantiate the allegation that the executive director used the CERV credit card inappropriately. However, the team identified some financial controls that were inadequate or absent. In addition, the audit team found that the Cincinnati VA Medical Center did not comply with VA internal controls to ensure services were performed in accordance with the agreement before approving invoices for payment. The OIG made four recommendations to CERV and the Cincinnati VA Medical Center.

RISK ASSESSMENT OF VA'S GRANT CLOSEOUT PROCESS

OIG staff performed a risk assessment of VA's grant closeout process to determine if an audit or review of the process was warranted, as required by the Grants Oversight and New Efficiency Act of 2016. The assessment team concluded that neither was warranted. VA reported 34 expired grants more than two years old with undisbursed balances as of the end of FY 2019. The reported undisbursed balances were reduced to less than $500,000 when the team adjusted for discrepancies between a grants payment system and VA's financial management system. For FY 2020, the estimated budgets for the assessed grant programs totaled only about one percent of VA's overall budget estimate. Moreover, VA's largest grant program, State Home Per Diem, obligates funds when an invoice is paid. Accordingly, for about 67 percent of the $2.27 billion grant budget, VA has implemented a process to mitigate the risk of undisbursed balances.

PUBLICATIONS ON MANAGEMENT OF INFORMATION TECHNOLOGY AND SECURITY

OIG audits and reviews VA's information technology (IT) systems and security operations. This work ensures the policies focusing on the adequacy of managing and protecting veterans and VA employees, facilities, and information are in place and fully implemented. OIG audit reports present VA with constructive recommendations to improve IT management and security. OIG is also statutorily required

to review VA's compliance with the Federal Information Security Modernization Act of 2014 (P.L. 113-283), as well as IT security evaluations conducted as part of the consolidated financial statements audit.

MISHANDLING OF VETERANS' SENSITIVE PERSONAL INFORMATION ON VA SHARED NETWORK DRIVES

The OIG conducted this review in response to an allegation that veterans' sensitive personal information was stored on shared network drives and was likely accessible to unauthorized users. The OIG team found sensitive personal information was left unprotected on two shared VA enterprise network drives, putting veterans at risk of fraud or identity theft. VA's Office of Information and Technology (OIT) senior representatives said authenticated network users with access to the shared drives could have accessed that information regardless of having a business need. These issues occurred as a result of negligence and lack of oversight. The OIG recommended VA officials provide remedial training to users on the safe handling and storage of sensitive personal information on network drives. The OIG also recommended establishing technical controls and improving oversight procedures to prevent sensitive personal information from being stored on the shared network drives.

VA'S MANAGEMENT OF MOBILE DEVICES GENERALLY MET INFORMATION SECURITY STANDARDS

VA's OIT manages more than 50,000 mobile devices that store and transmit veteran information that must be protected. The OIG conducted this audit to determine whether OIT's policies and procedures provide enough security for that information. The OIG found OIT's security practices for mobile devices generally minimized security weaknesses within VA's network. However, the OIG did find vulnerabilities associated with configuration management. An OIT director said the office decided not to use blacklisting (blocking) or other configuration management tools because of concerns about workload. The OIG recommended the Assistant Secretary for Information and Technology either enforce blacklisting or formally assess and document whether training would work to prevent users from downloading and using non-VA approved applications. OIT has now awarded a contract to Lookout for a new application vetting tool, but it was not available for OIG review before report publication.

FEDERAL INFORMATION SECURITY MODERNIZATION ACT AUDIT FOR FY 2019

CLA, under a contract with the OIG, assessed VA's information security program for FY 2019, in accordance with the Federal Information Security Modernization Act (FISMA). The firm evaluated 49 major applications and general support systems hosted at 24 VA facilities. The firm concluded that VA continues to face significant challenges meeting FISMA requirements and made 25 recommendations. Recommendations included improving both performance monitoring and the deployment of security patches and system upgrades. The firm noted that all recommendations were repeated or modified from previous reports on FISMA compliance. CLA will follow up on outstanding recommendations and evaluate VA's corrective actions during its FISMA audit for FY 2020. If delays in addressing recommendations continue, the OIG is concerned that a material weakness in informational technology security controls may be reported in the FY 2020 audit of VA's consolidated financial statements.

PUBLICATIONS ON ACQUISITION AND PROCUREMENT ADMINISTRATION AND OVERSIGHT

OIG audits and reviews VA's acquisition processes and oversight operations. These reports provide insight into the challenges of a large, decentralized purchasing system, through which a variety of offices play significant roles. Compliance with the Federal Acquisition Regulation (as well as title 48 C.F.R.) and VA's internal acquisition regulations ensures VA staff and veterans receive the best and most timely supplies and services. The recommendations in these reports present VA with insightful and constructive means to improve the acquisition and procurement processes.

INSUFFICIENT OVERSIGHT OF VA'S UNDELIVERED ORDERS

This audit examined whether VA's management of undelivered orders ensured the most effective use of appropriated funds. Undelivered orders are those with items or services that have not been received, and their value represents legal financial commitments. The OIG found that VA did not effectively ensure appropriated funds that were no longer needed were identified and deobligated. Undelivered orders management lapses were related to VA issuing conflicting guidance and not properly monitoring and reconciling excess funds or providing supporting documentation. The audit team estimated that VA had not deobligated at least $132.6 million of $3.5 billion in excess funds in a timely manner, as required by VA policy. The OIG recommended that VHA leaders make certain that obligation policy includes timeframes for internal communication to identify funds for deobligation. Other recommendations focused on compliance with policies related to reviewing, adjusting, and maintaining documentary evidence for obligations.

OPPORTUNITIES MISSED TO CONTAIN SPENDING ON SLEEP APNEA DEVICES AND IMPROVE VETERANS' OUTCOMES

The OIG conducted this audit to determine if VHA efficiently manages positive airway pressure devices and supplies for veterans diagnosed with sleep apnea. The number of veterans who receive devices and supplies increased dramatically in five years, increasing VA's financial risk. VHA did not efficiently manage devices and associated supplies—almost half of the 250,000 veterans issued a device from October 2016 through May 2018 used it less than half the time. VHA could save up to $39.9 million annually with alternative processes such as loaning devices to patients rather than purchasing them. A loan program could save up to an additional $12.4 million annually by not purchasing device supplies for veterans who do not use their devices. The OIG made three recommendations to the under secretary for health regarding management of sleep apnea devices including looking at staffing levels, ways to better monitor device use, and alternatives to purchasing and giving the devices to patients who are not using them.

REVIEW OF REGIONAL PROCUREMENT OFFICE EAST'S CONTRACT CLOSEOUT COMPLIANCE

Audit personnel reviewed whether Regional Procurement Office East followed Federal Acquisition Regulation and VHA requirements when closing out contracts. Noncompliance increases financial and legal risks, and resulting excess funds may not be effectively directed for other uses that benefit veterans. The review team examined a random sample of 40 closed contracts worth $500,000 or more from FY 2018 to determine whether closeout procedures were followed. The team also reviewed an open obligations report to identify contracts with remaining excess funds. The OIG found contracting

officers did not consistently close out contracts on time and did not fully document requirements. The review team also identified about $6.8 million in unreleased excess funds. The OIG recommended the VHA procurement executive director establish quality assurance reviews for contracts to ensure closeout requirements are met and all contracting officers are retrained on procedures.

FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT OF 1996

The Federal Financial Management Improvement Act (FFMIA) requires all Chief Financial Officer Act agencies to implement financial management systems that substantially comply with three essential requirements: (1) federal financial management systems requirements, (2) federal accounting standards, and (3) the United States Standard General Ledger at the transaction level. The law further requires that the head of the agency annually assess and the agency auditor report whether the agency's financial management systems substantially comply with the law's essential requirements.

Accordingly, the VA OIG is required to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA. The *Audit of VA's Financial Statements for Fiscal Years 2019 and 2018* reported the following:

- VA did not substantially comply with federal financial management systems requirements and the United States Standard General Ledger at the transaction level under FFMIA, which has been repeatedly reported in part for more than 10 years.
- VA did not fully comply with the intent of the Federal Managers' Financial Integrity Act, which has been reported by the OIG since FY 2015. Improvements are needed.
- There were instances of noncompliance with 38 U.S.C. § 5315 pertaining to the charging of interest and administrative costs, which has been reported for more than 10 years.
- VA reported one violation of the Antideficiency Act, 31 U.S.C. § 1341(a), in July 2019 and had one potential violation. In addition, five other violations, which are carried forward from prior years, are under further discussion with the Office of Management and Budget. Violations of the Antideficiency Act have been reported since FY 2012.
- VA did not comply with the Improper Payments Elimination and Recovery Act for FY 2018, as reported by the OIG since 2012.

These conditions are primarily due to VA's complex and disjointed legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. VA continues to be challenged in its efforts to apply consistent enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems.

RESULTS FROM THE OFFICE OF CONTRACT REVIEW

OVERVIEW

The Office of Contract Review provides VA's Office of Acquisition, Logistics, and Construction with preaward, postaward, and other reviews of vendors' proposals and contracts. In addition, the OIG provides advisory services for Office of Acquisition, Logistics, and Construction contracting activities. The Office of Contract Review issued 56 reports during this reporting period including two public reports. The majority of reports completed by the Office of Contract Review are released only to the contracting officer because of proprietary and privacy information contained in the reports. The information that follows provides an overview of the Office of Contract Review's performance.

PREAWARD REVIEWS

Preaward reviews provide information to assist VA contracting officers in negotiating fair and reasonable contract prices and ensuring price reasonableness during the term of the contract. Thirty-one preaward reviews identified over $59.3 million in potential cost savings during this reporting period. In addition to Federal Supply Schedule (FSS) and Architect/Engineer Services proposals, preaward reviews during this reporting period included 11 healthcare provider proposals, accounting for approximately $22.8 million of the identified potential savings.

31
PREAWARD REVIEWS

$59M
POTENTIAL COST SAVINGS

POSTAWARD REVIEWS

Postaward reviews ensure vendors' compliance with contract terms and conditions, including compliance with the Veterans Health Care Act of 1992 (P.L. 102-585) for pharmaceutical products. Postaward reviews resulted in VA recovering contract overcharges totaling over $8.4 million, including approximately $2.9 million related to compliance with the Veterans Health Care Act's pricing requirements, recalculation of federal ceiling prices, and appropriate classification of pharmaceutical products. Postaward reviews continue to play a critical role in the success of VA's voluntary disclosure process. Of the 23 postaward reviews performed, 16 involved voluntary disclosures. In 13 of the 16 voluntary disclosure reviews, the OIG identified additional funds due. VA recouped 100 percent of the recommended recoveries for postaward contract reviews.

23
POSTAWARD REVIEWS

$8M
DOLLAR RECOVERIES

CLAIM REVIEWS

The OIG assists contracting officers when contractors have filed claims against VA. The objective of these reviews is to validate the basis of the claim and to determine that the claimed amount is supported by accounting and other financial records. During this period, the OIG reviewed two claims and determined that $395,440 of claimed costs were unsupported and should be disallowed.

2
CLAIM REVIEWS

$395K
POTENTIAL COST SAVINGS

PUBLICATIONS

THE IMPACT OF VA ALLOWING GOVERNMENT AGENCIES TO BE EXCLUDED FROM TEMPORARY PRICE REDUCTIONS ON FEDERAL SUPPLY SCHEDULE PHARMACEUTICAL CONTRACTS

VA is responsible for negotiating FSS prices (volume discounts) for billions of dollars of pharmaceuticals on behalf of all federal agencies. This review examined how VA administers temporary price reductions (TPRs) and the impact on government-wide contract negotiations when VA accepted TPRs offered only to certain government agencies and not all authorized FSS users. VA's National Acquisition Center has been routinely facilitating the award of agency-specific TPRs, which the OIG found did not benefit all authorized FSS users. The OIG determined taxpayers paid an estimated $602 million more over two years for pharmaceuticals purchased government-wide than if the lowest price reduction had been offered to all federal agencies. Agency-specific TPRs appeared to have negatively affected the negotiation of FSS prices and were being processed as unilateral modifications. Also, the TPRs were not published as required for FSS prices, potentially reducing competition. VA nonconcurred with one of the OIG's four recommendations to develop and implement a policy that prohibits restricted agency-specific TPRs on FSS contracts.

QTC MEDICAL SERVICES COMPLIED WITH MEDICAL DISABILITY EXAMINATION BILLING REQUIREMENTS

The VA OIG conducted this review of QTC Medical Services, a company VA contracts with to conduct medical disability exams for veterans and active military members. Prior VA OIG and independent auditor reviews identified deficiencies with the company's billing practices that yielded significant questioned costs. The review team's objective was to determine whether the company maintained corrective measures to address the previously identified issues, and to follow up on recent billing practices. The review team sampled two months of billings totaling more than $12 million and found QTC Medical Services was complying with the billing requirements in its current contracts and not engaging in overbilling or other previously identified concerning practices. The VA OIG therefore made no recommendations.

RESULTS FROM THE OFFICE OF HEALTHCARE INSPECTIONS

OVERVIEW

During this reporting period, OHI published three national healthcare reviews and 17 inspection reports responsive to OIG hotline complaints on topics that are related to VHA operations and the access to and quality of care provided to patients. They addressed a broad range of topics such as mental health care, sterile processing, community living centers, and leadership. The office also published 34 CHIP reports, which resulted from unannounced OIG inspections of VA facilities' key clinical and administrative processes that are associated with promoting positive healthcare outcomes for veterans. As with other OIG published reports, the OHI recommendations for corrective action are detailed at www.va.gov/oig. Dashboard users can track the status of report recommendations published since October 2012.

54
PUBLICATIONS

2,101
HOTLINE REFERRALS REVIEWED

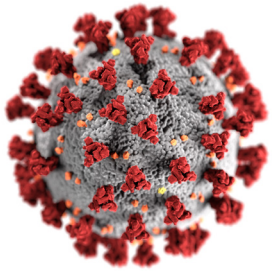
6
IN-DEPTH CLINICAL CONSULTATIONS

FEATURED PUBLICATIONS

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

OIG INSPECTION OF VHA'S COVID-19 SCREENING PROCESSES AND PANDEMIC READINESS

More than 50 OIG staff, nearly all with healthcare experience and following Centers for Disease Control and Prevention guidelines, conducted an inspection to evaluate novel coronavirus disease (COVID-19) screening processes at 237 VA facilities (medical centers, community-based outpatient clinics, and community living centers) and to collect data on pandemic preparations. Screening processes at 71 percent of visited medical centers were adequate, while 28 percent had opportunities for improvement. The vast majority of community-based outpatient clinics had screening procedures in place. Although VA announced a no visitors policy for community living centers on March 10, 2020, OIG staff not yet identified to facility personnel had access to nine. Almost all medical facilities visited were collecting COVID-19 specimens, but none had the capability to process them on site. Facility leaders indicated that the VA Palo Alto Health Care System (a site not visited by OIG) was processing specimens.



CDC/ALISSA ECKERT, MS; DAN HIGGINS, MAMS

Facility leaders reported that the medication inventory used to (1) manage symptoms, (2) treat critically ill patients to support cardiovascular functions, and (3) sedate intubated patients may be insufficient. Some facility leaders expressed concerns with their inventory of COVID-19 testing kits and personal protective equipment supplies. Almost half of facility leaders reported a rise in absenteeism but were able to provide coverage or offer overtime pay to minimize impact. Some facilities reported low staffing levels for police and environmental management services. As of March 19, 2020, 43 percent of facility leaders reported plans to share intensive care beds, personal protective

equipment supplies, or both, with community providers. Most leaders stated they would send patients to either another VA medical center or a private, community, university, or Department of Defense hospital if unable to meet patient care needs related to COVID-19. The OIG recognizes VA staff's tremendous efforts and that challenges related to the pandemic may change rapidly. The OIG will continue to monitor VHA's readiness efforts.

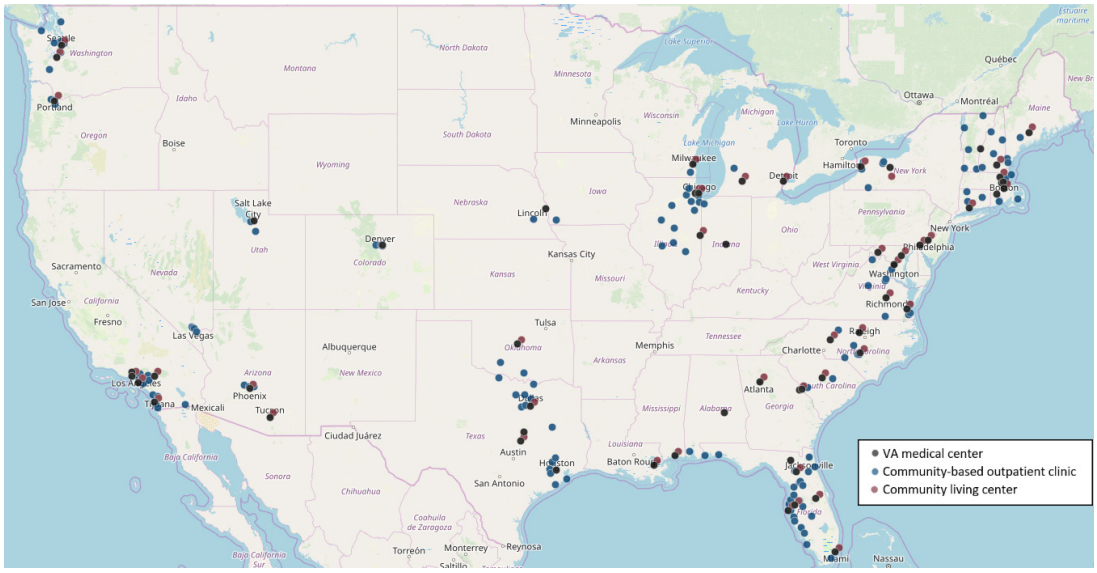


Figure 1: Map of selected VA medical facilities visited March 19–24, 2020

Note: Sites selected were within driving distance (to avoid air travel or mass transit) for OIG staff who prescreened for COVID-19 indicators before conducting inspections.

DEFICIENCIES IN CARE COORDINATION AND FACILITY RESPONSE TO A PATIENT SUICIDE AT THE MINNEAPOLIS VA HEALTH CARE SYSTEM IN MINNESOTA

The OIG conducted a healthcare inspection to examine care coordination for a patient who died by suicide while admitted to an inpatient medicine unit at the facility. The patient was assessed as at heightened but not imminent risk for suicide. Facility emergency department staff failed to report the patient's suicidal ideation to the facility's Suicide Prevention Coordinator. Two consulting staff members and an inpatient registered nurse (who had completed required suicide prevention training) failed to involve clinicians when the patient verbalized suicidal thoughts and warning signs. Two of the three staff documented the patient's suicidal thoughts and warning signs in consult results notes, but the OIG did not find documentation that the inpatient medicine resident reviewed or acted on the consult results. During an internal review, the facility's root cause analysis team did not interview staff members involved in the patient's care. The internal review team identified many lessons learned for which VHA does not require action. VHA does not provide written guidance on the identification of lessons learned, related action expectations, and how to distinguish lessons learned from root causes. The absence of formal guidance may have contributed to the team's failure to identify critical actions in the prevention of adverse patient events. Facility leaders did not make an institutional disclosure to the patient's next of kin. The Patient Safety Committee and the Quality Management Council meeting minutes did not document deliberations and track actions to resolution. The OIG made a recommendation to the under secretary for health related to written guidance for lessons learned, and six recommendations to the

facility director related to Suicide Prevention Coordinator notification, a review of the patient's care, consult results, institutional disclosure, the root cause analysis process, and documentation of meeting minutes.

COMPREHENSIVE HEALTHCARE INSPECTION SUMMARY REPORT FOR FISCAL YEAR 2018

This report is the first OIG CHIP summary report that aggregates the results of all CHIP reviews performed during a fiscal year to identify national trends and areas for improvement for executive leaders at VHA headquarters. The CHIP reviews provide focused evaluations of the quality of care delivered by VHA facilities selected by the OIG for examination every three years. Although the OIG noted that 85 percent of leaders were assigned permanently at the 51 VA facilities visited from October 2017 through September 2018, tenure of facility directors ranged from approximately one week to almost six years, with the average at two years, during the time of the facility inspections. Chiefs of staff were slightly more stable with tenure ranging from approximately one week to 17 years; the average tenure was four years for these physician leaders. Sixteen of the surveyed facilities with a "1-" or "2-star" rating in the Strategic Analytics for Improvement and Learning system had significant opportunities for improvement, and facilities with higher star ratings had fewer OIG recommendations for corrective action. The OIG issued 16 recommendations to the under secretary for health, VISN directors, and facility senior leaders related to (1) quality, safety, and value; (2) credentialing and privileging; (3) environment of care; (4) medication management: controlled substances inspections; and (5) geriatric care program oversight.

NATIONAL HEALTHCARE REVIEWS

National healthcare reviews focus on VHA programs, activities, or functions from a systemwide perspective. Such reviews may be used to provide factual and analytical information, monitor compliance with established criteria and standards, measure performance, assess the efficiency and effectiveness of programs and operations, or identify and share best practices within VHA facilities. National reviews may be mandated or requested by Congress or initiated by the OIG. In addition to the report discussed below, see the Featured Publications section above for two additional OHI national reviews.

REVIEW OF VHA COMMUNITY LIVING CENTERS AND CORRESPONDING STAR RATINGS

In response to a congressional request, the OIG examined the community living center (CLC) rating system (Compare), the rating system's limitations, and what information from the system can reasonably be used to understand the long-term care delivered at CLCs. The OIG found star ratings provided only a limited look at care delivered in CLCs. Despite the limitations associated with using CLC Compare, problematic evaluations still raise concerns about quality of care. It is incumbent on VA to determine whether such evaluations reflect shortcomings in the rating system or the care delivered. Three recommendations were made to the under secretary for health related to supplementing CLC Compare with adjustment measures to address CLC and Center for Medicare and Medicaid Services comparison challenges, developing measures with more rigorous risk adjustment for CLC staffing and quality performance, and creating a resource that provides an understandable narrative for all.

HEALTHCARE INSPECTIONS

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

OPHTHALMOLOGY EQUIPMENT AND RELATED CONCERNS AT THE JAMES A. HALEY VETERANS' HOSPITAL IN TAMPA, FLORIDA

Allegations were received by the OIG involving ophthalmology equipment maintenance and repair issues and other concerns at the facility. The OIG did not substantiate allegations related to specific ophthalmology equipment and was unable to determine whether Eye Clinic procedures were canceled due to equipment issues. The OIG did substantiate an increase in community care consults for eye care; however, the increased volume was largely the result of the restructuring of the appointment scheduling process. The OIG also substantiated that the Prosthetic and Sensory Aids Service took four to six weeks to issue a purchase order, resulting in patients waiting six to eight weeks for eyeglasses. The OIG was unable to substantiate an allegation that facility leaders had not responded to complaints for at least 15 years. The OIG made four recommendations related to work order documentation, equipment corrective maintenance and communication, timeliness of eyeglass purchase order processing, and addressing the backlog of open eyeglass purchase order requests.

TWO PATIENT SUICIDES, A PATIENT SELF-HARM EVENT, AND MENTAL HEALTH SERVICES ADMINISTRATIVE DEFICIENCIES AT THE ALASKA VA HEALTHCARE SYSTEM IN ANCHORAGE, ALASKA

The OIG reviewed allegations of deficiencies in quality of care and administrative processes that contributed to two patient deaths by suicide and one patient's self-harm behavior at the Alaska VA Healthcare System's outpatient Social and Behavioral Health Services. The OIG found that facility staff failed to follow missing patient policies and to schedule follow-up appointments, and that the care a patient received from multiple providers did not contribute to the patient's self-harm behavior. Also, the OIG found that the Same Day Access Clinic had gaps in triage staff coverage, lacked morning psychiatric coverage, and had providers that were double booked. However, the OIG was unable to determine that these deficits contributed to adverse patient outcomes. Facility staff also closed scheduling orders without contacting patients and completing documentation and there was a backlog of scheduling orders. Additionally, the facility lacked policies for missed appointments, the Mental Health Treatment Coordinator, and behavioral health emergencies. Facility leaders did not implement Behavioral Health Interdisciplinary Program teams as well. The OIG identified opportunities for improving the culture of safety and made 11 recommendations.

DEFICIENCIES IN STERILE PROCESSING SERVICES AND DECREASED SURGICAL VOLUME AT THE VA CONNECTICUT HEALTHCARE SYSTEM IN NEWINGTON AND WEST HAVEN

The OIG conducted an inspection in response to Senator Richard Blumenthal's request to review Surgical and Sterile Processing Services (SPS) concerns within the VA Connecticut Healthcare System.

The request came after The Joint Commission and the National Program Office for Sterile Processing surveys of the system found SPS deficiencies. Consequently, system leaders immediately reduced SPS reprocessing services and limited surgical procedures. The OIG inspection reviewed SPS standard operating procedures (SOPs), training, competencies, and staffing; surgical cancellations; patient safety; and surgical and post-operative infection rates. The team identified additional concerns regarding leaders' decision-making, the system's infrastructure, and the residency program. The OIG made two recommendations to the VISN director related to oversight and nine recommendations to the system director regarding decision-making, restoration of trust in system leaders, oversight of pending SPS projects, SOPs, competencies and training, staffing, evaluation of surgical supplies, review of the residency programs, and VISN collaboration.

ALLEGED WRONGFUL DEATH AND DEFICIENCIES IN DOCUMENTATION OF A PATIENT'S DNAR STATUS AT THE BALTIMORE VA MEDICAL CENTER IN MARYLAND

The OHI team evaluated allegations that a patient at the Baltimore VA Medical Center "may have died wrongfully," and that resuscitation was attempted despite a "Do Not Attempt Resuscitation" (DNAR) order. The patient died due to aspiration pneumonia and cardiopulmonary arrest, but the OIG was unable to determine whether the death was wrongful. The OIG substantiated that staff attempted resuscitation on a patient with a DNAR status. There was no DNAR order in the patient's electronic health record when resuscitation was attempted, but the patient had a DNAR status. Residents and physicians did not comply with DNAR documentation requirements and failed to communicate the DNAR status to healthcare team members. Further, facility leaders failed to act on an identified pharmacy safety issue related to the administration of haloperidol in patients with Parkinson's disease; facility staff did not comply with code blue documentation requirements; measures to identify and rectify challenges with resuscitation processes were insufficient; and leaders failed to hold staff accountable. The OIG made four recommendations related to the facility leaders' review of the patient's course of treatment; the identification, documentation, and communication of patients' DNAR status; tracking, documenting, and completing action items in the Executive Committee of the Medical Staff; and tracking code blue/rapid response events.

ALLEGED DEFICIENCIES IN ONCOLOGY PSYCHOSOCIAL DISTRESS SCREENING AND ROOT CAUSE ANALYSIS PROCESSES AT A FACILITY IN VETERANS INTEGRATED SERVICE NETWORK 15

The OIG evaluated staff's adherence to the facility's psychosocial distress screening SOP and facility leaders' response to the root cause analyses following two patient deaths. Facility oncology service staff demonstrated compliance with psychosocial distress screening SOPs. However, a mental health evaluation, which may have identified additional risk factors and provided opportunity for suicide prevention interventions, was not completed prior to one patient leaving the clinic. Facility oncology service nursing staff administered the psychosocial distress screening at every visit, which exceeded SOP requirements. To ensure clear guidance for staff, the alignment of the SOP with facility oncology nursing staff's psychosocial distress screening at every visit is critical. Additionally, the facility's Patient Safety Manager also did not monitor progress toward root cause analysis action item completion. After a patient's death by suicide in 2017, the Acting Suicide Prevention Coordinator did not complete documentation required by VHA. The OIG made four recommendations related to mental health evaluation coverage, alignment of SOPs for psychosocial distress screening with the National Comprehensive Cancer Network's ideal standards, tracking of action items to completion, and the completion of Suicide Behavior and Overdose Reports and Behavioral Health Autopsies.

REVIEW OF STAFFING AND ACCESS CONCERNS AT THE MANN-GRANDSTAFF VA MEDICAL CENTER IN SPOKANE, WASHINGTON

This healthcare inspection revealed that seven providers left the facility from early June through mid-July, with the losses due to a combination of internal transfers, planned retirements, and resignations. The OIG found that access to some outpatient care started to decline around May 2019. The facility formed a team to analyze the potential for closing the intensive care unit due to low utilization. The facility used one of its two operating rooms and temporarily reduced its procedures and services to decrease the volume of items requiring sterile processing. The chief of dental service was detailed to the acting chief of radiology position based on previous leadership experience and qualifications. The OIG made two recommendations related to patients' access to care and completion of corrective actions the facility initiated pursuant to its most recent National Program Office for Sterile Processing review and report.

A DELAY IN PATIENT NOTIFICATION OF TEST RESULTS AND OTHER COMMUNICATION ISSUES AT THE BATH VA MEDICAL CENTER IN NEW YORK

A healthcare inspection team assessed allegations of delays in providing patient test results, communication issues between providers and paramedics related to transporting patients to a community hospital emergency department, violations of the Emergency Medical Treatment and Labor Act, and quality of care concerns resulting from paramedic care at the facility. The OIG substantiated a surrogate provider failed to follow test notification policies; however, the delay did not result in an adverse event. The OIG substantiated a paramedic failed to comply with the facility's standard operating procedure by transporting a patient to a different hospital than instructed by the provider. The OIG noted that the facility's policy for paramedic transfers was unclear. The OIG did not substantiate that the paramedics violated the intent of the law or provided poor quality of care. The OIG made two recommendations to the facility director related to surrogate providers and the Patient Transfer Policy.

ALLEGED DEFICIENCIES IN A HOSPITALIST'S INTERACTIONS WITH A PATIENT AT THE VETERANS HEALTH CARE SYSTEM OF THE OZARKS IN FAYETTEVILLE, ARKANSAS

The OIG evaluated allegations regarding a hospitalist's interactions with a patient and family when obtaining consent for "Do Not Resuscitate" (DNR) status and determining discharge plans at the facility. The OIG was unable to determine whether the hospitalist demonstrated inappropriate and unprofessional behavior with the patient and family. The hospitalist followed policy when determining the patient's decision-making capacity and obtaining consent for a DNR status. The facility coordinated the patient's discharge and addressed medication and nutrition needs and aspiration precautions. After discharge, the family requested, and the patient received, home hospice services and a nasogastric tube. The OIG evaluated three additional cases involving the hospitalist's determination of patients' DNR status and noted that the hospitalist's interactions lacked evidence of discussions of patients'

preferences and quality of life. The facility had processes to provide oversight of physician behavior. The OIG made no recommendations.

DEFICIENCIES IN THE WOMEN VETERANS HEALTH PROGRAM AND OTHER QUALITY MANAGEMENT CONCERNS AT THE NORTH TEXAS VA HEALTHCARE SYSTEM

This healthcare inspection evaluated concerns related to deficiencies in the Women Veterans Health Program, quality management for patient safety and resuscitation attempts, and leaders' responses to recommendations from oversight bodies at the facility. The facility had an insufficient number of women's health primary care providers available to provide gender-specific comprehensive primary care for women veterans. Resources needed to support comprehensive women veterans' health care were insufficient. Community care results were not consistently tracked. The facility's quality management performance measurement and evaluation processes did not ensure awareness of quality of care concerns to inform facility leaders of required institutional disclosures and adverse event decision-making. The resuscitation committee did not capture and review all resuscitation attempts, or take corrective actions to identify the causes surrounding these events. The OIG made 18 recommendations related to staffing, appointment times, current and future resources, community care, and quality management processes.

CONCERN REGARDING A PATIENT DEATH AND ALLEGED CONFLICTS OF INTEREST AT THE VA WESTERN COLORADO HEALTH CARE SYSTEM IN GRAND JUNCTION

A facility urologist performed extracorporeal shock wave lithotripsy (ESWL) on a patient who died 25 days later. However, the patient did not have significant risk factors and was a suitable candidate for ESWL. Additionally, a non-urologist provider failed to address an abnormal blood smear result. The associate chief of staff for Acute Care Services was associated with the same private practice as urologists hired by the facility; however, the associate chief of staff did not sign the request to recruit the urologists. The OIG was unable to determine whether an increase in ESWL procedures was due to the urologists' ownership interest in a company associated with ESWL rental equipment. The Office of General Counsel found "no actual conflict of interest," however, facts given to the General Counsel may have contained inaccurate statements. The OIG made two recommendations related to abnormal blood tests and resubmission of the request for an Office of General Counsel conflict of interest review that included more detailed information.

QUALITY OF CARE ISSUES IN THE COMMUNITY LIVING CENTER AND EMERGENCY DEPARTMENT AT THE DAYTON VA MEDICAL CENTER IN OHIO

An inspection was initiated regarding a patient who died after transfer from the facility's CLC to the emergency department. Deficiencies were identified in an emergency department physician's medical decision-making, provision of care, and handoff communication. Also, an emergency department registered nurse failed to adequately monitor the patient. Deficits in the physician's practices were not limited to this case and the physician's privileges were revoked. However, while the VA Disciplinary Appeals Board overturned the physician's removal, the physician then resigned. The OIG did not substantiate that the registered nurse under review was involved in additional patient deaths or that emergency department staffing was inadequate. The OIG made 13 recommendations that addressed these and other findings including provider and peer review training, transitions of care policies, standing orders, critically ill patient care, Peer Review Committee documentation, leaders' responses to care concerns, supplies, bar code medication administration compliance, and document management procedures.

ALLEGED ISSUES IN THE CARDIOLOGY DEPARTMENT AT THE RICHARD L. ROUDEBUSH VA MEDICAL CENTER IN INDIANAPOLIS, INDIANA

A healthcare inspection was conducted at the facility to evaluate allegations concerning delays in interpreting and reporting patient cardiology tests and scheduling patients for cardiology procedures, deficiencies in pacemaker data recordkeeping, and supervisory concerns in the Device Clinic. The OIG did not substantiate that electrocardiogram or cardiac event tracings reports were not interpreted timely, that patients requiring cardiac surgery procedures were not scheduled for over a year, or that there was improper supervision of the Device Clinic. The facility's cardiologist turnover rate was high, and Cardiology and Surgery Services staff did not use the VHA's consult process and maintained an unauthorized wait list for a procedure. The OIG did not find evidence of adverse clinical outcomes related to these issues. The OIG made four recommendations related to cardiologist turnover, staff understanding of authorized and unauthorized patient wait lists, and the training of staff on consult process and wait list policies.

ALLEGED DEFICIENCIES RELATED TO THE CARDIAC CATHETERIZATION AND ELECTROPHYSIOLOGY LABORATORIES AT THE JESSE BROWN VA MEDICAL CENTER IN CHICAGO, ILLINOIS

The OIG initiated an inspection in response to concerns within the cardiac catheterization and electrophysiology laboratories at the facility and substantiated that complications occurred in patients who underwent cardiac procedures. However, the complications were not due to facility deficiencies and were consistent with known risks. Leaders followed VHA policy in response to the death of one patient who underwent a cardiac catheterization procedure. The VA OIG did not substantiate that an anesthesiologist had concerns about the cardiac catheterization laboratory. The Cardiopulmonary Resuscitation Committee meeting minutes lacked a way to identify a specific code event; however, a previous OIG team recommended the committee review each resuscitative episode. The OIG substantiated that the acting chief of staff was aware of cardiac catheterization laboratory issues but did not substantiate that no follow-up action occurred. The OIG did not substantiate that a cardiologist was absent during procedures or that cardiology fellows performed procedures independently. The OIG made no recommendations.

DEFICIENT STAFFING AND COMPETENCIES IN STERILE PROCESSING SERVICES AT THE VA BLACK HILLS HEALTHCARE SYSTEM IN FORT MEADE CAMPUS, SOUTH DAKOTA

The OIG healthcare team assessed an allegation that a facility leader endangered patient safety by placing an unqualified leader as the acting chief of SPS at the facility. The OIG did not substantiate that the detailed acting chief endangered patient safety. Facility leaders based incumbent selection on leadership experience and the individual's workload, which the detailed acting chief had. The OIG found no patients were harmed. Facility leaders failed to comply with a 2009 memorandum requiring complexity Level 1 and 2 facilities to have SPS assistant chief positions. Unreliable processes for identifying changes in manufacturer's instructions led to improper sterilization of some instruments; however, appropriate actions were taken, and an analysis determined that patient risk was minimal. A lack of stable SPS leadership was identified as a possible reason for failure to identify the change to the manufacturer's instructions and update staff competencies. The OIG made three recommendations related to staffing, compliance with manufacturer's instructions, and competencies.

DEFICIENCIES IN A CARDIAC RESEARCH STUDY AT THE VA ST. LOUIS HEALTH CARE SYSTEM IN MISSOURI

This healthcare inspection evaluated a research cardiologist's provision of follow-up care, a cardiology fellow's follow-up care and interpretation of electrocardiograms, the oversight of facility research bodies, and stress-test procedure instructions. After a research cardiologist failed to initiate cardiac follow-up care or notify a patient and the patient's primary care provider of positive stress-test results, the cardiology fellow managed follow-up care. However, the VA OIG was unable to determine whether the fellow had difficulty interpreting electrocardiograms. The facility research oversight bodies did not ensure primary care providers' notification of patient enrollments in a research study. Instructions provided to cardiology fellows differed from the protocol used by facility staff. The OIG made six recommendations related to stress-test results, a review of enrolled patients' result notifications and follow-up care, disclosures, research oversight, and review of the stress-test laboratory educational material.

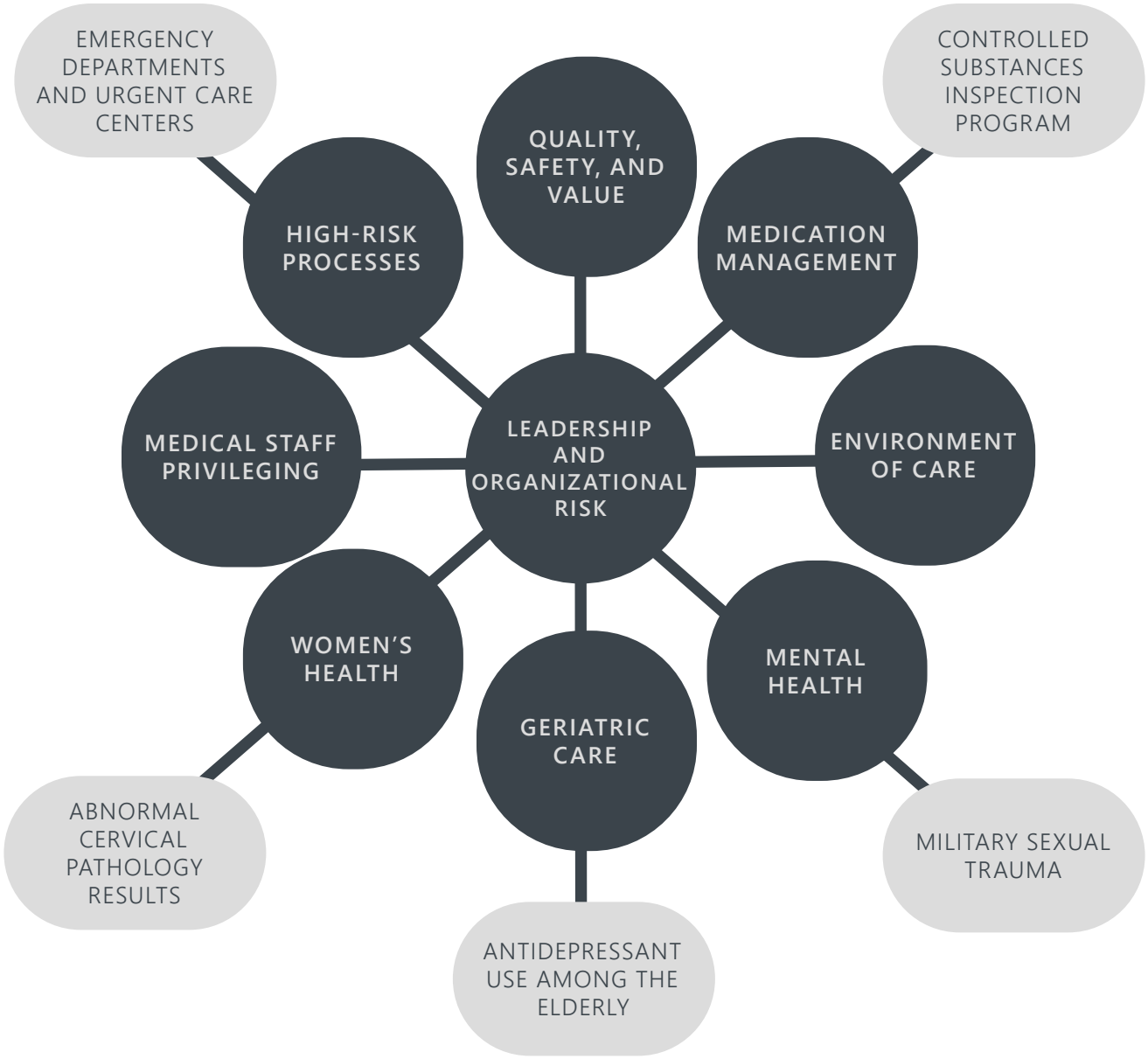
DEFICIENCIES IN THE ADMINISTRATION OF EMERGENT MENTAL HEALTH SERVICES AT THE COATESVILLE VA MEDICAL CENTER IN PENNSYLVANIA

The OIG inspected a patient's emergent (urgent) mental health services, medication management, and emergency procedures at the facility. Findings include that VHA did not provide guidance on time frames for requesting emergent mental health services be extended or on notification processes. The chief of staff failed to review treatment notes and submit the extension request to the chief medical officer. The OIG did not substantiate that providers discontinued medications without transition to another program. Grant and Per Diem Program staff were instructed to call different emergency services for patients with other than honorable discharge status. Staff failed to follow up with one of five patients identified by the Recovery and Engagement and Coordination for Health—Veterans Enhanced Treatment Program. The patient died by suicide approximately three months later. The OIG made two recommendations to the under secretary for health and two recommendations to the facility director related to processing requests to extend emergent mental health services, Grant and Per Diem Program medical emergency procedures, and follow-up for patients identified by the Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment Program.

COMPREHENSIVE HEALTHCARE INSPECTIONS

CHIP reviews are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality VA healthcare services. During the reporting period, the OIG issued 34 CHIP reports, which are listed in appendix A. CHIP reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. For example, this past reporting period's areas of focus are depicted in the illustration on the next page. There were 31 medical centers and healthcare systems and three VISNs reviewed in the six-month reporting period.

COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM AREAS OF FOCUS



RESULTS FROM THE OFFICE OF INVESTIGATIONS

OVERVIEW

The Office of Investigations (OI) focuses on a wide range of criminal and civil cases that have the greatest impact on the lives of veterans and VA operations. Investigations target crimes that affect the benefits and services afforded eligible veterans and their families; criminal activity by and against any of VA's more than 408,000 employees; and offenses affecting the Department's programs and operations.

142
ARRESTS

118
CONVICTIONS

$209M
MONETARY BENEFITS

FEATURED INVESTIGATIONS

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

SIXTEEN DEFENDANTS CHARGED IN CONNECTION WITH BRIBERY SCHEME

Sixteen defendants, which included vendors and current and former VA employees, were charged in the Southern District of Florida with bribery, conspiracy to commit healthcare fraud, healthcare fraud, false statements, theft of government funds, and falsification of records. To date, six defendants (four vendors and two VA employees) have pleaded guilty. A VA OIG investigation, which was initiated based on a hotline complaint, resulted in charges alleging the vendors engaged in a bribery and kickback scheme with employees of the West Palm Beach and Miami VA medical centers in Florida. The charging documents allege that VA employees placed supply orders with the vendors in exchange for cash bribes and kickbacks. In many instances, the prices of supplies were grossly inflated. In other instances, the orders were only partially fulfilled or not fulfilled at all. Since 2009, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts. Another aspect of this investigation involved one vendor who allegedly submitted false statements in an application to VA in order to be designated as a service-disabled veteran-owned small business, which resulted in further business transactions.

FORMER VA FIDUCIARY SENTENCED IN CONNECTION WITH FRAUD SCHEME

A former VA-appointed professional fiduciary was sentenced in the District of New Mexico to 240 months' imprisonment, 36 months' supervised release, and ordered to pay restitution in the amount of $11,184,200. A VA OIG hotline-initiated investigation by the VA OIG, Social Security Administration (SSA) OIG, Federal Bureau of Investigation (FBI), and the Internal Revenue Service Criminal Investigation (IRS CI) revealed the defendant and three other codefendants engaged in a sophisticated financial scheme to use their nonprofit organization to defraud victims of their VA and

SSA beneficiary funds. The defendants unlawfully transferred money from their clients' accounts to their own business accounts. The defendants then used funds from these comingled accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were impacted by this scheme. The loss to VA is approximately $3.3 million.

FORMER PHARMACEUTICAL EXECUTIVES SENTENCED FOR RICO ACT CONSPIRACY

Eight former pharmaceutical company executives, including the founder and majority owner, chief executive officer, and vice president of sales, were sentenced in the District of Massachusetts for their roles in a Racketeer Influenced and Corrupt Organizations (RICO) Act conspiracy. Each defendant received a custodial sentence with incarceration time ranging from 12 to 66 months. The investigation resulted in charges alleging that the pharmaceutical company's executives led a nationwide conspiracy to bribe medical practitioners to unnecessarily prescribe their drug, a powerful fentanyl-based narcotic intended to treat cancer patients suffering intense episodes of breakthrough pain. In exchange for speaker fees used as bribes, practitioners wrote large numbers of prescriptions for patients, most of whom were not diagnosed with cancer. Through the creation of a reimbursement center, the defendants also conspired to mislead and defraud health insurance providers by using a variety of fraudulent reimbursement schemes to obtain payment authorizations from insurers. VA's Civilian Health and Medical Program (CHAMPVA) paid the company approximately $3.3 million for this drug. This case was investigated by the VA OIG, Department of Labor (DOL) OIG, U.S. Postal Service OIG, Health and Human Services (HHS) OIG, U.S. Postal Inspection Service, Food and Drug Administration Office of Criminal Investigations, Drug Enforcement Administration, Office of Personnel Management OIG, FBI, and Defense Criminal Investigation Service.

SELECTED VETERANS HEALTH ADMINISTRATION INVESTIGATIONS

OI conducts criminal investigations into allegations of patient abuse, drug diversion, theft of VA pharmaceuticals or medical equipment, false claims for healthcare benefits, and other fraud relating to the delivery of health care to millions of veterans. For this SAR period, OI opened 74 cases; made 79 arrests; obtained over $5.8 million in court-ordered payments of fines, restitution, penalties, and civil judgments; and achieved nearly $2 million in savings, efficiencies, cost avoidance, and dollar recoveries in healthcare-related cases. The selected case summaries that follow illustrate the type of VHA investigations conducted during this period.

Public Corruption by VHA Employees

FORMER VHA OFFICE OF COMMUNITY CARE BENEFITS ADVISER FOUND GUILTY IN CONNECTION WITH FRAUD SCHEME

A former VHA Office of Community Care benefits adviser was found guilty by a federal jury in the District of Colorado of healthcare fraud, conspiracy, payment of illegal kickbacks and gratuities, money laundering, and conflict of interest. An investigation by the VA OIG, FBI, and IRS CI resulted in charges that, from May 2017 through June 2018, the defendant referred over 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives. The unlawful referrals led to payments totaling approximately $19 million from VA to these home health agencies.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

FORMER SACRAMENTO, CALIFORNIA, VA MEDICAL CENTER CHIEF OF PODIATRY SENTENCED FOR HEALTHCARE FRAUD

The former chief of podiatry for the Sacramento, California, VA Medical Center was sentenced in the Eastern District of California to 78 months' imprisonment and 24 months' supervised release and ordered to pay $234,260 in restitution to VA. A former VA prosthetics vendor, who was previously sentenced to 60 months' imprisonment and 36 months' supervised release, was also ordered to pay $479,360 in restitution to VA. An investigation by the VA OIG, Homeland Security Investigations, and VA Police Service resulted in charges that, between March 2008 and February 2015, the former chief and the vendor engaged in a scheme to defraud VA by billing for custom prescription footwear containing carbon graphite plates but instead provided veterans with inferior footwear containing preinstalled components. In addition, the chief, vendor, and a former employee of the vendor who separately pleaded guilty in December 2016 agreed to make materially false statements to VA regarding where their shoes were manufactured while applying for a national VA contract worth over $11 million per year.

FORMER ANCHORAGE, ALASKA, VA MEDICAL CENTER CONTRACTING OFFICER REPRESENTATIVE AND BUSINESS OWNER INDICTED FOR ALLEGED PARTICIPATION IN BRIBERY SCHEME

A former medical center contracting officer representative (COR) and the owner of a general contracting company were indicted in the District of Alaska for false statements, wire fraud, bribery of public officials, conspiracy, and prohibited contracting acts. A VA OIG investigation resulted in charges alleging that the former COR received bribes totaling approximately $29,000 in connection with purchase card orders and service-disabled veteran-owned small business set-aside housekeeping and snow removal contracts at the Anchorage medical center. The total value of the contracts and purchase card orders awarded by VA was over $2 million.

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

DAUGHTER OF EX-EMPLOYEE AT THE VILLAGES, FLORIDA, VA OUTPATIENT CLINIC PLEADS GUILTY TO FALSE STATEMENTS

The daughter of a former transportation assistant at VA's outpatient clinic in The Villages, Florida, pleaded guilty in the Middle District of Florida to false statements. A VA OIG investigation resulted in charges that the former VA employee conspired with the defendant and another relative to create and control two companies to which he steered VA transportation assignments. As a result, VA paid the companies $305,673. The former VA employee also allegedly solicited and received $76,789 in kickbacks from two other transportation vendors.

SIX FORMER VA OFFICE OF COMMUNITY CARE EMPLOYEES PROSECUTED FOR ROLES IN OVERTIME FRAUD SCHEME

A VA OIG investigation revealed the defendants allegedly collected overtime compensation totaling more than $178,000 for hours that were not worked. Five former VA Office of Community Care (OCC) employees pleaded guilty in the Northern District of Ohio to theft of government property, and a sixth

former VA OCC employee was indicted on charges of theft of government property, wire fraud, and false statements.

FORMER MEMPHIS, TENNESSEE, VA MEDICAL CENTER POLICE AND SECURITY SERVICE SERGEANT SENTENCED FOR CONFLICT OF INTEREST

A defendant who was previously employed as a police and security service sergeant at the Memphis VA Medical Center in Tennessee was sentenced in the Western District of Tennessee to three years' supervised probation and ordered to pay $118,000 in restitution to VA after pleading guilty to conflict of interest. A VA OIG investigation revealed that the defendant created a shell security company, which she then paid using her government purchase card for purported security services rendered at VA facilities throughout the Memphis area. The payments were laundered through an account with a third-party processor that was opened by the defendant in the name of the shell company and subsequently deposited into the defendant's personal bank account.

False Claims Act Settlement

FORMER OPERATOR OF MINNESOTA VA COMMUNITY-BASED OUTPATIENT CLINICS AGREES TO PAY $1.85 MILLION TO RESOLVE FALSE CLAIMS ACT ALLEGATIONS

The company that formerly operated two VA community-based outpatient clinics in Minnesota and the U.S. Attorney's Office for the District of Minnesota agreed to a civil settlement under which the company agreed to pay $1.85 million to settle False Claims Act allegations. A VA OIG investigation revealed that between July 2013 and April 2014, the company violated contract requirements for scheduling patient appointments at the Hibbing, Minnesota, community-based outpatient clinic and falsified the dates when veterans requested appointments to make wait times appear shorter.

Cases Involving Patient Harm

FORMER COMMUNITY-BASED OUTPATIENT CLINIC NURSE PRACTITIONER IN FLORISSANT, MISSOURI, CHARGED WITH SODOMY AND SEXUAL ABUSE

A now former VA nurse practitioner was charged in the Circuit Court of St. Louis County, Missouri, with felony sodomy and misdemeanor sexual abuse. A VA OIG and VA Police Service investigation resulted in charges alleging that the defendant sexually assaulted a veteran at the outpatient clinic during an acupuncture appointment.

Civilian Health and Medical Program Fraud

DEFENDANT SENTENCED FOR DEFRAUDING VA'S CIVILIAN HEALTH AND MEDICAL PROGRAM

A defendant in a nationwide healthcare fraud scheme involving the use of durable medical equipment, telemedicine doctors, and telemarketers was sentenced in the District of New Jersey to imprisonment of time served (10 months) and deported. The defendant, who previously pleaded guilty to money laundering and conspiracy to commit money laundering, was also ordered to forfeit $1.78 million. An investigation by the VA OIG, HHS OIG, the FBI, and the IRS CI resulted in charges that the defendant participated in a scheme that solicited durable medical equipment to patients and used telemedicine doctors to certify medical necessity. The telemedicine doctors did not have relationships with

the patients, and the telemarketers sold the completed orders to the durable medical equipment companies. Many of the target companies identified in the scheme received payments from CHAMPVA. The loss to the government exceeds $1 billion. Of this amount, VA's loss is approximately $330,000.

MEDICAL BILLING COMPANY OWNER PLEADS GUILTY TO DEFRAUDING VA'S CIVILIAN HEALTH AND MEDICAL PROGRAM

The owner of a medical billing company conspired with the owner of three clinics to bill government healthcare programs, including CHAMPVA, for office visits, tests, and services that were rendered by prohibited providers. As a result, the billing company owner pleaded guilty in the Middle District of Florida to conspiracy to commit healthcare fraud. The loss to VA is approximately $180,000. The investigation was conducted by the VA OIG, FBI, Defense Criminal Investigative Service, and HHS OIG.

Healthcare Fraud

EYE SURGEON AND FORTY-SIX CURRENT AND FORMER EYE CENTER EMPLOYEES INDICTED IN FRAUD SCHEME

An eye surgeon and 46 current and former employees of an eye center were indicted in Yavapai County Superior Court in Arizona on various fraud-related charges. An investigation by the VA OIG, Arizona Attorney General's Office Special Investigations Section, Arizona Health Care Cost Containment System, and HHS OIG resulted in charges alleging the employees falsified patients' medical records to induce government agencies and third-party insurers to pay for cataract and other eye surgeries between 2009 and 2018. The indictment alleges that some patients possibly underwent cataract surgeries that were not medically necessary. It is further alleged the eye surgeon did not have the specific equipment necessary to perform the tests billed to VA. The loss to VA is approximately $1.3 million.

NONVETERAN INDICTED IN CONNECTION WITH FRAUD SCHEME

A nonveteran was arrested in the Eastern District of Pennsylvania after being indicted for stolen valor, healthcare fraud, mail fraud, fraudulent military papers, false statements, and false statements to the SSA. A VA OIG and SSA OIG investigation resulted in charges alleging that the defendant defrauded VA by obtaining healthcare benefits and attempting to obtain VA compensation benefits from approximately April 2010 to September 2019. The defendant is also alleged to have falsely claimed to be a decorated veteran, specifically, a U.S. Navy SEAL, prisoner of war, and Silver Star award recipient. The loss to VA is $302,121.

DEFENDANT CHARGED IN CONNECTION WITH COVID-19 FRAUD SCHEME

A defendant was arrested after being charged in the District of New Jersey with conspiracy to violate the Anti-Kickback Statute and conspiracy to commit healthcare fraud. An investigation by the VA OIG, FBI, IRS CI, Defense Criminal Investigative Service, and HHS OIG resulted in charges alleging the defendant participated in a conspiracy to defraud federally funded and private healthcare benefit programs by submitting fraudulent testing claims for coronavirus disease (COVID-19) and genetic cancer screenings. The defendant allegedly agreed with others to be paid kickbacks for each COVID-19 test bundled with an expensive respiratory pathogen panel test, which does not identify or treat COVID-19.

Drug Distribution at VA Facilities

DEFENDANT PLEADS GUILTY TO DRUG DISTRIBUTION AT A MASSACHUSETTS VA RESIDENTIAL FACILITY

An individual was arrested by VA OIG and Drug Enforcement Administration agents after a joint investigation indicated the subject may have been the source of drugs that caused the fatal overdose of a veteran living at a VA residential facility in Massachusetts. The defendant pleaded guilty in the District of Massachusetts to the distribution of fentanyl, the distribution of 40 grams or more of fentanyl, and possession with intent to distribute 28 grams or more of crack cocaine.

FORMER SAN DIEGO, CALIFORNIA, VA MEDICAL CENTER MEDICAL SUPPORT ASSISTANT SENTENCED FOR DRUG DISTRIBUTION

A VA OIG, Drug Enforcement Administration, and VA Police Service investigation revealed that a former VA medical support assistant sold methamphetamine and cocaine at the medical center during normal duty hours. The defendant was sentenced in the Southern District of California to 24 months' imprisonment and three years' supervised release. Also, as a result of this investigation, a former San Diego VA medical center canteen service barber previously pleaded guilty to the distribution of methamphetamine and was sentenced to 22 months' imprisonment and three years' supervised release.

TWO DEFENDANTS PLEAD GUILTY TO DRUG DISTRIBUTION AT THE CLEVELAND, OHIO, VA MEDICAL CENTER

A VA OIG and FBI investigation discovered that three defendants allegedly sold a substance containing heroin, fentanyl, carfentanil (one of the most potent synthetic opioids), and acetylfentanyl (another potent synthetic opioid) to an inpatient veteran while on the property of the Cleveland, Ohio, VA Medical Center. The veteran injected the substance directly into her peripherally inserted central catheter (or PICC line, a form of intravenous access), which resulted in a nonfatal overdose. As a result of the investigation, two defendants pleaded guilty in the Northern District of Ohio to drug distribution resulting in serious bodily injury and conspiracy to distribute heroin. The third defendant was indicted in the Cuyahoga County Court of Common Pleas on charges of corrupting another with drugs and permitting drug abuse.

Drug Diversion by VA Employees

EX-PHARMACIST OF SHREVEPORT, LOUISIANA, VA MEDICAL CENTER FOUND GUILTY OF ACQUIRING CONTROLLED SUBSTANCES BY FRAUD

A pharmacist formerly employed by the Overton Brooks VA Medical Center was found guilty by a federal jury in the Western District of Louisiana of acquiring controlled substances by fraud. A VA OIG investigation resulted in charges alleging the defendant diverted pills from outpatient prescriptions that were being prepared to be mailed to veterans. When performing final verifications, the defendant allegedly diverted between one and five pills before sealing the packages and placing them in the outgoing mail.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

SELECTED VETERANS BENEFITS ADMINISTRATION INVESTIGATIONS

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

OIG's IT and Data Analysis Division, in coordination with OI, conducts an ongoing "Death Match" project to proactively identify deceased beneficiaries whose benefits continue because VA was not notified of the death. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. Within this reporting period, field personnel, including investigative assistants and special agents, teamed with headquarters personnel to process and work cases resulting in the arrest of one individual, recoveries of $473,704, and a projected five-year savings to VA estimated at $2.67 million.

OI opened 94 investigations involving the fraudulent receipt of VA monetary benefits including those for deceased payees, fiduciary fraud, identity theft, and fraud by beneficiaries, which resulted in 46 arrests. OI obtained over $15.7 million in court-ordered fines, restitution, penalties, and civil judgments; achieved more than $29.7 million in savings, efficiencies, and cost avoidance; and recovered more than $4.4 million. The case summaries that follow provide a sampling of the types of VBA investigations conducted during this reporting period.

Educational Benefits Fraud

TECHNICAL TRAINING SCHOOL OWNER AND WIFE PLEAD GUILTY IN CONNECTION WITH FRAUD SCHEME

A VA OIG and FBI investigation revealed the owner of a technical training school submitted fraudulent documents to VA for several years. The owner and his wife admitted to falsifying student enrollment documents and employer verification information dating back to 2015, which caused VA to pay over $29 million in tuition, books, fees, and monthly student housing allowances. As a result of the investigation, both the owner and his wife pleaded guilty in the Southern District of California to wire fraud and making false statements.

UNIVERSITY AGREES TO CIVIL SETTLEMENT

A New Jersey university's board of trustees and the U.S. Attorney's Office for the District of New Jersey agreed to a civil settlement whereby the university will pay $4,883,000, of which $2,441,500 is restitution to VA. An investigation by the VA OIG, Department of Education OIG, and FBI revealed that between 2011 and 2013, the university conspired with a private business to fraudulently obtain millions of dollars in tuition assistance and other education-related benefits under the Post-9/11 GI Bill. This case previously resulted in the arrest and convictions of a former dean as well as the owner and a senior executive of the private business. The three were ordered to pay $24,024,465 in restitution.

OWNER OF TWO FIREARMS INSTRUCTION SCHOOLS AGREES TO SETTLE FRAUD ALLEGATIONS

The owner of two firearms instruction schools and the U.S. Attorney's Office for the Eastern District of Louisiana agreed to a civil settlement agreement under which he agreed to pay $700,000 to VA to settle False Claims Act allegations. A VA OIG investigation revealed that the schools submitted false course enrollments for VA students. In addition, the schools did not notify VA when students failed to attend or dropped a course. The school also failed to reimburse VA for any resulting overpayments.

Compensation Benefits Fraud

SEVEN INDIVIDUALS INDICTED FOR IDENTITY THEFT SCHEME

Seven nonveterans were indicted in the Southern District of Florida for conspiracy to commit bank fraud, conspiracy to commit wire fraud, and aggravated identity theft. Five of the defendants were subsequently arrested and two remain at large. A VA OIG, Homeland Security Investigations, and U.S. Postal Inspection Service investigation discovered defendants in Jamaica were allegedly redirecting the monthly benefit payments of veterans and Social Security recipients to alternate bank accounts. The stolen funds were then loaded onto prepaid cards and mailed to codefendants in the Miami area. Once in Miami, a portion of the funds were removed and the remainder was sent back to Jamaica. Additionally, these defendants allegedly participated in telemarketing scams that targeted elderly U.S. citizens. To date, 17 nonveterans have been indicted, 14 arrested, and nine sentenced to a combined 451 months' incarceration, 288 months of supervised release, 36 months' probation, and approximately $2.5 million in restitution. The total loss to VA is more than $7 million.

VETERAN CHARGED IN CONNECTION WITH FRAUD SCHEME

A VA OIG investigation resulted in charges alleging that for more than 20 years, a veteran fraudulently received approximately $9,000 per month from VA for the loss of use of his limbs and hearing problems with associated vertigo. The investigation examined allegations that the defendant was able to ambulate without difficulty and did not require assistance as he claimed to VA. The defendant was captured on video driving, walking, bending, and using all his limbs without assistance. During the investigation, the defendant attended two Compensation and Pension examinations in a wheelchair and received assistance from a co-conspirator when attending his medical appointments. Ultimately, the veteran was charged in the District of South Carolina with healthcare fraud and theft of government funds. The loss to VA is nearly $2 million.

VETERAN SENTENCED FOR COMPENSATION BENEFITS FRAUD SCHEME

A veteran was sentenced in the District of South Carolina to 21 months' imprisonment, 2 years' probation, and restitution of $175,448. The veteran and his wife previously pleaded guilty to conspiracy to defraud VA for providing false statements to obtain additional VA compensation benefits and income from the VA Caregiver Support Program. The veteran's father previously pleaded guilty to misprision (concealment) of a felony for providing misleading statements regarding his son's disabilities. A VA OIG investigation revealed the veteran owned various companies while receiving Individual Unemployability benefits and claiming to be unemployed due to his service-connected disabilities. The veteran obtained multiple government set-aside contracts, most with VA, totaling over $2 million while being rated permanently and totally disabled. An investigation revealed the veteran obtained a private pilot license and an aircraft mechanic certification days after reporting multiple disabilities to VA but not to the

Federal Aviation Administration. The defendants' companies were debarred from government contracting.

VETERAN INDICTED FOR COMPENSATION BENEFITS FRAUD

A VA OIG proactive investigation resulted in charges alleging that a veteran grossly exaggerated the severity of his service-connected conditions in order to receive more than $8,000 per month in VA compensation benefits. Members of the U.S. Marshals Service Fugitive Task Force assisted the VA OIG investigation in serving four seizure warrants for a vehicle, a motorized scooter, and approximately $170,000 of funds from two of the veteran's bank accounts. The defendant was arrested after being indicted in the Middle District of North Carolina for healthcare fraud and theft. The loss to VA is approximately $1.2 million.

VETERAN SENTENCED FOR COMPENSATION BENEFITS FRAUD

A veteran was sentenced in the Eastern District of Missouri to 12 months' and one day imprisonment, three years' probation, and was ordered to pay $1,036,170 in restitution to VA. An investigation by the VA OIG revealed that the defendant fraudulently led VA to believe he had suffered from blindness since 1969. The defendant filed for, and received, disability compensation benefits at the 100 percent rate beginning in July 1991. The investigation determined that although the defendant was discharged from military service in 1969 for vision issues, he was in possession of a valid driver's license that he had obtained by passing the vision test with 20/40 acuity in both eyes. The investigation also determined the defendant drove on a routine basis and performed other activities that were not consistent with blindness.

REWARD FOR REPORT OF COMPENSATION BENEFITS FRAUD

The VA OIG presented a reward to a confidential complainant who contacted the VA OIG hotline to allege that a veteran was fraudulently receiving monthly VA and SSA disability benefits. This information led to an investigation by the VA OIG and SSA OIG, which resulted in felony convictions of the veteran and his wife for conspiring to defraud VA and SSA. Because of the complainant's disclosure, VA saved over $1.9 million in benefits the veteran would have received based on this false information. The defendants were also ordered to pay $177,270 in restitution to VA.

VETERAN FOUND GUILTY FOR COMPENSATION BENEFITS FRAUD SCHEME

A veteran was found guilty of healthcare fraud, theft of government money, false statements, and Social Security Disability Insurance fraud by a federal jury in the District of Montana. A VA OIG and SSA OIG investigation uncovered allegations that the defendant was witnessed driving a Harley-Davidson motorcycle while receiving Aid and Attendance compensation for the loss of the use of his hands and feet. During a Compensation and Pension examination, the defendant was found to have misled the VA examiner about his ability to drive and walk. The loss to VA is over $617,000.

VETERAN INDICTED FOR COMPENSATION BENEFITS FRAUD SCHEME

A veteran was arrested after being indicted in the Western District of Texas for theft of government funds, healthcare fraud, Social Security Disability fraud, false claims to VA, and false statements related to a healthcare matter. A VA OIG and SSA OIG investigation resulted in charges alleging that the

defendant misled VA and SSA about his ability to walk. As a result, the defendant received 100 percent service-connected disability benefits for the loss of the use of both feet since October 2010 and Social Security Disability Insurance benefits since 2008. The total loss to the government is approximately $594,000. Of this amount, the loss to VA is approximately $434,000.

VETERAN INDICTED FOR THEFT OF GOVERNMENT FUNDS AND FALSE STATEMENTS

A veteran was arrested after being indicted in the Middle District of Florida for theft of government funds and false statements. A VA OIG investigation resulted in charges alleging that the defendant fraudulently led VA to believe he was blind. As a result, the defendant received 100 percent service-connected disability benefits for legal blindness since June 2011. It is alleged that the defendant possessed a valid driver's license with a motorcycle endorsement and drove on a routine basis. The loss to VA is $394,935.

VETERAN INDICTED FOR THEFT OF GOVERNMENT FUNDS

A veteran was arrested after being indicted in the Southern District of Florida for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant lied about his military history to receive VA compensation and healthcare benefits. The loss to VA is $318,423.

VETERAN SENTENCED FOR THEFT OF GOVERNMENT FUNDS

A veteran was sentenced in the Eastern District of North Carolina to six months' incarceration and three years' supervised release and was also ordered to pay $312,807 in restitution after pleading guilty to theft of government funds. A VA OIG investigation revealed that for more than 17 years, the defendant made false statements to VA about his disabilities. As a result of his claimed injuries to his neck, back, shoulders, arms, and hips, the veteran was rated permanently and totally disabled. Surveillance video footage showed the defendant powerlifting several times per week at gyms located on military installations. In addition, the defendant posted powerlifting competition videos of himself on Facebook.

Fiduciary Fraud[1]

VA FIDUCIARY PLEADS GUILTY TO MAIL FRAUD

A VA fiduciary pleaded guilty in the District of Nevada to mail fraud. A VA OIG and FBI investigation revealed that, while claiming to offer home healthcare and fiduciary services to veterans and surviving spouses, the defendant submitted fraudulent applications for pension, survivor's pension, and Aid and Attendance benefits to VA on behalf of 35 elderly veterans. The defendant then had the benefits paid to bank accounts that she controlled without the knowledge or consent of the victims. The defendant also altered medical records to ensure that the victims' physical and mental conditions rendered them eligible for the benefits. The total loss to VA is about $1.8 million.

1 See the Featured Investigations section for an additional fiduciary fraud case.

Sexual Assault[2]

FORMER CONTRACT PHYSICIAN SENTENCED FOR SEXUAL ASSAULT

A former contract physician was sentenced in the County of San Diego to 36 months' imprisonment (all of which were suspended) and 36 months' probation after pleading guilty to the sexual assault of five female patients who were referred to him by VA. The defendant was also ordered to surrender his medical license and register as a sex offender. A VA OIG and Medical Board of California investigation revealed the defendant engaged in inappropriate acts while conducting Compensation and Pension (C&P) examinations. In support of this investigation, a VA C&P Physician determined through an independent review that the defendant conducted examinations that exceeded standard practices, to include unnecessary pelvic examinations.

OTHER INVESTIGATIONS

OI investigates a diverse array of criminal offenses in addition to the types and examples listed above, including information management crimes such as theft of IT equipment and data, network intrusions, and child pornography. OI also investigates allegations of bribery and kickbacks; bid rigging and antitrust violations; false claims submitted by contractors; and other fraud relating to VA procurement practices. During this reporting period, in the area of procurement practices alone, OI opened 29 cases and made seven arrests. These investigations resulted in over $66.2 million in court-ordered payments of fines, restitution, penalties, and civil judgments, as well as over $394,000 in savings, efficiencies, and cost avoidance.

Service-Disabled Veteran-Owned Small Business Fraud

FORMER CONSTRUCTION COMPANY EXECUTIVE SENTENCED FOR ROLE IN SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

A former construction company executive was sentenced in the Eastern District of Wisconsin to 78 months' imprisonment and two years' supervised release and was also ordered to forfeit assets worth nearly $4 million. A multiagency investigation involving the VA OIG, Defense Criminal Investigative Service, General Services Administration OIG, Small Business Administration OIG, and the FBI revealed the defendant led a 12-year fraud scheme involving over $260 million in government-funded contracts intended to benefit small businesses, including those owned by service-disabled veterans. The scheme involved the purported operation of three construction companies by "straw" owners who qualified either as a disadvantaged individual or a service-disabled veteran, but who did not actually control the companies. A certified public accountant was also found guilty by a jury of conspiracy to commit wire and mail fraud for his role in this scheme.

2 See the Selected Veterans Health Administration Investigations section for an additional sexual assault case.

THREE INDIVIDUALS PLEAD GUILTY IN CONNECTION WITH SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

Three individuals, including one veteran, pleaded guilty in the District of Massachusetts to conspiracy to defraud the United States and mail fraud. In addition, each defendant agreed to forfeit $300,000. An investigation by the VA OIG, General Services Administration OIG, and Army Criminal Investigation Command revealed that the defendants defrauded VA's and the Department of Defense's set-aside programs for service-disabled veteran-owned small businesses (SDVOSB) and Historically Underutilized Business Zone-certified businesses. The defendants allegedly used a veteran-owned small business to apply for and receive set-aside contracts through which a nonveteran-owned business completed most, if not all, of the work. The value of these set-aside contracts totaled approximately $10 million for VA and $6.4 million for the Department of Defense.

BUSINESS OWNER FOUND GUILTY FOR ROLE IN SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

A joint investigation by the VA OIG, Navy Criminal Investigative Service (NCIS), NASA OIG, Defense Criminal Investigative Service, and Small Business Administration OIG resulted in charges alleging that individuals conspired to obtain set-aside contracts by falsely certifying eligibility and passing work through to the principal defendant's company, which did not qualify as an SDVOSB. The scheme involved falsifying records and moving employees among companies to give those entities the appearance of self-performance. The defendants allegedly obtained at least $15 million in government contracts fraudulently through this scheme, including approximately $4.4 million in SDVOSB set-aside contracts awarded by VA. The principal defendant was found guilty of conspiracy, major fraud against the government, and wire fraud following a week-long jury trial in the Northern District of Ohio. Six other defendants, including a service-disabled veteran, pleaded guilty prior to trial.

VETERAN INDICTED IN CONNECTION WITH SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS FRAUD SCHEME

The veteran owner of an SDVOSB was indicted in the District of Kansas on charges of wire fraud and making a false statement. An investigation by the VA OIG, DOL OIG, and General Services Administration OIG resulted in charges alleging the defendant participated in a "pass-through" scheme in which she falsely claimed to control the business, when in fact other individuals held ownership interest and controlled the company. The defendant also allegedly submitted false information to several government agencies to qualify her business as an SDVOSB. From March 2010 to February 2018, the defendant's company was awarded approximately $4.8 million in set-aside contracts, of which approximately $4.2 million were awarded by VA.

Bribery and Kickbacks[3]

INDIVIDUAL SENTENCED IN KICKBACK SCHEME

The president of a government subcontracting company was sentenced in the District of the Virgin Islands to 18 months' incarceration as well as three years' supervised release and ordered to pay restitution of $218,000 and a fine of $4,000. This defendant previously pleaded guilty to paying over $200,000 in kickbacks to a senior project manager whose company was awarded a large General

3 See the Featured Investigations and Selected Veterans Health Administration Investigations sections for additioanl bribery cases.

Services Administration Energy Savings Performance Contract. This subcontractor previously bid on a VA Energy Savings Performance Contract, which was valued at approximately $18.5 million, that was canceled prior to award by VA due to findings from this investigation. This investigation was conducted by VA OIG, NCIS, Department of Agriculture OIG, Coast Guard Investigative Service, and General Services Administration OIG.

Workers' Compensation Program Fraud

MEDICAL OFFICE ADMINISTRATOR FOUND GUILTY FOR ROLE IN WORKERS' COMPENSATION FRAUD SCHEME

A medical office administrator was found guilty of healthcare fraud by a federal jury in the Northern District of Texas. A VA OIG, U.S. Postal Service OIG, DOL OIG, Department of Justice OIG, and Army Criminal Investigation Command-Major Procurement Fraud Unit investigation resulted in charges alleging the defendant submitted false claims to the DOL's Office of Workers' Compensation Program on behalf of VA and other federal agencies. The defendant, who worked for a private healthcare provider, allegedly assigned inaccurate billing codes to increase the practice's Office of Workers' Compensation Program reimbursement payments. According to the evidence at trial, some of the medical procedures were medically unnecessary, while others were not even performed. One other defendant previously pleaded guilty in the case and will be sentenced in August 2020. The loss to VA is approximately $2.9 million.

HEALTH CLINIC OWNER INDICTED IN WORKERS' COMPENSATION FRAUD SCHEME

The owner of a health clinic was arrested after being indicted in the Middle District of Florida for healthcare fraud and aggravated identity theft. An investigation by the VA OIG, Department of Homeland Security OIG, DOL OIG, and U.S. Postal Service OIG resulted in charges alleging the defendant, a former VA nurse, submitted fraudulent claims to DOL's Office of Workers' Compensation Programs on behalf of VA and other federal agencies. The defendant allegedly used the names and signatures of other physicians to make it appear as if those doctors performed or supervised examinations and treatments when, in fact, they had not. The loss to VA is approximately $688,000.

WORKERS' COMPENSATION CLINIC OWNER SENTENCED FOR FRAUD SCHEME

The owner of a workers' compensation clinic was sentenced in the Western District of Texas to seven years' imprisonment, three years' supervised release, and ordered to pay more than $6 million in restitution to the government. A VA OIG, FBI, DOL OIG, and U.S. Postal Service OIG investigation resulted in charges alleging that between October 2012 and December 2016 the defendant charged multiple federal agencies for fraudulent claims and for services not rendered. The defendant also allegedly used the name and physical therapy license number of another person without their knowledge to further the scheme. In June 2019, the defendant was found guilty by a federal jury of healthcare fraud, wire fraud, and aggravated identity theft. The total loss to VA is nearly $507,000.

Life Insurance Fraud

THREE VETERANS INDICTED FOR LIFE INSURANCE FRAUD SCHEME

An investigation resulted in charges alleging that three veterans, and at least nine others, submitted numerous Traumatic Servicemembers Group Life Insurance (TSGLI) claims that reflected fraudulent

narratives of catastrophic injuries and exaggerated the loss of activities of daily living to generate payouts of $25,000 to $100,000 per claim. The leader allegedly recruited a Naval command medical doctor and a Navy nurse to create false medical records and sign the claims. VA supervises the administration of the TSGLI program, and the investigation was conducted by the VA OIG, NCIS, and the FBI. The three veterans were indicted in the Southern District of California for conspiracy to commit wire fraud, wire fraud, and making a false claim. The loss to the TSGLI program is approximately $2 million.

Embezzlement

POLITICAL CONSULTING BUSINESS OWNER SENTENCED IN CONNECTION WITH FRAUD SCHEME

The owner of a political consulting business was sentenced in the Eastern District of Pennsylvania to 12 months' imprisonment and 36 months' supervised release and ordered to forfeit $973,807. This investigation revealed that the defendant participated in a conspiracy to unjustly enrich himself and others through a nonprofit organization that contracted with VA to provide substance abuse counseling and housing services for veterans. The defendants allegedly used the nonprofit's funds for political contributions, excessive lobbying, and political advocacy, and paid themselves through a system of kickbacks that disguised the nature and source of the payments. The conspirators allegedly caused the nonprofit to seek out and obtain additional sources of revenue, including federal program funds, through "political outreach" that violated both law and public policy. From 2010 to 2016, the nonprofit had revenues of approximately $837 million, to include $1.7 million contributed by VA. This investigation was conducted by the VA OIG, IRS CI, Housing and Urban Development OIG, Federal Deposit Insurance Corporation OIG, Medicaid Fraud Control Unit of the Missouri Attorney General's Office, HHS OIG, DOL OIG, and FBI.

Compounding Pharmacy Fraud

SIX DEFENDANTS CHARGED IN COMPOUNDING PHARMACY SCHEME

Six defendants were charged in the Northern District of Texas with various offenses to include conspiracy to solicit and receive illegal kickbacks related to healthcare fraud. An investigation resulted in charges alleging that the defendants received kickbacks from a compounding pharmacy in exchange for referring patient prescriptions that were covered under federal health programs. One of the defendants allegedly received kickbacks that were disguised as a salary from this compounding pharmacy. It is further alleged that this defendant subsequently disbursed portions of the kickbacks to multiple shell entities that were controlled by the other defendants. The approximate loss to the government is $7 million and the loss to VA is approximately $850,000. This investigation was conducted by the VA OIG, FBI, DOL OIG, U.S. Postal Service OIG, Defense Criminal Investigation Service, and HHS OIG.

RESULTS FROM THE OFFICE OF INVESTIGATIONS

ASSAULTS AND THREATS MADE AGAINST VA EMPLOYEES

During this reporting period, OI initiated 14 criminal investigations resulting from assaults and threats made against VA facilities and employees. This work resulted in charges filed against 10 individuals. Investigations resulted in over $168,000 in savings, efficiencies, cost avoidance, and dollar recoveries.

Threats Against VA Employees

VETERAN SENTENCED FOR MAKING THREATS AGAINST VA EMPLOYEES

A veteran was sentenced in the Northern District of California to 28 months' imprisonment. An investigation by the VA OIG, FBI, and VA Police Service revealed the defendant threatened to kill five employees at the VA medical centers in Palo Alto and San Francisco, California. The defendant was already serving a 92-month sentence in California State Prison for threatening to harm U.S. Congresswomen Jackie Speier and her staff. During the transfer from state to federal custody for legal proceedings, the defendant physically assaulted and threatened to kill a VA OIG agent. The defendant will serve his federal sentence and then be remanded back to the custody of the California Department of Corrections and Rehabilitation to serve the remainder of his state sentence.

LAS VEGAS, NEVADA, VA MEDICAL CENTER INTERMEDIATE HEALTH TECHNICIAN CHARGED IN CONNECTION WITH HOAX THAT IMPAIRED FACILITY OPERATIONS

A North Las Vegas, Nevada, VA Medical Center intermediate health technician was charged in the District of Nevada with furnishing false information and perpetuating a hoax related to purported biological and chemical weapons. The defendant was subsequently arrested and is being detained pending trial. A VA OIG, Las Vegas Metropolitan Police Department, and VA Police Service investigation resulted in charges alleging the defendant left two envelopes containing an unknown white powder on two coworkers' desks in the facility's podiatry department. This resulted in the quarantine of three VA healthcare providers, a six-hour partial shutdown of the facility, and more than 150 canceled appointments.

Assaults Against VA Employees

DEFENDANT SENTENCED FOR ASSAULT ON A FEDERAL OFFICER

A nonveteran was sentenced in the Western District of Washington to 20 months' imprisonment and 36 months' supervised release for assault on a federal officer. An investigation by the VA OIG, VA Police Service, and the FBI revealed that the defendant was involved in a hit-and-run collision with VA Police Service officers at the American Lake VA Medical Center in Tacoma, Washington. The collision caused injury to one of the officers.

VETERAN PLEADS GUILTY IN CONNECTION WITH SHOOTING AT WEST PALM BEACH, FLORIDA, VA MEDICAL CENTER

A veteran pleaded guilty in the Southern District of Florida to possession of a firearm in a federal facility to commit a crime and assaulting federal employees. A VA OIG and FBI investigation revealed that on February 27, 2019, the defendant inflicted non-life-threatening injuries on three VA emergency room employees by firing a handgun inside the West Palm Beach, Florida, VA Medical Center.

FUGITIVE FELON PROGRAM

OI continues to identify and apprehend fugitive veterans and VA employees as a direct result of the Fugitive Felon Program. Since 2002, 86.3 million felony warrants have been received from the National Crime Information Center and participating states, resulting in 101,337 investigative leads being referred to law enforcement agencies. More than 2,636 fugitives have been apprehended by VA OIG special agents and other law enforcement agencies as a direct result of these leads. Since the inception of the Fugitive Felon Program in 2002, the OIG has identified nearly $1.54 billion in estimated overpayments and cost avoidance of more than $2 billion. During this reporting period, OI made 10 arrests of fugitive felons, provided assistance to other federal and state agencies in the apprehension of 12 additional fugitive felons, and identified $83.5 million in estimated overpayments.

CLOSED CRIMINAL INVESTIGATIONS OF SENIOR GOVERNMENT EMPLOYEES

Substantiated Allegations of Misconduct Against Senior Government Officials

Under §5(a)(19) of the IG Act, inspectors general must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) in which allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether (1) the matter was referred to the Department of Justice, (2) the date of such referral, and (3) if applicable, the date of declination by the Department of Justice. During this reporting period, OI closed one criminal investigation with substantiated allegations against senior government employees.

TWO SAN ANTONIO, TEXAS, VA MEDICAL CENTER PODIATRISTS

The OIG received a referral alleging that two GS-15 podiatrists at the San Antonio VA Medical Center used excessively large amounts of wound care products on patients when the use of such products was not medically necessary. This investigation revealed that the two podiatrists received several thousand dollars in free meals from a company that produces wound care products in return for this excessive usage. The case was referred to the U.S. Attorney's Office in August 2017. At the conclusion of this investigation, the U.S. Attorney's Office declined prosecution of the two podiatrists. As a result of the investigation, one podiatrist retired and the other resigned. This case was closed on December 23, 2019.

Closed Criminal Investigations of Senior Government Employees Not Disclosed to the Public

Section 5(a)(22)(B) of the IG Act requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the public. When allegations in criminal investigations are unsubstantiated, or

if investigations are referred to another office such as the Office of Special Counsel, the OIG may close its own investigation. During this reporting period, OI closed one criminal investigation with unsubstantiated allegations against a senior government employee.

FORMER VA ASSISTANT SECRETARY FOR PUBLIC AND INTERGOVERNMENTAL AFFAIRS ALLEGED MISCONDUCT

The OIG received a referral alleging that a former VA Assistant Secretary for Public and Intergovernmental Affairs misused her senior position of authority in attempts to steer government contracts to multiple companies, including a VA contractor for whom she was previously employed. This VA contactor allegedly subcontracted work to a company owned by her husband. The complainants alleged that this former VA senior executive failed to prevent the appearance of a conflict of interest, directly engaged in a conflict of interest, failed to act impartially in the performance of her official duties, and misused her position for personal gain. The complainants alleged that the former VA senior executive influenced contract deliverables, funding deliverables, indirect costs, and purchase orders through various methods. The complainants reported that these actions resulted in fraud, waste, and abuse of government funds and personnel. During numerous interviews, document reviews, and database queries, no evidence was identified that substantiated the allegations that the former VA senior executive attempted to or did steer government contracts. This matter was not referred to the Department of Justice because no criminal conduct was identified. The investigation was closed on December 9, 2019.

RESULTS FROM THE OFFICE OF MANAGEMENT AND ADMINISTRATION

OVERVIEW

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

OVERSIGHT ACTIVITIES

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

- Received and screened 14,747 contacts from complainants, including VA employees, veterans, and the public and directed potential cases to the appropriate OIG directorate for further review
- Referred 766 cases to and required a written response from applicable VA offices after

determining that allegations pertained to higher-risk topics, but where insufficient resources were available for OIG staff to complete a prompt independent review at that time

- Made 565 non-case referrals to appropriate VA offices after determining that the allegations pertained to lower-risk topics and that VA was the most appropriate entity to review the allegations to determine whether action was indicated
- Closed 702 cases for which nearly 36 percent of allegations were substantiated, 531 administrative sanctions and corrective actions were taken, and $453,434 in monetary benefits were achieved
- Responded to more than 233 requests for record reviews from VA staff offices
- Issued 3,024 semi-custom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope, and finalized a contract to significantly increase the volume of semi-custom responses in the future

FEATURED HOTLINE CASES

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

DELAY IN CARE

The OIG hotline received a complaint that a veteran experienced excessive wait times for mental health and specialty care appointments at the Augusta, Georgia, VA Medical Center. The facility reviewed the allegations and determined that in both instances scheduling for the veteran's appointments was delayed beyond the VA standard. As a result, the medical center implemented a 16-point plan to improve timely scheduling and completion of consults. Specific actions included changing community care leadership, hiring additional staff, improving staff training, leveraging overtime, and enhancing scheduling with top community care providers.

OVERPAYMENT OF DISABILITY BENEFITS

An anonymous complainant alleged that a veteran was claiming a spouse on his disability benefits despite being divorced for several years. The OIG hotline referred the issue to the St. Paul VA Regional Office in Minnesota and staff substantiated the allegations. After serving the veteran a due-process letter and failing to receive a response, the regional office created a debt for the overpayment effective the first of the month following the reported date of divorce, which totaled $13,263.

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

INADEQUATE HOME HEALTH CARE

A veteran's caregiver reported that a home health aide, contracted for by the VA, failed to report for work on occasions, arrived late in other instances, and did not perform all required duties. The issue was referred to the Albany, New York, VA Medical Center and the allegations were substantiated. As a result, the agency providing services assigned a different aide and the VA medical center initiated follow-up calls to the caregiver to confirm the quality of service from the new aide.

PATIENT SAFETY

A complainant reported that patient safety at the Greater Los Angeles, California, VA Medical Center was at risk because a nuclear medicine technologist willfully failed to perform daily quality control of their rubidium-82 generator. OIG hotline staff sent the issues to VISN 22 for review and the allegations were substantiated. A total of 10 corrective actions were outlined, including terminating the technologist from federal service.

FEATURED DATA-DRIVEN INITIATIVE

The Data Analysis Division, in conjunction with the Office of Investigations, created a user-friendly, self-service dashboard that bolsters oversight of the nearly $13 billion educational benefits programs administered by VA by facilitating the proactive identification of educational institutions that may be engaged in fraud. The tool includes over 200 risk indicators for educational institutions, including factors related to ownership, student enrollment patterns, and characteristics of students enrolled in courses that were not approved for distance learning. OIG staff also use the dashboard to search for specific educational institutions and obtain just-in-time, descriptive information to inform a variety of business decisions, including triaging incoming hotline complaints. In addition to placing user-friendly information at users' fingertips, this tool has generated multiple new preliminary or full investigative cases and is providing insights and visualizations to inform audit proposals in development.

RESULTS FROM THE OFFICE OF SPECIAL REVIEWS

OVERVIEW

The Office of Special Reviews increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single existing OIG directorate or office. Staffed with professionals possessing a broad array of expertise, the Office of Special Reviews undertakes projects assigned to it by the Inspector General and Deputy Inspector General, works collaboratively with the other directorates to review topics and issues of interest that span multiple offices, and conducts administrative investigations.

2
REPORTS

FEATURED PUBLICATION

FAILURES IMPLEMENTING ASPECTS OF THE VA ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION ACT OF 2017

In response to congressional requests and allegations made to the OIG's hotline, the Office of Special Reviews examined whether VA was properly implementing aspects of the VA Accountability and Whistleblower Protection Act of 2017. This examination reviewed the operations of the Office of Accountability and Whistleblower Protection (OAWP) from June 2017 through December 2018. The OIG also reviewed operational changes implemented by new OAWP leaders as of August 2019. Specifically, the review focused on determining whether OAWP exercised its legal authority appropriately; conducted adequate, thorough, and procedurally fair investigations; and protected whistleblowers from retaliation. The OIG examined whether VA employees were held accountable using the Act's authorities and whether VA complied with other Act requirements, including timely and accurate reporting to Congress. The OIG identified significant deficiencies within each area of inquiry, including the OAWP misinterpreting its statutory mandate. OAWP referred out matters it should have investigated to VA entities without appropriately protecting whistleblowers' identities. The OAWP also investigated matters outside its authority. Former OAWP leaders also made avoidable mistakes that distracted from the office's core mission and undermined the confidence of some whistleblowers, thereby chilling reporting. A lack of clear written guidance for OAWP personnel contributed to the inaccuracy, perceived bias, and lack of thoroughness in investigations—causing some disciplinary officials to reduce proposed disciplinary sanctions. Insufficient safeguards put whistleblowers at risk of becoming the subject of retaliatory investigations, and in one troubling instance the OAWP initiated an investigation that could itself be considered retaliatory. Other failures related to whistleblower protection training, congressional reporting, and disclosing routine uses of information. The OAWP's current Assistant Secretary started implementing changes after taking office in January 2019. Given the magnitude of the challenges, significant enhancements are needed to fulfill the Act's requirements and the office's mission. VA concurred with the OIG's 22 recommendations.

ADMINISTRATIVE INVESTIGATION

The Office of Special Reviews evaluates allegations and conducts investigations generally concerning high-ranking senior officials and matters of particular interest to Congress, the Department, and other stakeholders.

Under §5(a)(19) of the IG Act, OIGs must report each investigation of a senior government employee (defined in the Act as an employee at the GS-15 grade level or above) where allegations of misconduct were substantiated, including the facts and circumstances of the case and the status and disposition of the matter, including whether the matter was referred to the Department of Justice (DOJ), the date of such referral, and, if applicable, the date of declination by the DOJ. During this reporting period, the Office of Special Reviews closed no administrative investigations with substantiated allegations of misconduct by senior government employees.

Section 5(a)(22)(B) of the IG Act also requires OIGs to provide detailed descriptions of the particular circumstances of each investigation involving a senior government employee that is closed and was not disclosed to the public. The OIG publishes all closed administrative investigations, whether or not the allegations were substantiated. This reporting period, the OIG published one administrative investigation, the details of which follow.

ALLEGED IMPROPER LOCALITY PAY FOR TELEWORKING EMPLOYEE

The OIG investigated an allegation that an employee was approved to change duty stations from Pittsburgh to Altoona, Pennsylvania, but continued to improperly receive the higher locality pay for the Pittsburgh area. The OIG substantiated that the employee's telework agreement did not comply with applicable regulations requiring employees to report to the official worksite twice per pay period when the employee is not in a permanent telework arrangement. Although temporary exceptions can be granted, there is no discretion to grant a permanent exception. The OIG determined that the employee and the employee's supervisors took appropriate corrective action once the issue became known, prior to OIG's investigation. The OIG did not identify any evidence to suggest that maintaining higher locality pay was intentional. Accordingly, the OIG did not substantiate misconduct. The OIG made one recommendation to clarify the authority and obligations of telework-approving supervisors within the Office of General Counsel.

CONGRESSIONAL RELATIONS AND PUBLIC AFFAIRS

CONGRESSIONAL TESTIMONY

During this reporting period, OIG staff testified at eight congressional hearings on a range of topics. Table 6 provides links to the OIG's full statements for each hearing. All previous statements made by the OIG before Congress are available at www.va.gov/oig/publications/statements.asp.

ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS TESTIFIES ON VHA CREDENTIALING AND PRIVILEGING PROGRAMS

Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections, testified at a hearing before the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations, regarding the challenges facing VHA's Credentialing and Privileging programs. Dr. Daigh's testimony was drawn from numerous OIG reports, including the *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2018*; *Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility*; and Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina. He discussed the OIG's findings, explained VHA's failure to implement policies appropriately, and urged VHA to look at appointing national practice leaders to strengthen oversight over credentialing and privileging functions, including conducting more hands-on skills checks of new providers.

INSPECTOR GENERAL TESTIFIES BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS ABOUT THE OIG'S REVIEW OF VA'S OAWP

Inspector General Michael Missal testified at a hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on October 29, 2019. The hearing focused on the OIG report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*. Inspector General Missal provided an overview of the report's six findings, which noted how leadership failures undermined OAWP's core mission and diminished the confidence of whistleblowers and other potential complainants in the operations of the office. The report also included 22 recommendations to improve VA processes that increase employee accountability and whistleblower protection.

INSPECTOR GENERAL MISSAL TESTIFIES BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ABOUT THE OIG'S REVIEW OF VA'S OAWP

Inspector General Michael Missal also testified at a hearing before the House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies on November 14, 2019, concerning the OIG's review of OAWP. Mr. Missal discussed the report's six findings and 22 recommendations, as well as how leadership failures distracted OAWP from its core mission and diminished the confidence of whistleblowers and other potential complainants in the office's operations.

DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS TESTIFIES BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

Mr. Nick Dahl, Deputy Assistant Inspector General for Audits and Evaluations, testified about VA's cybersecurity challenges and cyber risk management at a November 14, 2019, hearing held by the House Committee on Veterans' Affairs Subcommittee on Technology Modernization. Mr. Dahl's

testimony focused on the challenges to protecting the confidentiality, integrity, and availability of VA systems and data. He was accompanied by Mr. Michael Bowman, Director of the Information Technology and Security Audit Division.

DEPUTY ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS TESTIFIES BEFORE THE HOUSE VETERANS' AFFAIRS COMMITTEE

Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testified at a January 29, 2020, hearing on "Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach." Dr. Kroviak's testimony was drawn from nearly two dozen OIG reports, such as *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2018*, *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, and *Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center in Florida*, and two reports discussing veteran deaths by suicide at the Minneapolis VA Medical Center (*Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota*, and *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota*). In these reports, the OIG found inadequate coordination of care to be an underlying theme in many of the suicides. During questioning, Dr. Kroviak reiterated OIG findings that the root causes for poorly implemented VHA policies include staffing shortages, inadequate training, and leadership failures.

DEPUTY ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS TESTIFIES BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS AND WOMEN VETERANS TASK FORCE

Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak testified at a February 5, 2020, hearing before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations and Women Veterans Task Force. The hearing examined how VA supports survivors of military sexual trauma (MST). Dr. Kroviak's testimony discussed the results of the OIG's fiscal year 2019 Comprehensive Healthcare Inspection Program, which in part evaluated VA medical facilities' compliance with selected VHA requirements related to MST. These included processes carried out by MST coordinators, the provision of care to patients after positive screening, and mandatory staff training. Dr. Kroviak discussed that, while VHA had high compliance with several of the selected requirements, the OIG noted opportunities for improvement such as ensuring MST coordinators communicate issues concerning MST services and initiatives with local leaders, making facility staff aware of MST issues, and ensuring that new staff receive required training. Dr. Kroviak also provided updated information on the status of recommendations contained in the OIG Office of Audits and Evaluations' 2018 report *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*.

DEPUTY INSPECTOR GENERAL TESTIFIES BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

Mr. David Case, Deputy Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Technology Modernization Subcommittee on March 5, 2020, on "Getting It Right: Challenges with the Go-Live of Electronic Health Record Modernization." Mr. Case's testimony was drawn from two not-yet-published OIG reports. He explained that the OIG's work found VA had not met its own readiness guidelines for deploying the new electronic health record to the Mann-Grandstaff VA Medical Center in Spokane, Washington, and that the mitigations for incomplete capabilities—for example, requiring staff to use at least two internal systems and sometimes third-party software to find and manually transfer information, verify patient eligibility, and track approvals, all while providing

patient care—posed significant patient safety risks. During the hearing, Mr. Case explained that the OIG would continue oversight of the Electronic Health Record Modernization program and monitor VA's new schedule for going live and deploying the system's full capabilities incrementally.

COUNSELOR TO THE INSPECTOR GENERAL TESTIFIES BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. Christopher Wilber, Counselor to the Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Oversight and Investigations Subcommittee on March 10, 2020, on pending legislation including H.R. 5843, the Strengthening Oversight for Veterans Act of 2020. Mr. Wilber testified in support of the bill, which would give the OIG testimonial subpoena authority. He explained how it would strengthen the OIG's work, discussed examples of inspections and investigations where the VA OIG could not interview former VA employees, and noted safeguards for witnesses.

TABLE 6. OIG CONGRESSIONAL TESTIMONY (OCTOBER 1, 2019–MARCH 31, 2020)

WITNESS	COMMITTEE	TOPIC	DATE
Assistant Inspector General for Healthcare Inspections Dr. John D. Daigh Jr., CPA	House Veterans' Affairs Committee, Subcommittee on Oversight and Investigations	Broken Promises: Assessing VA's Systems for Protecting Veterans from Clinical Harm	10/16/2019
Inspector General Michael J. Missal	House Veterans' Affairs Committee, Subcommittee on Oversight and Investigations	Protecting Whistleblowers and Promoting Accountability: Is VA Doing Its Job?	10/29/2019
Inspector General Michael J. Missal	House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies	Office of Accountability and Whistleblower Protection's Failures at VA	11/14/2019
Deputy Assistant Inspector General for Audits and Evaluations Nicholas Dahl	House Veterans' Affairs Committee, Subcommittee on Technology Modernization	Cybersecurity Challenges and Cyber Risk Management at the Department of Veterans Affairs	11/14/2019
Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak	House Veterans' Affairs Committee	Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach	1/29/2020
Deputy Assistant Inspector General for Healthcare Inspections Dr. Julie Kroviak	House Veterans' Affairs Committee, Subcommittee Oversight and Investigations and Women Veterans Task Force	Examining How the Department of Veterans Affairs Supports Survivors of Military Sexual Trauma	2/5/2020

WITNESS	COMMITTEE	TOPIC	DATE
Deputy Inspector General David Case	House Veterans' Affairs Committee, Subcommittee on Technology Modernization	Getting It Right: Challenges with the Go-Live of Electronic Health Record Modernization	3/5/2020
Counselor to the Inspector General Christopher Wilber	House Veterans' Affairs Committee, Subcommittee on Oversight and Investigations	Hearing on H.R. 5843 and Other Pending Legislation	3/10/2020

PRESS RELEASE

All OIG press releases, as well as press releases made by the U.S. Department of Justice regarding VA OIG criminal investigations, are available at www.va.gov/oig/publications/press-releases.asp.

TABLE 7. OIG PRESS RELEASE
(OCTOBER 1, 2019–MARCH 31, 2020)

TITLE	ISSUE DATE
VA Office of Inspector General and Department of Justice Announce VA Health Care Fraud Task Force	10/1/2019

PODCASTS

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

TABLE 8. OIG PODCASTS
(OCTOBER 1, 2019–MARCH 31, 2020)

TITLE	ISSUE DATE
VA OIG September 2019 Highlights	10/3/2019
VA OIG October 2019 Highlights	11/6/2019
VA OIG November 2019 Highlights	12/19/2019
Semiannual Report to Congress: April 1, 2019–September 30, 2019	1/21/2020
VA OIG December 2019 Highlights	1/22/2020
VA OIG January 2020 Highlights	2/23/2020
The Challenges in Rating VHA Community Living Centers	3/4/2020
VA OIG February 2020 Highlights	3/23/2020

OTHER REPORTING REQUIREMENTS

OIG REVIEWS OF PROPOSED LEGISLATION AND REGULATIONS

Inspectors general are required by §4(a)(2) of the Inspector General Act of 1978 (IG Act) (P.L. 95-452) to review existing and proposed legislation and regulations and make recommendations in the SAR concerning the impact of such legislation or regulations on the economy, efficiency, or the prevention and detection of fraud and abuse in the administration of programs and operations administered or financed by VA. During this reporting period, the OIG reviewed three legislative or regulatory proposals and made no comments. The OIG also reviewed 22 internal VA directives and handbooks that guide the work of VA employees and provided nine comments.

REFUSALS TO PROVIDE INFORMATION OR ASSISTANCE TO THE OIG

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

PEER AND QUALITATIVE ASSESSMENT REVIEWS

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

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

MOST RECENT PEER REVIEWS CONDUCTED OF THE VA OIG

On October 10, 2018, the Department of Energy OIG initiated a peer review of VA OIG's audit operations for the three-year period ending September 2018. The DOE OIG issued a final report on August 28, 2019 and concluded that VA OIG's system of quality controls provides reasonable assurance that the

Office of Audits and Evaluations performs its work and reports its findings in conformity with applicable standards in all material respects.

On December 10, 2018, the NASA OIG completed a peer review of VA OIG's Office of Investigations for the three-year period ending September 2018. The NASA OIG found VA OIG's internal system of safeguards and management procedures for its investigative function to be in compliance with the quality standards established by Council of the Inspectors General on Integrity and Efficiency and other applicable guidelines and statutes.

MOST RECENT PEER REVIEWS CONDUCTED BY THE VA OIG

During this reporting period, there were no peer reviews conducted by the VA OIG.

INSTANCES OF WHISTLEBLOWER RETALIATION

Inspectors general are required by §5(a)(20) of the IG Act to report information concerning officials found to have engaged in retaliation against whistleblowers. In addition, the Act requires inspectors general to detail the consequences imposed by the Department to hold those officials accountable. While the VA OIG's current practice is to refer individuals making allegations of whistleblower reprisal to either the VA OAWP or the U.S. Office of Special Counsel, the OIG's Office of Special Reviews reported two actions taken by former OAWP leaders that could be considered retaliatory. The first related to the proposed removal of an OAWP employee who had made a disclosure of misconduct. The second related to the initiation of an investigation of a whistleblower who had made allegations of misconduct relating to a senior political appointee. In both instances, the official alleged to have engaged in retaliation was no longer a VA employee when the OIG identified the conduct. As a result, neither official was held accountable. These matters were reported in the October 24, 2019 publication, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*.

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

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

CLOSED OFFICE OF INSPECTOR GENERAL WORK NOT DISCLOSED TO THE PUBLIC

The VA OIG is required by §5(a)(22)(A) of the IG Act to provide detailed descriptions of the particular circumstances of each inspection, evaluation, and audit conducted by the OIG that is closed and

was not disclosed to the public. The VA OIG's practice is to publish all reports that are not otherwise prohibited from disclosure; therefore, the VA OIG has no information responsive to this reporting requirement.

GOVERNMENT CONTRACT AUDIT FINDINGS

The IG Act, as amended by the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110-181), requires each Inspector General to submit an appendix on final, completed contract audit reports issued to the contracting activity (agency component) that contain significant audit findings—unsupported, questioned, or disallowed costs in an amount in excess of $10 million, or other significant findings—as part of the SAR. During this reporting period, the VA OIG did not issue any reports meeting these requirements.

AWARDS AND RECOGNITION

EMPLOYEE RECOGNITION OF MILITARY PERSONNEL

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

- Matthew Clark, an auditor in Dallas, Texas, was activated by the United States Army in July 2019.
- Brian Celatka, a criminal investigator in Nashville, Tennessee, returned from duty in October 2019.
- Danielle Head, a procurement analyst in Arlington, Virginia, was activated by the United States Army in October 2019.
- George Kurtzer, an information technology specialist in Hines, Illinois, returned from duty in December 2019.
- Damian Donahoe, a training management coordinator in Kansas City, Missouri, was activated by the United States Army in January 2020.
- Peter Moore, a criminal investigator in Dallas, Texas, returned from duty in February 2020.
- Christopher Dong, an attorney in Washington, DC, was activated by the United States Air Force in March 2019.
- Katherine Bostick, a health systems specialist in Aurora, Colorado, was activated by the United States Army in March 2020.

PRESIDENTIAL RANK DISTINGUISHED EXECUTIVE AWARD RECIPIENT

In December 2019, Dr. Lin Clegg was awarded the Presidential Rank Distinguished Executive Award. Presidential Rank Awards are reserved for career senior executives who have a record of achievement that is recognized throughout the agency and/or is acknowledged on a national or international level. In reaching this pinnacle of achievement, rank award recipients are also required to have demonstrated strong leadership abilities, inspired their employees, and earned the respect of those they serve. Since 2006, Dr. Clegg has been the Director of Biostatistics, Program Evaluation, and Consultation in the Office of Healthcare Inspections. She has successfully championed nearly 600 national evaluations and healthcare inspections of VHA. Dr. Clegg is recognized as a prominent scholar, ingenious methodologist, and consummate professional by the OIG, other scholars in her field, and high-ranking officials within VA and other government agencies, particularly those from DoD. She has authored more than 60 peer-reviewed publications in prestigious journals, including the *New England Journal of Medicine* and the *Journal of the American Statistical Association*.

AWARDS AND RECOGNITION

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION INVESTIGATION OF THE YEAR AWARD

At the 2019 Annual Training Conference, the National Health Care Anti-Fraud Association (NHCAA) recognized the investigation and prosecution team involved in United States v. Barry J. Cadden by awarding the team the NHCAA's Investigation of the Year Award for Honorable Mention. Special Agent Jason Kravetz was part of this team. The team was responsible for the investigation and prosecution of the owners and executives of the New England Compounding Center, a compounding pharmacy that manufactured contaminated steroids that led to the 2012 nationwide outbreak of fungal meningitis. According to the Centers for Disease Control and Prevention, the outbreak infected approximately 1,000 individuals and led to 76 deaths throughout the country. It is considered the deadliest medication contamination case in U.S. history. Although no VA patients are known to have died, VA purchased approximately $516,000 of the compounding center's products that were allegedly produced in unsanitary conditions and in an unsafe manner.

HEALTH AND HUMAN SERVICES INSPECTOR GENERAL'S AWARD FOR EXCELLENCE

On February 18, 2020, the multiagency Insys Therapeutics investigative team, which included VA OIG Resident Agent-in-Charge Robert Bosken, received the HHS Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse. The team earned this prestigious award after their successful investigation and prosecution of Insys Therapeutics and former employees for their role in a racketeering conspiracy in connection with bribing medical practitioners to prescribe their drug, called Subsys.

STAY CONNECTED

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APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

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

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

Federal inspectors general are also required under §5(a)(11) and (12) of the IG Act to provide a description and explanation of the reasons for any significant revised management decision made during the reporting period, as well as information concerning any significant management decisions with which the Inspector General is in disagreement. While VA OIG reports that there were no significant revised management decisions made during the reporting period, there were two significant management decisions in two reports with which the Inspector General is in disagreement. In the report *The Impact of VA Allowing Government Agencies to Be Excluded from Temporary Price Reductions on Federal Supply Schedule Pharmaceutical Contracts*, the Department nonconcurred with OIG recommendation 1 related to the development and implementation of a policy that prohibits restricted agency-specific temporary price reductions on federal supply schedule contracts. For this recommendation, the Department contended that their practices regarding temporary price reductions were consistent with public law. Also, in the report *Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts*, the Department nonconcurred with OIG Recommendation 30 related to the availability of equipment and supplies in the urgent care center that are necessary to care for patients. Specifically, the Department contended that appropriate supplies are on hand at the facility to maintain the high-level of quality care that is provided in the urgent care center. However, the OIG stands by its findings and recommendations for both reports. The Department's comments and OIG responses are available in full in the respective reports on the VA OIG's website.

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

AUDITS AND REVIEWS	BETTER USE OF FUNDS	QUESTIONED COSTS
Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives *Issued 10/17/2019 | Report Number 19-06125-218*	--	--
VA's Management of Mobile Devices Generally Met Information Security Standards *Issued 10/22/2019 | Report Number 18-04608-212*	--	--
FY 2019 Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2019| Report Number 19-07247-251*	--	--
Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters *Issued 11/14/2019 | Report Number 19-05960-244*	--	--
Audit of VA's Financial Statements for Fiscal Years 2019 and 2018 *Issued 11/19/2019| Report Number 19-06453-12*	--	--
VHA Did Not Effectively Manage Appeals of Non VA Care Claims *Issued 11/21/2019 | Report Number 18-06294-213*	--	--
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Boston VA Research Institute *Issued 12/2/2019 | Report Number 18-00711-211*	--	$45,900,000
Delays and Deficiencies in Management of Selected Radiology and Nuclear Medicine Outpatient Exams *Issued 12/10/2019 | Report Number 18-02300-236*	--	--
Insufficient Oversight of VA's Undelivered Orders *Issued 12/16/2019 | Report Number 17-04859-196*	$132,600,000	--
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers *Issued 12/17/2019 | Report Number 17-03718-240*	$84,000,000	--

AUDITS AND REVIEWS (CONTINUED)	BETTER USE OF FUNDS	QUESTIONED COSTS
Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes *Issued 1/14/2020 | Report Number 19-00021-41*	$261,300,000	--
Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities *Issued 1/16/2020 | Report Number 18-05121-36*	--	--
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Cincinnati Education and Research for Veterans Foundation *Issued 1/16/2020 | Report Number 18-00711-42*	--	$950,000
Little Rock VARO Employee Inaccurately Established and Decided Claims *Issued 1/30/2020 | Report Number 19-06757-70*	--	$311,000
Veterans Received Inaccurate Disability Benefit Payments After Reserve or National Guard Drill Pay Adjustments *Issued 2/11/2020 | Report Number 18-05738-56*	--	$56,900,000
Telehealth Public-Use Questionnaires Were Used Improperly to Determine Disability Benefits *Issued 2/18/2020 | Report Number 19-07119-80*	--	$613,000
Review of Regional Procurement Office East's Contract Closeout Compliance *Issued 2/27/2020 | Report Number 19-05866-82*	$6,840,219	--
Risk Assessment of VA's Grant Closeout Process *Issued 3/25/2020 | Report Number 19-09126-115*	--	--
Federal Information Security Modernization Act Audit for Fiscal Year 2019 *Issued 3/31/2020 | Report Number 19-06935-96*	--	--
Total	**$484,740,219**	**$104,674,000**

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

Office of Contract Review preaward reviews of prospective VA contracts and postaward reviews of awarded contracts are submitted only to the Department and are not publicly released. These reports contain nonpublic, confidential, and proprietary data relating to the contractors' business and include trade secret information protected from public release by 18 U.S.C. § 1905. Section 1905 provides for criminal penalties for any government employee or contractor who publicly discloses such protected

information. Further, the reports are exempt, in whole or in part, from mandatory public disclosure under subparagraphs (b)(3), (b)(4), and (b)(5) of the Freedom of Information Act (FOIA), 5 U.S.C. § 552. Portions of the reports that pertain to contractor proposals are also protected from disclosure by 41 U.S.C. § 4702 (prohibiting disclosure of contractor proposals under FOIA).

PREAWARD REVIEWS	SAVINGS AND COST AVOIDANCE
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/2/2019 | Report Number 19-08014-01*	$48,645
Review of Proposal Submitted under a Solicitation *Issued 10/7/2019 | Report Number 19-09506-02*	$3,480
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/7/2019 | Report Number 19-09375-03*	--
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/15/2019 | Report Number 19-08844-246*	$2,965,900
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/15/2019 | Report Number 19-08346-04*	--
Review of Proposal Submitted under a Solicitation *Issued 10/16/2019 | Report Number 19-09535-05*	$1,757,152
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 10/28/2019 | Report Number 19-09083-08*	--
Review of Request for Modification– Product Additions – Submitted under a Federal Supply Schedule Contract *Issued 11/6/2019 | Report Number 19-09577-17*	$154,388
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/12/2019 | Report Number 19-07957-20*	$3,000
Review of Proposal Submitted under a Solicitation *Issued 11/13/2019 | Report Number 20-00388-19*	$921,765
Review of Proposal Submitted under a Solicitation *Issued 11/14/2019 | Report Number 20-00121-22*	$3,202,727
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 11/18/2019 | Report Number 19-09204-28*	--

PREAWARD REVIEWS (CONTINUED)	SAVINGS AND COST AVOIDANCE
Review of Request for Modification – Product Additions – Submitted under a Federal Supply Schedule Contract *Issued 11/25/2019 | Report Number 19-09772-37*	--
Review of Request for Product Addition Submitted under a Federal Supply Schedule Contract *Issued 11/26/2019 | Report Number 20-00304-35*	--
Review of Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 11/29/2019 | Report Number 19-07488-44*	--
Review of Proposal Submitted under a Solicitation *Issued 12/5/2019 | Report Number 20-00539-46*	$791,035
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 12/5/2019 | Report Number 19-09336-49*	$13,488,663
Review of Proposal Submitted under a Solicitation *Issued 12/9/2019 | Report Number 20-00254-52*	$2,156,009
Review of Proposal Submitted under a Solicitation *Issued 12/10/2019 | Report Number 20-00381-53*	$377,515
Review of Request for Modification for Product Addition Submitted under a Federal Supply Schedule Contract *Issued 12/11/2019 | Report Number 19-08894-50*	$1,056,818
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 1/15/2020 | Report Number 19-09476-77*	--
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 1/15/2020 | Report Number 19-08588-65*	--
Review of Proposal Submitted under a Solicitation *Issued 1/31/2020 | Report Number 19-09777-76*	--
Review of Proposal Submitted under a Solicitation *Issued 1/31/2020 | Report Number 20-01034-83*	$7,928,876
Review of Request for Modification – Product Additions – Submitted under a Federal Supply Schedule Contract *Issued 2/5/2020 | Report Number 20-00366-86*	$16,056
Review of Request for Contract Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 2/5/2020 | Report Number 19-08463-87*	$1,393,279

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

PREAWARD REVIEWS (CONTINUED)	SAVINGS AND COST AVOIDANCE
Review of Request for Modification Submitted under a Federal Supply Schedule Contract *Issued 3/9/2020 | Report Number 20-00569-100*	$70,763
Review of Proposal Submitted under a Solicitation *Issued 3/16/2020 | Report Number 20-01673-109*	$226,395
Review of Extension Proposal Submitted under a Federal Supply Schedule Contract *Issued 3/16/2020 | Report Number 20-00789-101*	$6,906,646
Review of Proposal Submitted under a Solicitation *Issued 3/16/2020 | Report Number 20-01725-102*	$5,411,270
Review of Federal Supply Schedule Proposal Submitted under a Solicitation *Issued 3/20/2020 | Report Number 20-00401-116*	$10,444,447
Total	**$59,324,829**

POSTAWARD REVIEWS	DOLLAR RECOVERIES
Review of a Voluntary Disclosure for Price Reductions under a Federal Supply Schedule Contract *Issued 10/16/2019 | Report Number 19-00649-245*	$8,807
Review of a Voluntary Disclosure for Price Reductions under a Federal Supply Schedule Contract *Issued 10/21/2019 | Report Number 19-08523-248*	$1,984
Review of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 10/25/2019 | Report Number 19-07045-250*	--
***Special Project:* The Impact of VA Allowing Government Agencies to Be Excluded from Temporary Price Reductions on Federal Supply Schedule Pharmaceutical Contracts** *Issued 10/30/2019 | Report Number 18-04451-06*	--
Review of Voluntary Disclosure for Price Reductions under a Federal Supply Schedule Contract *Issued 11/6/2019 | Report Number 18-03063-18*	$20,407
Review of Compliance with Public Law 102-585 Section 603 under an Interim Agreement *Issued 11/19/2019 | Report Number 20-00376-254*	$213,840

POSTAWARD REVIEWS (CONTINUED)	DOLLAR RECOVERIES
Review of Voluntary Disclosure of Public Law Pricing Errors under Federal Supply Schedule Contracts *Issued 11/19/2019 | Report Number 18-06092-09*	$7,890
Review of Voluntary Disclosure of Pricing Errors under a Federal Supply Schedule Contract *Issued 11/21/2019 | Report Number 19-06457-21*	$13,260
Review of Voluntary Disclosure Submitted under a Federal Supply Schedule Contract *Issued 11/22/2019 | Report Number 19-07051-31*	$101,461
Review of Voluntary Disclosure of Public Law Pricing Errors under a Federal Supply Schedule Contract *Issued 11/26/2019 | Report Number 18-06102-32*	$269
Review of Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 11/26/2019 | Report Number 17-05416-45*	$76,546
Review of Voluntary Disclosure of Pricing Errors under a Federal Supply Schedule Contract *Issued 11/27/2019 | Report Number 18-02443-34*	$1,080,062
Follow-Up Review of Compliance with Public Law 102-585 Section 603 and Price Reduction Clause 552.238-75 under Federal Supply Schedule Contracts *Issued 1/15/2020 | Report Number 16-00675-71*	$1,457,658
Review of Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 1/21/2020 | Report Number 17-03094-78*	$2,423,012
Review of Voluntary Disclosure due to Non-compliance with the Trade Agreements Act under Federal Supply Schedule Contracts *Issued 1/21/2020 | Report Number 19-07714-79*	$69,052
Review of Voluntary Disclosure under a Federal Supply Schedule Contract *Issued 2/25/2020 | Report Number 19-09347-93*	$4,845
Review of Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 3/3/2020 | Report Number 20-01313-97*	$2,326
Review of Voluntary Disclosure of Pricing Errors under a Federal Supply Schedule Contract *Issued 3/5/2020 | Report Number 20-01212-98*	$581,607

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

POSTAWARD REVIEWS (CONTINUED)	DOLLAR RECOVERIES
Review of Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 3/12/2020 | Report Number 18-01993-104*	$921,615
***Special Project:* QTC Medical Services Complied with Medical Disability Examination Billing Requirements** *Issued 3/16/2020 | Report Number 19-08397-99*	--
Review of Compliance with Public Law 102-585 Section 603 under Federal Supply Schedule Contracts *Issued 3/18/2020 | Report Number 18-03874-110*	$1,205,454
Review of Voluntary Disclosure and Refund Offer under a Federal Supply Schedule Contract *Issued 3/19/2020 | Report Number 15-04000-114*	$185,688
Review of Compliance with Public Law 102-585 Section 603 under a Federal Supply Schedule Contract *Issued 3/19/2020 | Report Number 19-08468-113*	$57,615
Total	**$8,433,398**

CLAIM REVIEWS	SAVINGS AND COST AVOIDANCE
Review of Certified Claim Submitted under a Contract *Issued 10/24/2019 | Report Number 19-09701-07*	--
Review of Certified Claim Submitted under a VA Contract *Issued 2/4/2020 | Report Number 20-01009-85*	$395,440
Total	**$395,440**

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

COMPREHENSIVE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas	10/23/2019	19-00035-247
Fargo VA Health Care System, North Dakota	11/7/2019	19-00018-252
Carl Vinson VA Medical Center, Dublin, Georgia	11/12/2019	18-04682-256
James A. Haley Veterans' Hospital, Tampa, Florida	11/14/2019	19-00011-255

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

COMPREHENSIVE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
VA Connecticut Healthcare System, West Haven, Connecticut	11/20/2019	18-04675-23
Charlie Norwood VA Medical Center, Augusta, Georgia	11/21/2019	19-00013-15
Manchester VA Medical Center, New Hampshire	11/25/2019	19-00040-10
El Paso VA Health Care System, Texas	11/26/2019	19-00033-11
Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania	11/26/2019	18-04667-13
VA Greater Los Angeles Healthcare System, California	12/2/2019	18-04671-25
Sioux Falls VA Health Care System, South Dakota	12/3/2019	19-00019-26
VA Pacific Islands Health Care System, Honolulu, Hawaii	12/5/2019	19-00023-29
Northern Arizona VA Health Care System, Prescott, Arizona	12/5/2019	19-00014-33
VA Butler Health Care Center, Pennsylvania	12/10/2019	19-00049-43
VA Manila Outpatient Clinic, Pasay City, Philippines	12/11/2019	19-00024-39
Kansas City VA Medical Center, Missouri	12/12/2019	18-06504-27
Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio	12/18/2019	19-00051-40
Coatesville VA Medical Center, Pennsylvania	12/18/2019	19-00048-48
St. Cloud VA Health Care System, Minnesota	12/19/2019	19-00055-38
VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon	12/19/2019	19-00052-54
Louis Stokes Cleveland VA Medical Center, Ohio	12/19/2019	19-00015-47
VA Western New York Healthcare System, Buffalo, New York	1/7/2020	18-04666-55
Veterans Integrated Service Network 4: VA Healthcare, Pittsburgh, Pennsylvania	1/8/2020	19-06871-59
Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington	1/8/2020	19-00053-57
Canandaigua VA Medical Center, New York	1/9/2020	19-00037-58
VA Maryland Health Care System, Baltimore, Maryland	1/9/2020	19-00016-61
Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts	1/13/2020	19-00043-66
VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts	1/13/2020	19-00038-63
Richard L. Roudebush VA Medical Center, Indianapolis, Indiana	1/14/2020	19-00012-51
Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network, Arlington, Texas	1/15/2020	19-06863-69
West Texas VA Health Care System, Big Spring, Texas	1/15/2020	19-00034-62

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

COMPREHENSIVE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana	1/16/2020	19-00046-60
Alaska VA Healthcare System, Anchorage, Alaska	1/28/2020	19-00054-72
Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts	1/29/2020	19-06866-68

HOTLINE HEALTHCARE INSPECTIONS	ISSUE DATE	REPORT NUMBER
Ophthalmology Equipment and Related Concerns at the James A. Haley Veterans' Hospital, Tampa, Florida	11/7/2019	19-07095-253
Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System, Anchorage, Alaska	11/19/2019	19-00002-16
Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut	11/20/2019	19-00075-14
Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status at the Baltimore VA Medical Center, Maryland	11/26/2019	19-05916-24
Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in VISN 15	12/11/2019	19-06562-30
Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota	1/7/2020	19-00468-67
Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center Spokane, Washington	1/8/2020	19-09017-64
A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York	1/21/2020	19-07070-75
Alleged Deficiencies in a Hospitalist's Interactions with a Patient at the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas	1/22/2020	18-05565-74
Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System, Dallas, Texas	1/23/2020	19-06378-73
Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction, Colorado	2/4/2020	19-06435-84
Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio	2/20/2020	18-01275-89

HOTLINE HEALTHCARE INSPECTIONS (CONTINUED)	ISSUE DATE	REPORT NUMBER
Alleged Issues in the Cardiology Department at the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana	2/27/2020	19-07090-90
Alleged Deficiencies Related to the Cardiac Catheterization and Electrophysiology Laboratories at the Jesse Brown VA Medical Center, Chicago, Illinois	3/3/2020	19-07535-92
Deficient Staffing and Competencies in Sterile Processing Services at the VA Black Hills Healthcare System, Fort Meade Campus, South Dakota	3/23/2020	19-07096-108
Deficiencies in a Cardiac Research Study at the VA St. Louis Health Care System, Missouri	3/24/2020	19-07682-103
Deficiencies in the Administration of Emergent Mental Health Services at the Coatesville VA Medical Center, Pennsylvania	3/25/2020	19-08374-112

NATIONAL HEALTHCARE REVIEWS	ISSUE DATE	REPORT NUMBER
Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018	10/10/2019	19-07040-243
Review of Veterans Health Administration Community Living Centers and Corresponding Star Ratings	2/12/2020	18-05113-81
OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness	3/26/2020	20-02221-120

TABLE A.4. PUBLICATIONS ISSUED BY THE OFFICE OF SPECIAL REVIEWS

ADMINISTRATIVE INVESTIGATION	ISSUE DATE	REPORT NUMBER
Alleged Improper Locality Pay for Teleworking Employee	2/18/2020	18-03251-88

SPECIAL REVIEW	ISSUE DATE	REPORT NUMBER
Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017	10/24/2019	18-04968-249

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

TABLE A.5. TOTAL MONETARY BENEFITS IDENTIFIED IN PUBLICATIONS

MONETARY BENEFIT TYPE	AMOUNT THIS PERIOD
Questioned Costs	$104,674,000
Better Use of Funds	$484,740,219
Savings and Cost Avoidance	$59,720,269
Dollar Recoveries	$8,433,398
Total	**$657,567,886**

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

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with questioned costs issued during the reporting period	5	$104,674,000
Total inventory this reporting period	**5**	**$104,674,000**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	5	$104,674,000
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**5**	**$104,674,000**
Total carried over to next reporting period	**0**	**$0**

APPENDIX A: REPORTS ISSUED DURING THE REPORTING PERIOD

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

RESOLUTION STATUS	NUMBER	DOLLAR VALUE
Reports with no management decision made by the commencement of the reporting period	0	$0
Reports with recommended funds to be put to better use issued during the reporting period	4	$484,740,219
Total inventory this reporting period	**4**	**$484,740,219**
REPORTS WITH MANAGEMENT DECISIONS MADE DURING THE REPORTING PERIOD	**NUMBER**	**DOLLAR VALUE**
Reports with disallowed costs (agreed to by management)	4	$484,740,219
Reports with allowed costs (not agreed to by management)	0	$0
Total management decisions this period	**4**	**$484,740,219**
Total carried over to next reporting period	**0**	**$0**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

The follow-up reporting and tracking of federal inspector general recommendations is required by the Federal Acquisition Streamlining Act of 1994 (P.L. 103-355), as amended by the National Defense Authorization Act of 1996 (P.L. 104-106). The acts require agencies to complete final action on each management decision required with regard to a recommendation in any federal office of inspector general report within 12 months of the report's issuance/publication. If the agency fails to complete final action within the 12-month period, federal inspectors general are required by §5(a)(3) of the IG Act to identify the matter in each Semiannual Report to Congress until final action on the management decision is completed. The tables that follow identify all unimplemented VA OIG reports and recommendation. All data in the tables are current as of March 31, 2020. Real-time information on the status of VA OIG recommendations is available through the OIG's Recommendation Dashboard.

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

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

Table B.1 identifies the number of VA OIG reports with at least one unimplemented recommendation, with results sorted by action office. As of March 31, 2020, there are 156 total open reports, with 31 open more than a year and 125 open less than a year. However, table B.1 shows a total of 167 open reports, with 36 open more than a year and 131 open less than a year. This is because 10 reports are counted multiple times in the table, as they have open recommendations at more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	22	105	127
Veterans Benefits Administration	6	11	17
Office of Acquisition, Logistics, and Construction	1	3	4
Office of General Counsel	1	1	2
Office of Human Resources and Administration	1	2	3
Office of Information and Technology	1	6	7
Office of Management	1	2	3
Office of Operations, Security, and Preparedness	3	0	3
Office of Accountability and Whistleblower Protection	0	1	1
Totals	**36**	**131**	**167**

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

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

Table B.2 identifies the number of open VA OIG recommendations with results sorted by action office. As of March 31, 2020, there are 1,001 total open recommendations, with 82 open more than a year and 919 open less than a year. However, table B.2 shows a total of 1,011 open recommendations, with 89 open more than a year and 922 open less than a year. This is because 10 recommendations are counted twice in the table as they have actions pending at more than one VA office.

VA ACTION OFFICE	OPEN MORE THAN ONE YEAR	OPEN LESS THAN ONE YEAR	TOTAL
Veterans Health Administration	53	809	862
Veterans Benefits Administration	11	30	41
Office of Acquisition, Logistics, and Construction	2	11	13
Office of General Counsel	1	1	2
Office of Human Resources and Administration	2	6	8
Office of Information and Technology	1	34	35
Office of Management	1	17	18
Office of Operations, Security, and Preparedness	18	0	18
Office of Accountability and Whistleblower Protection	0	14	14
Totals	**89**	**922**	**1,011**

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

Table B.3 identifies the 125 reports and 919 recommendations that, as of March 31, 2020, have been open less than one year. The total monetary benefit attached to these recommendations is $1,377,923,086.

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Quality and Coordination of a Patient's Care at the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 4/11/2019 | Report Number 18-01455-108*	VHA	1, 4	--
Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package *Issued 5/1/2019 | Report Number 17-05246-98*	VHA	3–6	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Staffing, Quality of Care, Supplies, and Care Coordination Concerns at the VA Loma Linda Healthcare System, California *Issued 5/6/2019 | Report Number 17-02186-114*	VHA	1–6, 8	--
Deferrals in the Veterans Benefits Management System *Issued 5/15/2019 | Report Number 18-00215-83*	VBA	3, 4	--
Comprehensive Healthcare Inspection of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan *Issued 5/28/2019 | Report Number 18-04669-125*	VHA	1, 5–7	--
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2018 *Issued 6/3/2019 | Report Number 18-05864-127*	VHA	1	--
Inadequate Oversight of Contracted Disability Exam Cancellations *Issued 6/10/2019 | Report Number 18-04266-115*	VBA	1, 2	--
Alleged Complications Associated with Phototherapy at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 6/11/2019 | Report Number 17-03399-140*	VHA	2	--
VA's Administration of the Transformation Twenty-One Total Technology Next Generation Contract *Issued 6/13/2019 | Report Number 17-04178-46*	OALC	1–7	$37,500,000
Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership, VA Loma Linda Healthcare System, California *Issued 6/18/2019 | Report Number 18-02405-146*	VHA	2–5, 10, 11, 14	--
Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center, Chicago, Illinois *Issued 6/18/2019 | Report Number 18-04673-138*	VHA	2–4, 9–11	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Edward Hines, Jr. VA Hospital, Hines, Illinois *Issued 6/18/2019 | Report Number 18-04676-142*	VHA	7–9	--
Alleged Unapproved Acquisition of a Robotic Surgical System for the W.G. (Bill) Hefner Veterans Affairs Medical Center, Salisbury, North Carolina *Issued 6/19/2019 | Report Number 18-03260-102*	VHA	1	--
Alleged Deficiencies in Out of Operating Room Airway Management Processes at the Colmery-O'Neil VA Medical Center within the VA Eastern Kansas Health Care System, Topeka, Kansas *Issued 6/20/2019 | Report Number 18-02765-144*	VHA	6	--
Staffing and Vacancy Reporting under the MISSION Act of 2018 *Issued 6/25/2019 | Report Number 19-00266-141*	OHRA	3, 5	--
Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility *Issued 6/26/2019 | Report Number 19-00022-153*	VHA	1, 2, 6, 7	--
Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities *Issued 6/27/2019 | Report Number 18-00037-154*	VHA	6, 7, 9	--
Management of Major Medical Leases Needs Improvement *Issued 7/2/2019 | Report Number 17-05859-131*	OALC	6	$152,300,000
Deficiencies in Discharge Planning for a Mental Health Inpatient Who Transitioned to the Judicial System from a Veterans Integrated Service Network 4 Medical Facility *Issued 7/2/2019 | Report Number 18-03576-158*	VHA	1, 3, 5, 6, 8, 9	--
Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 7/11/2019 | Report Number 19-00497-161*	VHA	1, 2, 6, 8, 10, 12, 15, 17, 20, 21, 23–25, 27	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Alleged Interference and Failure to Comply with the Pain Management Directive and the Opioid Safety Initiative at the VA Northern Indiana Health Care System, Fort Wayne, Indiana *Issued 7/16/2019 | Report Number 17-05835-165*	VHA	3–6, 8, 9, 11, 12	--
Alleged Inadequate Response to a Missing Patient and Safety Concerns at the Bay Pines VA Healthcare System, Florida *Issued 7/18/2019 | Report Number 18-04132-163*	VHA	1–3	--
Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico *Issued 7/23/2019 | Report Number 17-05572-170*	VHA	3–5, 9, 10, 12	--
Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center, Wyoming *Issued 7/24/2019 | Report Number 18-04680-162*	VHA	12, 15	--
Comprehensive Healthcare Inspection of the Amarillo VA Health Care System, Texas *Issued 7/24/2019 | Report Number 19-00007-168*	VHA	1–6, 8, 9, 16, 17, 19	--
Program of Comprehensive Assistance for Family Caregivers: Timely Discharges, But Oversight Needs Improvement *Issued 7/25/2019 | Report Number 18-04924-112*	VHA	2	$824,467
Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center, Maryland *Issued 7/29/2019 | Report Number 18-05731-176*	VHA	3–6	--
Episodes of Non-Adherence to Privacy and Security Policies at the Tibor Rubin VA Medical Center, Long Beach, California *Issued 7/31/2019 | Report Number 17-03557-177*	OIT	5	--
Follow-Up Review of the Veterans Crisis Line, Canandaigua, New York; Atlanta, Georgia; and Topeka, Kansas *Issued 7/31/2019 | Report Number 18-03390-178*	VHA	1	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Non VA Emergency Care Claims Inappropriately Denied and Rejected *Issued 8/6/2019 | Report Number 18-00469-150*	VHA	1, 3, 4, 9–11	$533,000,000
Mismanagement of a Resuscitation and Other Concerns at the Gulf Coast Veterans Health Care System, Biloxi, Mississippi *Issued 8/6/2019 | Report Number 18-00808-186*	VHA	4, 5	--
Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California *Issued 8/7/2019 | Report Number 19-00501-175*	VHA	1	--
Health Information Management Medical Documentation Backlog *Issued 8/21/2019 | Report Number 18-01214-157*	VHA	1–9	--
Comprehensive Healthcare Inspection of the Central California VA Health Care System, Fresno, California *Issued 8/22/2019 | Report Number 19-00006-191*	VHA	1, 2	--
Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida *Issued 8/22/2019 | Report Number 19-07429-195*	VHA	1–3, 5–11	--
Pathology Processing Delays at the Memphis VA Medical Center, Tennessee *Issued 8/27/2019 | Report Number 18-02988-198*	VHA	1–7	--
Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi *Issued 8/28/2019 | Report Number 17-03399-200*	VHA	1, 4, 7, 8, 11, 12, 18	--
National Review of Hospice and Palliative Care at the Veterans Health Administration *Issued 9/5/2019 | Report Number 17-05251-194*	VHA	1	--
Accuracy of Claims Decisions Involving Conditions of the Spine *Issued 9/5/2019 | Report Number 18-05663-189*	VBA	1–5	$64,800,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Security and Access Controls for the Beneficiary Fiduciary Field System Need Improvement *Issued 9/12/2019 | Report Number 18-05258-193*	VBA OIT	1–4	--
Quality of Care and Patient Safety Concerns on the Acute Behavioral Health Unit at the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania *Issued 9/19/2019 | Report Number 18-00777-224*	VHA	1, 2, 5, 7–9	--
Boston, Massachusetts, VA Regional Office Supervisor Incorrectly Processed Work Items *Issued 9/19/2019 | Report Number 19-07350-192*	VBA	1	$84,400
State Prescription Drug Monitoring Programs Need Increased Use and Oversight *Issued 9/23/2019 | Report Number 18-02830-164*	VHA OIT	1–6, 8	--
Alleged Care Delays and Inadequate Instrument Precleaning at the New Mexico VA Health Care System, Albuquerque *Issued 9/23/2019 | Report Number 18-03526-230*	VHA	1–8, 10, 11	--
Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma *Issued 9/24/2019 | Report Number 18-06510-222*	VHA	1–3, 7, 10	--
Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility *Issued 9/24/2019 | Report Number 19-06429-227*	VHA	1–3	--
Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico *Issued 9/26/2019 | Report Number 18-01879-232*	VHA	4–6	--
Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming *Issued 9/26/2019 | Report Number 18-04681-228*	VHA	1–9, 11–22	--
Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia *Issued 9/26/2019 | Report Number 19-00260-215*	VHA	4–7, 9	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia *Issued 9/27/2019 | Report Number 18-04679-239*	VHA	2, 3, 5, 9–18	--
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida *Issued 9/27/2019 | Report Number 19-00010-237*	VHA	1–7, 10–17, 19–21, 24	--
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Alabama *Issued 9/27/2019 | Report Number 19-00057-238*	VHA	2–5, 9, 11, 13	--
Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions at the Louis Stokes Cleveland VA Medical Center, Ohio *Issued 9/27/2019 | Report Number 19-07818-242*	VHA	1	--
Oversight and Resolution of Home Loan Defaults *Issued 9/30/2019 | Report Number 18-03979-204*	VBA	1	--
Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina *Issued 9/30/2019 | Report Number 18-05316-234*	VHA	2	--
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2019 *Issued 9/30/2019 | Report Number 19-00346-241*	VHA	1	--
Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 *Issued 10/10/2019 | Report Number 19-07040-243*	VHA	1–16	--
Mishandling of Veterans' Sensitive Personal Information on VA Shared Network Drives *Issued 10/17/2019 | Report Number 19-06125-218*	VBA OIT	1, 3	--
VA's Management of Mobile Devices Generally Met Information Security Standards *Issued 10/22/2019 | Report Number 18-04608-212*	OIT	1, 3	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas *Issued 10/23/2019 | Report Number 19-00035-247*	VHA	1–11	--
Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017 *Issued 10/24/2019 | Report Number 18-04968-249*	OAWP OGC OHRA	1–4, 6–15, 17–19, 21, 22	--
The Impact of VA Allowing Government Agencies to Be Excluded from Temporary Price Reductions on Federal Supply Schedule Pharmaceutical Contracts *Issued 10/30/2019 | Report Number 18-04451-06*	OALC	2–4	--
Ophthalmology Equipment and Related Concerns at the James A. Haley Veterans' Hospital, Tampa, Florida *Issued 11/7/2019 | Report Number 19-07095-253*	VHA	1–3	--
FY 2019 Audit of VA's Compliance under the DATA Act of 2014 *Issued 11/8/2019 | Report Number 19-07247-251*	OM	1–16	--
Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, Georgia *Issued 11/12/2019 | Report Number 18-04682-256*	VHA	1–9, 11–22	--
Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital, Tampa, Florida *Issued 11/14/2019 | Report Number 19-00011-255*	VHA	1, 2, 4–7	--
Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters *Issued 11/14/2019 | Report Number 19-05960-244*	VBA	1–5	--
Two Patient Suicides, a Patient Self-Harm Event, and Mental Health Services Administrative Deficiencies at the Alaska VA Healthcare System, Anchorage, Alaska *Issued 11/19/2019 | Report Number 19-00002-16*	VHA	1–11	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System, West Haven, Connecticut *Issued 11/20/2019 | Report Number 18-04675-23*	VHA	1–13	--
Deficiencies in Sterile Processing Services and Decreased Surgical Volume at the VA Connecticut Healthcare System, Newington and West Haven, Connecticut *Issued 11/20/2019 | Report Number 19-00075-14*	VHA	1, 2, 4–6, 10, 11	--
VHA Did Not Effectively Manage Appeals of Non VA Care Claims *Issued 11/21/2019 | Report Number 18-06294-213*	VHA	1–8	--
Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center, Augusta, Georgia *Issued 11/21/2019 | Report Number 19-00013-15*	VHA	1, 2, 4–10, 12–24	--
Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire *Issued 11/25/2019 | Report Number 19-00040-10*	VHA	1–17	--
Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania *Issued 11/26/2019 | Report Number 18-04667-13*	VHA	1–6	--
Comprehensive Healthcare Inspection of the El Paso VA Health Care System, Texas *Issued 11/26/2019 | Report Number 19-00033-11*	VHA	1–3, 5, 6	--
Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status at the Baltimore VA Medical Center, Maryland *Issued 11/26/2019 | Report Number 19-05916-24*	VHA	1–4	--
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Boston VA Research Institute *Issued 12/2/2019 | Report Number 18-00711-211*	VHA	1–7	$45,900,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of the VA Greater Los Angeles Healthcare System, California *Issued 12/2/2019 | Report Number 18-04671-25*	VHA	1, 3, 4, 6–10, 12–20, 22–25	--
Comprehensive Healthcare Inspection of the Sioux Falls VA Health Care System, South Dakota *Issued 12/3/2019 | Report Number 19-00019-26*	VHA	1–8	--
Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, Arizona *Issued 12/5/2019 | Report Number 19-00014-33*	VHA	3, 9–20	--
Comprehensive Healthcare Inspection of the VA Pacific Islands Health Care System, Honolulu, Hawaii *Issued 12/5/2019 | Report Number 19-00023-29*	VHA	1–5, 7–12	--
Delays and Deficiencies in Management of Selected Radiology and Nuclear Medicine Outpatient Exams *Issued 12/10/2019 | Report Number 18-02300-236*	VHA	1–3, 5–7	--
Comprehensive Healthcare Inspection of the VA Butler Health Care Center, Pennsylvania *Issued 12/10/2019 | Report Number 19-00049-43*	VHA	1–5	--
Comprehensive Healthcare Inspection of the VA Manila Outpatient Clinic, Pasay City, Philippines *Issued 12/11/2019 | Report Number 19-00024-39*	VHA	1, 3–7	--
Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in VISN 15 *Issued 12/11/2019 | Report Number 19-06562-30*	VHA	1–4	--
Comprehensive Healthcare Inspection of the Kansas City VA Medical Center, Missouri *Issued 12/12/2019 | Report Number 18-06504-27*	VHA	1–6, 8–13	--
Insufficient Oversight of VA's Undelivered Orders *Issued 12/16/2019 | Report Number 17-04859-196*	VHA OM	1–6	$132,600,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Inadequate Oversight of the Medical/ Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers *Issued 12/17/2019 | Report Number 17-03718-240*	VHA	1–11	$84,000,000
Comprehensive Healthcare Inspection of the Coatesville VA Medical Center, Pennsylvania *Issued 12/18/2019 | Report Number 19-00048-48*	VHA	1–16	--
Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio *Issued 12/18/2019 | Report Number 19-00051-40*	VHA	1–13	--
Comprehensive Healthcare Inspection of the Louis Stokes Cleveland VA Medical Center, Ohio *Issued 12/19/2019 | Report Number 19-00015-47*	VHA	1–9	--
Comprehensive Healthcare Inspection of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon *Issued 12/19/2019 | Report Number 19-00052-54*	VHA	1–5	--
Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System, Minnesota *Issued 12/19/2019 | Report Number 19-00055-38*	VHA	1–4	--
Comprehensive Healthcare Inspection of the VA Western New York Healthcare System, Buffalo, New York *Issued 1/7/2020 | Report Number 18-04666-55*	VHA	1–18	--
Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota *Issued 1/7/2020 | Report Number 19-00468-67*	VHA	1–7	--
Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington *Issued 1/8/2020 | Report Number 19-00053-57*	VHA	1–17	--

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 4: VA Healthcare, Pittsburgh, Pennsylvania *Issued 1/8/2020 | Report Number 19-06871-59*	VHA	1, 2	--
Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center Spokane, Washington *Issued 1/8/2020 | Report Number 19-09017-64*	VHA	1, 2	--
Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland *Issued 1/9/2020 | Report Number 19-00016-61*	VHA	1–23	--
Comprehensive Healthcare Inspection of the Canandaigua VA Medical Center, New York *Issued 1/9/2020 | Report Number 19-00037-58*	VHA	1–5, 9–14	--
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts *Issued 1/13/2020 | Report Number 19-00038-63*	VHA	1–27, 29, 30	--
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts *Issued 1/13/2020 | Report Number 19-00043-66*	VHA	1–18, 20, 21	--
Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana *Issued 1/14/2020 | Report Number 19-00012-51*	VHA	1–13	--
Opportunities Missed to Contain Spending on Sleep Apnea Devices and Improve Veterans' Outcomes *Issued 1/14/2020 | Report Number 19-00021-41*	VHA	1–3	$261,300,000
Comprehensive Healthcare Inspection of the West Texas VA Health Care System, Big Spring, Texas *Issued 1/15/2020 | Report Number 19-00034-62*	VHA	1–10	--

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REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 17: VA Heart of Texas Health Care Network, Arlington, Texas *Issued 1/15/2020 | Report Number 19-06863-69*	VHA	4–6	--
Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations: Cincinnati Education and Research for Veterans Foundation *Issued 1/16/2020 | Report Number 18-00711-42*	VHA	1–4	$950,000
Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities *Issued 1/16/2020 | Report Number 18-05121-36*	VHA	1–5	--
Comprehensive Healthcare Inspection of the Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana *Issued 1/16/2020 | Report Number 19-00046-60*	VHA	1–9, 11, 12, 14–16	--
A Delay in Patient Notification of Test Results and Other Communication Issues at the Bath VA Medical Center, New York *Issued 1/21/2020 | Report Number 19-07070-75*	VHA	1, 2	--
Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System *Issued 1/23/2020 | Report Number 19-06378-73*	VHA	1–18	--
Comprehensive Healthcare Inspection of the Alaska VA Healthcare System, Anchorage, Alaska *Issued 1/28/2020 | Report Number 19-00054-72*	VHA	1–6	--
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts *Issued 1/29/2020 | Report Number 19-06866-68*	VHA	1–12	--
Little Rock VA Regional Office Employee Inaccurately Established and Decided Claims *Issued 1/30/2020 | Report Number 19-06757-70*	VBA	1, 3	$311,000

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Concern Regarding a Patient Death and Alleged Conflicts of Interest at the VA Western Colorado Health Care System, Grand Junction, Colorado *Issued 2/4/2020 | Report Number 19-06435-84*	VHA	1, 2	--
Veterans Received Inaccurate Disability Benefit Payments After Reserve or National Guard Drill Pay Adjustments *Issued 2/11/2020 | Report Number 18-05738-56*	VBA	1–4	$56,900,000
Review of Veterans Health Administration Community Living Centers and Corresponding Star Ratings *Issued 2/12/2020 | Report Number 18-05113-81*	VHA	1–3	--
Telehealth Public-Use Questionnaires Were Used Improperly to Determine Disability Benefits *Issued 2/18/2020 | Report Number 19-07119-80*	VBA	1–4	$613,000
Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center, Ohio *Issued 2/20/2020 | Report Number 18-01275-89*	VHA	1–13	--
Review of Regional Procurement Office East's Contract Closeout Compliance *Issued 2/27/2020 | Report Number 19-05866-82*	VHA	1–3	$6,840,219
Alleged Issues in the Cardiology Department at the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana *Issued 2/27/2020 | Report Number 19-07090-90*	VHA	1–4	--
Deficient Staffing and Competencies in Sterile Processing Services at the VA Black Hills Healthcare System, Fort Meade Campus, South Dakota *Issued 3/23/2020 | Report Number 19-07096-108*	VHA	1–3	--
Deficiencies in a Cardiac Research Study at the VA St. Louis Health Care System, Missouri *Issued 3/24/2020 | Report Number 19-07682-103*	VHA	1–6	--

REPORT	ACTION OFFICES	UNIMPLEMENTED RECOMMENDATIONS	MONETARY IMPACT
Deficiencies in the Administration of Emergent Mental Health Services at Coatesville VA Medical Center, Pennsylvania *Issued 3/25/2020 | Report Number 19-08374-112*	VHA	1–4	--
Federal Information Security Modernization Act Audit for Fiscal Year 2019 *Issued 3/31/2020 | Report Number 19-06935-96*	OIT	1–25	--
Total			**$1,377,923,086**

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

Table B.4 identifies the 31 reports and 82 recommendations that, as of March 31, 2020, remain open for more than one year. The total monetary benefit attached to these reports is $535,963,584.

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of VA Regional Offices' Appeals Management Processes *Issued 5/30/2012 | Report Number 10-03166-75*	VBA	--
Recommendation 2: We recommended the Under Secretary for Benefits revise productivity standards for decision review officers assigned to appeal processing to limit credit to actions that progress the appeal such as Notices of Disagreement, issuance of Statements/Supplemental Statements of the Case, conducting requested hearings, and certification of appeals.		
Review of the Enhanced Use Lease between the Department of Veterans Affairs and Veterans Development, LLC *Issued 9/28/2012 | Report Number 12-00375-290*	OM OGC	--
Recommendation 6: We recommend that the Executive in Charge for the Office of Management and Chief Financial Officer and VA's General Counsel immediately determine what services VOA is actually performing and which services VA employees are performing and what services, if any, VA needs from VOA. Consideration should be given to simply leasing the existing space, with VA employees providing all the services, or relocating the domiciliary.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of Post-9/11 G.I. Bill Monthly Housing Allowance and Book Stipend Payments *Issued 7/11/2014 | Report Number 13-01452-214*	VBA	$205,000,000
Recommendation 5: We recommended the Under Secretary for Benefits ensure Long Term Solution calculations for book stipends align with the regulatory requirements established for students who are enrolled at 50 percent or less.		
Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses *Issued 12/6/2016 | Report Number 16-00790-417*	OIT	$7,200,000
Recommendation 1: We recommended the Assistant Secretary for Information and Technology implement a policy to ensure cost-effective utilization of information technology equipment, installed software, and services and ensure coordination of acquisitions with affected VA organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions.		
Audit of Recruitment, Relocation, and Retention Incentives *Issued 1/5/2017 | Report Number 14-04578-371*	OHRA	$77,500,000
Recommendation 1: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to ensure recruitment and relocation incentives are fully justified and authorized before being included on vacancy announcements for hard-to-fill positions or before the final selectee is identified in cases where a position is not filled through a vacancy announcement. Recommendation 3: We recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administrations to monitor compliance with its employee certification requirement before relocation incentives are authorized for payment.		
Audit of the Patient Advocacy Program *Issued 3/31/2017 | Report Number 15-05379-146*	VHA	--
Recommendation 5: We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities *Issued 6/5/2017 | Report Number 15-01080-208*	VHA	--
Recommendation 3: We recommended the Under Secretary for Health issue bills of collection, as necessary and in accordance with VA policy, to recover physician-administered drug overpayments made by Florida VA facilities.		
Audit of the Health Care Enrollment Program at Medical Facilities *Issued 8/14/2017 | Report Number 16-00355-296*	VHA	--
Recommendation 4: We recommended the Acting Under Secretary for Health develop and execute a process to distinguish new applications for health care enrollment in VistA from other registration data. Recommendation 5: We recommended the Acting Under Secretary for Health implement a plan to correct current data integrity issues in VistA to improve the accuracy and timeliness of enrollment data.		
OIG Determination of VHA Occupational Staffing Shortages, Fiscal Year 2017 *Issued 9/27/2017 | Report Number 17-00936-385*	VHA	--
Recommendation 1: We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations. Recommendation 3: We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model.		
Clinical Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado *Issued 9/29/2017 | Report Number 16-00546-388*	VHA	--
Recommendation 25: We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of VHA's Timeliness and Accuracy of Choice Payments Processed Through FBCS *Issued 12/21/2017 | Report Number 15-03036-47*	VHA	$39,000,000
Recommendation 1: We recommended the Executive in Charge, Veterans Health Administration, develop and issue written payment policies to guide staff processing medical claims received from Third Party Administrators, as well as establish expectations and obligations for the Third Party Administrators that submit invoices for payment.		
Recommendation 2: We recommended the Executive in Charge, Veterans Health Administration, ensure payment processing staff have access to documentation from the Third Party Administrators verifying amounts paid to providers to ensure the Third Party Administrators are not billing VA more than they paid the provider for medical claims.		
Recommendation 3: We recommended the Executive in Charge, Veterans Health Administration, ensure Veterans Health Administration payment staff have access to accurate data regarding veterans' other health insurance coverage and establish appropriate processes for collecting payments from these health insurers.		
Recommendation 4: We recommended the Executive in Charge, Veterans Health Administration, ensure the new payment processing systems used for processing medical claims from Third Party Administrators have the ability to adjudicate reimbursement rates accurately and to ensure duplicate claims are not paid.		
Recommendation 5: We recommended the Executive in Charge, Veterans Health Administration, ensure VA performs post-payment audits on a periodic basis to determine if payments made to Third Party Administrators for medical care are accurate.		
Healthcare Inspection Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility *Issued 1/4/2018 | Report Number 16-03576-53*	VHA	--
Recommendation 6: We recommended that the Facility Director ensure that non-VA care for psychiatric services is offered to patients who need to be seen sooner than VA appointment availability permits.		
Combined Assessment Program Summary Report – Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities *Issued 1/30/2018 | Report Number 17-04460-84*	VHA	--
Recommendation 1: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure Facility Directors establish Employee Threat Assessment Teams.		

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 2: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require attendance by VA Police Officers, Patient Safety and/or Risk Management Officials, and Patient Advocates at Disruptive Behavior Committee/Board meetings and monitor compliance. Recommendation 4: The OIG recommended that the Executive in Charge, Office of the Under Secretary for Health, in conjunction with Veterans Integrated Service Network senior managers, ensure facility senior managers require that within 90 days of hire, all employees complete Level I Prevention and Management of Disruptive Behavior training and additional training levels based on the type and severity of risk for exposure to disruptive and unsafe behaviors and monitor compliance.		
Critical Deficiencies at the Washington DC VA Medical Center *Issued 3/7/2018 | Report Number 17-02644-130*	VHA	--
Recommendation 25: The VISN 5 Director ensures that the Medical Center updates and maintains the Equipment Inventory List (EIL) as required by VA policy and makes certain that the Medical Center Director and Chief Logistics Officer are held accountable for the timely and accurate reporting of the Medical Center EIL. Recommendation 31: The Medical Center Director verifies that accurate and complete financial documentation to support medical supply and equipment purchases is readily available in accordance with GAO Standards for Internal Control in the Federal Government. Recommendation 33: The Deputy Under Secretary for Health for Operations and Management ensures that the VHA Procurement and Logistics Office conducts regular audits of the logistics services within VHA medical centers to assess compliance with VA and VHA policies pertaining to procurement and logistics, and makes certain that timely and effective remediation occurs in response to all noncompliant conditions identified as a result of those audits. Recommendation 39: The VISN 5 Director oversees implementation of recommendations directed to the Medical Center Director. Recommendation 40: The Under Secretary for Health verifies the successful implementation of all recommendations contained within this report.		
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 *Issued 3/13/2018 | Report Number 17-00481-117*	VHA	--
Recommendation 7: The OIG recommended the Veterans Health Administration Executive in Charge implement controls to ensure Choice medical documentation is received timely in accordance with Choice contracts.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Audit of the Personnel Suitability Program *Issued 3/26/2018 | Report Number 17-00753-78*	VHA OSP	--
Recommendation 2: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.		
Recommendation 4: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage the background investigation workload.		
Recommendation 5: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Office of the Under Secretary for Health, to implement a plan to review the suitability status of all Veterans Health Administration personnel and correct delinquencies to ensure a properly vetted workforce.		
Recommendation 6: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, improve management oversight of the personnel suitability program at VA medical facilities and ensure background investigations are properly initiated and adjudicated nationwide, and internal control mechanisms required by policy are properly implemented.		
Recommendation 8: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.		
Recommendation 9: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.		
Recommendation 10: The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.		
Recommendation 11: The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, coordinate with the Assistant Secretary for Operations, Security, and Preparedness to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.		
Audit of the Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls *Issued 5/7/2018 | Report Number 15-00022-139*	VHA	$34,500,000
Recommendation 5: The OIG recommended the Under Secretary for Health implement use of Centers for Medicare and Medicaid Services Rates when savings can be achieved for Special Mode of Transportation ambulance services in accordance with 38 U.S.C. Section 111(b)(3)(C).		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017 *Issued 5/15/2018 | Report Number 17-05460-169*	VHA VBA	--
Recommendation 1: The Executive in Charge, Office of the Under Secretary for Health, develops a timeline to reduce improper payments under the 10 percent threshold for the Beneficiary Travel; Communications, Utilities, and Other Rents; Medical Care Contracts and Agreements; Prosthetics; Purchased Long Term Services and Support; Supplies and Materials; and VA Community Care Programs and activities. This is a repeat finding and recommendation for the Purchased Long Term Services and Support and VA Community Care programs from our FY 2015 and 2016 reports. Recommendation 5: The OIG recommended the Executive in Charge, Veterans Benefits Administration, continue working with the Department of Defense to increase the frequency of drill pay adjustments from annually to monthly. This is a repeat recommendation from our FY 2016 report.		
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY18 *Issued 6/14/2018 | Report Number 18-01693-196*	VHA	--
Recommendation 1: The Under Secretary for Health refines and formalizes VHA's position categorization of individuals (clinical and nonclinical) who are necessary to VHA's mission of delivering health care by looking at various dimensions of each occupation, including staff skill set and function, enabling identification of positions based on the specific role a person would fill.		
Unwarranted Medical Reexaminations for Disability Benefits *Issued 7/17/2018 | Report Number 17-04966-201*	VBA	$100,600,000
Recommendation 1: The Under Secretary for Benefits establishes internal controls sufficient to ensure that a reexamination is necessary prior to employees ordering it, and modifies VBA procedures as appropriate to reflect these improved business processes. Recommendation 4: The Under Secretary for Benefits conducts a special focused quality improvement review of cases with unwarranted reexaminations to develop data sufficient to understand and redress the causes of any avoidable errors.		
Misuse of Time and Resources within the Veterans Engineering Resource Center in Indianapolis, Indiana *Issued 8/8/2018 | Report Number 17-04156-234*	VHA	--
Recommendation 3: The Principal Deputy Under Secretary confers with the Offices of General Counsel and Human Resources to determine the appropriate administrative action to take, if any, against Employee 3.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma *Issued 8/21/2018 | Report Number 17-05248-241*	VBA	--
Recommendation 1: The Under Secretary for Benefits reviews all denied military sexual trauma related claims since the beginning of FY 2017, determines whether all required procedures were followed, takes corrective action based on the results of the review, renders a new decision as appropriate, and reports the results back to the Office of Inspector General. Recommendation 3: The Under Secretary for Benefits requires an additional level of review for all denied military sexual trauma related claims and holds the second level reviewers accountable for accuracy. Recommendation 4: The Under Secretary for Benefits conducts special focused quality improvement reviews of denied military sexual trauma related claims and takes corrective action as needed. Recommendation 5: The Under Secretary for Benefits updates the current training for processing military sexual trauma related claims, monitors the effectiveness of the training, and takes additional actions as necessary.		
Accuracy of Effective Dates for Reduced Evaluations *Issued 8/29/2018 | Report Number 17-05244-226*	VBA	$37,900,000
Recommendation 2: The Under Secretary for Veterans Benefits Administration establish a plan to modify the Veterans Benefits Management System to apply correct effective dates for cases with reduced evaluations for conditions that were no longer service-connected and alert staff when the assigned effective dates are improper. Recommendation 6: The Under Secretary for Veterans Benefits Administration implement a plan to conduct periodic reviews for veterans who had evaluations reduced after the first of the month following the final notification letter and before the first of the month following 60 days after the final notification letter, take corrective actions as needed, and provide certification of completion to the Office of Inspector General.		
Review of Pain Management Services in Veterans Health Administration Facilities *Issued 9/17/2018 | Report Number 16-00538-282*	VHA	--
Recommendation 3: The Under Secretary for Health evaluates and determines the adequacy of the number of pain specialists at each facility through formalized assessments and takes action as appropriate. Recommendation 4: The Under Secretary for Health ensures that VA facilities without pain specialists have formalized designated resources of pain care provided by providers.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Alleged Nonacceptance of VA Authorizations by Community Care Providers *Issued 9/20/2018 | Report Number 17-05228-279*	VHA	--
Recommendation 4: The Executive in Charge, Office of the Under Secretary for Health, implement controls to ensure VA staff timely resolve medical claim inquiries from community providers.		
VA's Management of Land Use Under the West Los Angeles Leasing Act of 2016 *Issued 9/28/2018 | Report Number 18-00474-300*	VHA OALC	--
Recommendation 1: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System implement a plan that puts the West LA campus in compliance with the West Los Angeles Leasing Act of 2016, the Draft Master Plan, and other federal laws, including reasonable time periods to correct deficiencies noted in this report. Recommendation 2: The Principal Executive Director, Office of Acquisition, Logistics, and Construction and the Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure all non-VA entities operating on the West LA campus with expired or undocumented land use agreements establish new agreements compliant with the West Los Angeles Leasing Act. Recommendation 3: The Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System create a process to allow the Veterans Community Oversight and Engagement Board an opportunity to provide input to the executive leadership on West LA campus land use. Recommendation 5: The Acting Under Secretary for Health in conjunction with the Director, Greater Los Angeles Healthcare System ensure VA's Capital Asset Inventory accurately reflects all land use agreements six months or longer on West LA campus.		
Emergency Cache Program: Ineffective Management Impairs Mission Readiness *Issued 10/31/2018 | Report Number 18-01496-301*	VHA	$34,263,584
Recommendation 1: The Executive in Charge, Veterans Health Administration, should develop requirements for medical facilities with emergency caches to perform at least annually a wall-to-wall inventory of all cache drugs and supplies, and develop processes to (1) label all expired or excess drugs that are purposefully maintained to respond to drug shortages or for the purposes of Shelf Life Extension testing, and (2) remove and rectify cases of other expired, missing, or excess drugs. Recommendation 2: The Executive in Charge, Veterans Health Administration, should conduct an assessment to determine if the cost saving benefits of the Shelf Life Extension Program outweigh the risks expired drugs pose to the emergency cache's mission and to take corrective action as appropriate.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 4: The Executive in Charge, Veterans Health Administration, should initiate steps to update and reissue the Veterans Health Administration directives specifying oversight responsibilities for the Emergency Cache Program with a requirement for inventory to be timely rotated into the emergency cache after it is received.		
Recommendation 5: The Executive in Charge, Veterans Health Administration, should assess whether the Emergency Cache Program is properly aligned within VA and coordinate with other VA offices as necessary to determine the appropriate roles and responsibilities by program office, and then review, update, and reissue Emergency Cache Program requirements to include (1) robust annual cache inspection and activation exercise requirements, (2) processes to ensure cache inspection and activation requirements are met, (3) processes to ensure that violations identified during annual cache inspections are timely addressed, and (4) specific accountability measures for the program offices and local facility personnel responsible for program oversight.		
Recommendation 7: The Executive in Charge, Veterans Health Administration, should initiate steps to update and reissue the Veterans Health Administration directives specifying oversight responsibilities for the Emergency Cache Program to reflect the Office of Public Health's reorganization and reassign responsibilities as needed.		
Inadequate Governance of the VA Police Program at Medical Facilities *Issued 12/13/2018 | Report Number 17-01007-01*	VHA OSP	--
Recommendation 1: Clarify program responsibilities between the Veterans Health Administration and the Office of Operations, Security, and Preparedness, and evaluate the need for a centralized management entity for the security and law enforcement program across all medical facilities.		
Recommendation 2: Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.		
Recommendation 3: Make certain medical facilities use strategies to address police staffing challenges such as having documented recruitment plans for police officer positions that include a determination of the need for special salary rates and incentives.		
Recommendation 4: Assess the staffing levels for the Office of Security and Law Enforcement police inspection program, and authorize and provide sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues.		
Recommendation 5: Ensure procedures are developed for appropriately handling VA police investigations of medical facility leaders.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Comprehensive Healthcare Inspection Program Review of the Durham VA Medical Center, North Carolina *Issued 12/19/2018 | Report Number 18-01146-35*	VHA	--
Recommendation 1: The Chief of Staff ensures that Executive Council of Medical Staff minutes consistently reflect the documents reviewed and the rationale for the stated conclusion to recommend approval of clinical privileges for LIPs and monitors compliance.		
Mismanagement of the VA Executive Protection Division *Issued 1/17/2019 | Report Number 17-03499-20*	OSP	--
Recommendation 1: The Acting Assistant Secretary for Human Resources and Administration ensures that the VA Police Service publishes written operational policies and procedures designed to regulate essential functions of the Executive Protection Division, including threat assessment processes, motorcade operations, security drills, equipment maintenance, use of personal protective gear, and other topics deemed appropriate after consultation with executive protection experts.		
Recommendation 2: The Acting Assistant Secretary for Human Resources and Administration makes certain that an adequate threat assessment is developed and kept current for each principal secured by the Executive Protection Division.		
Recommendation 4: The Acting Assistant Secretary for Human Resources and Administration confers with the VA Offices of General Counsel and Accountability and Whistleblower Protection to ensure that bills of collection are issued to agents identified as receiving improper payments of overtime or travel reimbursement and to determine the appropriate administrative action to take, if any, against agents and supervisors who submitted or approved falsified time cards.		
Recommendation 7: The Acting Assistant Secretary for Human Resources and Administration establishes written procedures for documenting the review and approval of employee overtime within the Executive Protection Division and ensures compliance.		
Recommendation 8: The Acting Assistant Secretary for Human Resources and Administration assesses and takes remedial action, if necessary, to make certain that Executive Protection Division staff use parking and transit benefits in accordance with VA policy.		
Recommendation 9: The Acting Assistant Secretary for Human Resources and Administration confers with the Offices of General Counsel and Accountability and Whistleblower Protection to determine whether any agents inappropriately accepted transit benefits while using VA parking spaces, and if so, determine the appropriate administrative action to take, if any.		
Recommendation 10: The Acting Assistant Secretary for Human Resources and Administration works with the Offices of General Counsel and Accountability and Whistleblower Protection to institute procedures for an ombudsman or similar function that will enable the Executive Protection Division agents to address management disputes without needing to involve the VA Secretary.		

APPENDIX B: UNIMPLEMENTED REPORTS AND RECOMMENDATIONS

REPORT INFORMATION AND RECOMMENDATIONS	ACTION OFFICES	MONETARY IMPACT OF OPEN RECOMMENDATIONS
Recommendation 12: The Acting Assistant Secretary for Human Resources and Administration consults with the Offices of General Counsel and Accountability and Whistleblower Protection to provide adequate mechanisms and training for all staff within the Office of Operations, Security, and Preparedness, including the Executive Protection Division, that ensure allegations of perceived misconduct by the VA Secretary can be appropriately addressed without the threat of retaliation.		
Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center *Issued 1/28/2019 | Report Number 17-01757-50*	VHA	--
Recommendation 1: The Facility Director ensures that recommended actions from peer reviews and root cause analyses are implemented and monitored for improvement.		
Recommendation 3: The Chief of Staff ensures an interdisciplinary Facility group reviews utilization management data and monitors the group's compliance.		
Recommendation 5: The Chief of Staff ensures that Focused and Ongoing Professional Practice Evaluations are completed, and that the Professional Standards Board reviews these evaluations in considering whether to continue provider privileges, and monitors compliance.		
Recommendation 6: The Associate Director ensures that safety and infection prevention processes are in place at construction sites and monitors compliance.		
Recommendation 7: The Associate Director for Patient Care Services ensures that nursing staff dispose of expired or unsealed supplies and monitors the staff's compliance.		
Recommendation 8: The Associate Director ensures that a safe and clean environment is maintained throughout the Facility and monitors compliance.		
Recommendation 12: The Facility Director ensures that all deficiencies identified on the Annual Physical Security Survey are addressed or corrected and monitors compliance.		
Total		**$535,963,584**

APPENDIX C: REPORTING REQUIREMENTS

TABLE C.1. REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
§ 4. Duties and responsibilities; report of criminal violations to Attorney General (a) It shall be the duty and responsibility of each Inspector General, with respect to the establishment within which his Office is established—	--
(2) to review existing and proposed legislation and regulations and make recommendations in the semiannual reports concerning the impact of such legislation or regulations on the economy and efficiency in the administration of programs and operations administered or financed by such establishment or the prevention and detection of fraud and abuse in such programs and operations;	Other Reporting Requirements
§ 5. Semiannual reports; transmittal to Congress; availability to public; immediate report on serious or flagrant problems; disclosure of information; definitions (a) Each Inspector General shall, not later than April 30 and October 31 of each year, prepare semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to—	--

APPENDIX C: REPORTING REQUIREMENTS

REQUIREMENT	SAR SECTION(S)
(1) a description of significant problems, abuses, and deficiencies relating to the administration of VA programs and operations disclosed during the reporting period;	Results from the Office of Audits and Evaluations Results from the Office of Contract Review Results from the Office of Healthcare Inspections Results from the Office of Investigations Results from the Office of Management and Administration Results from the Office of Special Reviews
(2) a description of the recommendations for corrective action made by the Office during the reporting period;	Results from the Office of Audits and Evaluations Results from the Office of Contract Review Results from the Office of Healthcare Inspections Results from the Office of Investigations Results from the Office of Special Reviews
(3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed;	Appendix B
(4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted;	Results from the Office of Investigations
(5) a summary of each report made to the VA Secretary concerning instances when information or assistance requested was, in the judgment of the IG, unreasonably refused or not provided;	Other Reporting Requirements

REQUIREMENT	SAR SECTION(S)
(6) a listing, subdivided according to subject matter, of each audit, inspection, and evaluation report issued during the reporting period and for each report, where applicable, the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs) and the dollar value of recommendations that funds be put to better use;	Appendix A
(7) a summary of each particularly significant report;	Results from the Office of Audits and Evaluations Results from the Office of Contract Review Results from the Office of Healthcare Inspections Results from the Office of Special Reviews
(8) statistical tables showing the total number of audit, inspection, and evaluation reports and the total dollar value of questioned costs (including a separate category for the dollar value of unsupported costs), for reports— (A) for which no management decision had been made by the commencement of the reporting period; (B) which were issued during the reporting period; (C) for which a management decision was made during the reporting period, including— (i) the dollar value of disallowed costs; and (ii) the dollar value of costs not disallowed; and (D) for which no management decision has been made by the end of the reporting period;	Appendix A

APPENDIX C: REPORTING REQUIREMENTS

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

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

APPENDIX C: REPORTING REQUIREMENTS

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

DEFINITIONS

As defined in the IG Act:

Questioned cost means a cost that is questioned by the Office because of—

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

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

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

Unsupported cost means a cost that is questioned by the Office because the Office found that, at the time of the audit, such cost is not supported by adequate documentation;

Disallowed cost means a questioned cost that management, in a management decision, has sustained or agreed should not be charged to the Government;

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

(A) reductions in outlays;

(B) deobligation of funds from programs or operations;

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

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

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

(F) any other savings which are specifically identified;

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

Final action means—

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

(B) in the event that the management of an establishment concludes no action is necessary, final

action occurs when a management decision has been made; and

Senior government employee means—

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

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

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