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Description of document:	Department of Veterans Affairs (VA) records provided to Senator Charles E. Grassley and Senator Tom Coburn concerning the independence of Inspectors General necessary to promote efficiency and prevent fraud, waste and abuse in agency programs, in response to the Senators' inquiry, 2011-2012
Requested:	14-April-2012
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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

May 22, 2012

Re: Freedom of Information Act (FOIA) Request dated April 14, 2012; Received April 23, 2012; FOIA Case No. 12-00178-FOIA

This refers to your FOIA request for a copy of each biannual response to Senators Grassley and Coburn regarding their April 8, 2010, request to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) to provide a summary of the VA OIG's non-public management advisories and closed investigations. We have identified responses for the periods from January 2009 to April 2010; May 2010 to September 2010; October 2010 to March 2011; April 2011 to September 2011; and October 2011 to March 2012.

We have determined that the responses may be released to you in their entirety in accordance with the FOIA (5 U.S.C. § 552). We have enclosed 23 pages.

Sincerely,

DARRYL JOE
Chief, Information Release Office

Enclosures

Office of Inspector General
Department of Veterans Affairs

1. **Information on any instances when VA resisted and/or objected to oversight activities and/or restricted access to information.**

We have had no instances where VA has resisted and/or objected to our oversight activities. We have had no instances where VA has restricted access to information.

2. **Biannual reporting on all closed investigations, evaluations, and audits conducted by the office that were not disclosed to the public. The first report should cover the period of January 1, 2009 through April 30, 2010.**

The VA Office of Inspector General (OIG) conducts audits, investigations, and health care inspections, and we go to considerable lengths to make the results of our work public through our website, www.va.gov/oig. Under some circumstances, we cannot post information about our work on the internet. In most cases, the decision whether to post a report is determined by Federal laws that protect certain information from disclosure. The OIG receives over 30,000 Hotline contacts per year. In the interest of maximizing the use of our scarce resources, once we determine an allegation is unsubstantiated we terminate our investigation with an "administrative closure." The decision whether to publish a report is made by the OIG. VA management does not and has not influenced our decisions.

Office of Audits and Evaluations
In addition to audit and inspections reports, we also issue assessments and management representation letters and management information letters. A listing of non-published reports and other documents from the Office of Audits and Evaluations is attached.

Office of Healthcare Inspections
With regard to our health care inspections work, we produce several report types: Combined Assessment Program (CAP) reviews of medical centers; reports on Community Based Outpatient Clinics (CBOC); individual case reviews based on complaints to the OIG Hotline and congressional requests; national reviews; and consults to the OIG Office of Investigations and OIG Office of Audits and Evaluations.

All CAP and CBOC reports, with comments from Veterans Health Administration (VHA) senior officials, are published to the on the OIG website. Individual complaints to the Hotline that are accepted for review result in either a report that is published (with comments from VHA) or an administrative closure.

Consults for the OIG's Office of Investigations and Office of Audits and Evaluations are not made public unless they become part of an audit publication or an Office of Investigations action.

Office of Contract Review

The OIG Office of Contract Review (OCR) conducts pre-award reviews of proposals for Federal Supply Schedule (FSS) and other non-competitively awarded contracts awarded and administered by VA's National Acquisition Center for pharmaceuticals, medical/surgical supplies, and medical equipment and proposals submitted to VA medical centers to purchase health care services on a sole-source basis from medical schools and facilities affiliated with VA. These reports provide advice and guidance to the contracting officer regarding whether the prices offered are fair and reasonable and, if not, make recommendations for negotiations to obtain fair and reasonable pricing. Although the reports are listed in our Semiannual Report to Congress, they cannot be published or disclosed under the Freedom of Information Act (FOIA) because they are pre-decisional and include proprietary data such as the vendor's offered prices, commercial prices, and commercial pricing policies.

OCR also conducts post-award audits of VA's FSS contracts. These reviews focus on compliance with the contract's terms and conditions and address issues such as defective pricing, compliance with the Price Reductions Clause, and overcharges. In most cases, these reviews do not result in a report. If the vendor owes money to VA, the contracting officer is advised and a bill of collection is issued. In the event a settlement is not reached, we issue a report to the contracting officer to support a claim against the contractor. These reviews are listed in the OIG's Semiannual Report to Congress. However, when a report is written, it is not published or released under the FOIA because it contains proprietary information relating to the vendor's commercial sales practices, is pre-decisional, and may be considered attorney-work product because it was prepared in anticipation of litigation.

Office of Investigations

The OIG's investigative program provides public information on our work when public action of record such as indictments, arrests, convictions, and sentencing occur. However, privacy and confidentiality laws prohibit OIG from public disclosure of other closed criminal investigations.

Pursuant to Federal law and Attorney General Guidelines, OIG criminal investigators must refer evidence that a crime has occurred to the Department of Justice for prosecutive determination. If the Assistant United States Attorney declines prosecution, such as for cases that fall below the district's prosecutive threshold, the OIG will refer the case for prosecution to state and local authorities. If a VA employee is involved in misconduct and prosecution is declined, OIG will refer the matter to VA management for administrative action. If a veteran or contractor is involved, OIG will also refer substantiated misconduct to VA officials

for appropriate administrative action, such as termination of benefits or contractual remedies.

We also conduct administrative investigations of senior level officials. Titles of final report are published on the internet; however, because the reports are protected from disclosure under the Privacy Act, we cannot publish the reports unless a request has been made under the FOIA. Once the report has been reviewed for release under FOIA and meets other requirements of FOIA for publication on the internet, it will be published either in its entirety or redacted.

We issue advisory memoranda in those administrative investigations where an allegation has been substantiated and VA needs to take some action, but where the violation is not so significant that we make a formal recommendation requiring a VA response to the OIG. Because these reports contain information protected from disclosure under the Privacy Act and possibly other VA confidentiality statutes, we cannot publish them, even redacted, unless we receive the requests required under FOIA. Even then, our decision whether to publish the report, even in redacted format, involves judgment and discretion, because we must weigh the privacy interests of the individuals identified in the report and the public's right to know as required under FOIA. A listing of advisory memoranda and a management implication report from the Office of Investigations is attached.

3. **Information on any federal official who threatened or attempted to impede our ability to communicate with Congress.**

The OIG has not been threatened nor has our ability to communicate with Congress been impeded by any Federal official.

4. **Courtesy copy of our response to the Ranking Member of the House Committee on Oversight and Government Reform on outstanding recommendations that have not been implemented.**

Enclosed is our response to the Ranking Member of the House Committee on Oversight and Government Reform.

Office of Inspector General
Department of Veterans Affairs
Office of Audits and Evaluations
Non-Published Products

OIG Audits Not Published on the Internet - January 1, 2009, through April 30, 2010.

- Fiscal Year 2009 Federal Information Security Management Act Assessment (Report Number 09-01682-91, Issued March 4, 2010) – This report contains information protected from disclosure under the exemptions of the Freedom of Information Act.

- FY 2008 Federal Information Security Management Act Assessment (Report Number 08-01076-74, Issued February 26, 2009) – This report contains information protected from disclosure under the exemptions of the Freedom of Information Act.

Audits conducted by office that were not disclosed to the public January 1, 2009, through April 30, 2010.

- Independent Auditors' Report on Special-Purpose Financial Statements issued November 17, 2009, by our financial statement audit contractor, Deloitte & Touche, LLP. The purpose of this report was to provide financial information to the U.S. Department of Treasury and the U.S. Government Accountability Office for use in preparing and auditing the Financial Report of the U.S. Government, and was not intended to be a complete presentation of VA's financial statements.

- Independent Accountants' Report on Applying Agreed-Upon Procedures issued by our financial statement audit contractor on September 25, 2009. This report was issued solely to assist the U.S. Office of Personnel Management in assessing the reasonableness of the employee withholdings and employer contributions reported for the payroll periods ended August 30, 2008 and February 28, 2009.

Management Letters issued by office that were not disclosed to the public – January 1, 2009, through April 30, 2010.

- Management Letters issued in support of the Department of Veterans Affairs FY 2008 and 2009 financial statements audits, dated January 7, 2009, and February 12, 2010, respectively. These letters are not stand-alone audit reports. They are a by-product of the internal control and compliance report that is published with the audit opinion. The management letter aggregates other findings that did not reach the level of material weakness or significant deficiency reported in these two reports.

- Information Technology (IT) Management Letters issued in support of the Department of Veterans Affairs FY 2008 and 2009 financial statement audits, dated February 3, 2009, and February 12, 2010, respectively. These letters are not stand-alone audit reports. They are a by-product of the internal control and compliance report that is published with the audit opinion. The IT management letter provides

more specific detail on the IT material weakness cited in the internal control report. The letter contains information protected from disclosure under the exemptions of the Freedom of Information Act.

- Memorandum – Privacy Information Vulnerabilities Associated with the Personal Identification Verification (PIV) Enrollment System issued to Assistant Secretary for Operations, Security, and Preparedness on April 12, 2010. This memorandum was issued in advance of completing an audit in progress because system access vulnerabilities were identified that required immediate management attention.

Office of Inspector General
Department of Veterans Affairs
Office of Investigations
Non-Published Products

Management Implication Report

February 4, 2010 – This report pointed out deficiencies in VA's guidance and forms in the Veterans State Home Per Diem Program that may result in duplicate payments from VA, Medicare, and Medicaid for the same care provided to veterans.

Advisory Memorandums

January 13, 2009 – OIG investigated and substantiated that an employee was not fiscally responsible when on official travel. OIG found that he did not use transportation services that were the most advantageous to the Government when on official travel. When on official travel, he rented cars and used private limousine services rather than use less costly or free modes of travel. The OIG suggested that the employee receive refresher training on Federal Travel Regulations.

March 30, 2009 – OIG investigated and substantiated that an employee misused her official time when she attended personal physical therapy sessions during her official tour of duty. Although she had authorization from a former manager, the manager had improperly applied VA leave policy, and records reflected that the employee was on duty when on 30 occasions she was absent attending therapy sessions. The OIG suggested that the current manager and all employees for whom he was responsible become familiar with VA policy concerning properly charging leave when absent from their duty stations.

July 7, 2009 – OIG investigated and substantiated that an employee falsified official employment records to reflect that she earned a Masters in Business Administration. The employee was previously a graduate student, but she indicated on numerous official documents that she completed the program when she had not. Submitting false statements in official documents is a Federal crime, but the statute of limitations expired in this case. OIG suggested that the employee receive ethics and VA policy training and that she be counseled on the importance of a VA employee to testify freely and honestly.

July 29, 2009 – OIG investigated and substantiated that an employee engaged in unprofessional conduct when he made inappropriate comments and used inappropriate language in the workplace. Although he properly detailed an employee into a position, the employee improperly allowed the detailed employee to remain in the detailed position for 18 months. OIG suggested that the employee receive guidance concerning his unprofessional conduct and to ensure that he follows policy when detailing employees.

December 1, 2009 –OIG investigated and substantiated that employees violated Federal travel regulations and VA policy when they improperly used the Government

centrally billed account to initially pay for personal indirect travel and baggage fees. OIG suggested that the employees and fiscal service employees receive refresher training and guidance on Federal travel regulations and the use of the contractor-issued Government travel card.

January 10, 2010 – OIG investigated and substantiated that an employee improperly accepted a gift for herself and her subordinates from a prohibited source; improperly procured Government-owned vehicles to transport VA employees to a VA contractor's home; and misused her and her subordinate's official time when they did not conduct VA business during their official duty hours. Further, Veterans Canteen Service funds were improperly used to purchase food and beverages for an employee retreat. All findings were related to an annual employee retreat held at a VA contractor's home; however, this was the last one, with no further retreats. OIG provided the memorandum for official use and whatever action was deemed appropriate.

January 29, 2010 – OIG investigated and substantiated that some employees felt that they were not subject to the same rules and regulations as other Federal employees concerning the acceptance of gifts from prohibited sources. OIG suggested that the Office of General Counsel be consulted to create an ethics training program geared specifically toward real life ethics scenarios faced by these employees on a day-to-day basis and require that all these employees take the specialized training.

March 4, 2010 – OIG investigated and substantiated that an employee misused his official time when he was absent from his VA duty station without authorization on a number of occasions providing non-VA professional services for remuneration while receiving his VA salary. OIG suggested that the employee be issued a bill of collection to recoup the improperly paid salary, and that management provide training to the employee and his supervisors on VA time and attendance policy.

March 15, 2010 – OIG investigated and substantiated that an employee did not exercise prudence when incurring travel expenses for official business and misused travel funds when he improperly sought reimbursement for lodging and per diem while on personal travel. Although the employee conducted official business during his personal travel, the purpose of the trip was for a family vacation, and any official business was tangential to this vacation. OIG suggested that the employee be issued a bill of collection to recoup the improper reimbursements and provided with refresher training on Federal travel regulations.

Department of Veterans Affairs
Office of Inspector General Open Recommendations by Fiscal Year
Current as of March 31, 2010

1. Current Number of Open and Unimplemented OIG Recommendations:

There are 641 open and unimplemented Office of Inspector General (OIG) recommendations.

2. Recommendations Having an Associated Estimated Cost Savings:

The chart below represents open recommendations having associated estimated cost savings. Recommendations that are not yet 1 year old (issued after March 31, 2009) are not listed because we do not consider them to be outstanding at this time. All OIG recommendations issued prior to fiscal year 2005 have been implemented by VA.

FY	Number of Recommendations Made	Number of Recommendations Still Open	Number of Open Recommendations Having Associated Monetary Benefit	Potential Monetary Benefit from Open Recommendations
2005	1,436	1	0	$0
2006	1,289	3	0	$0
2007	681	1	1	$21,716,520
2008	654	16	7	$60,599,997
Total	**4,060**	**21**	**8**	**$82,316,517**

3. Most Important Open and Unimplemented Recommendations:

Listed below are the unimplemented recommendations that the OIG considers the most important. More than three recommendations are listed because several recommendations in one report have a combined total monetary benefit. In these instances, no specific monetary benefit was assigned to an individual recommendation. Therefore, in order to realize the savings, VA must implement all recommendations.

- ***Audit of the Acquisition and Management of Selected Surgical Device Implants*** **[Report No. 06-03677-221, 9/28/07] (Monetary Benefit of Recommendation—$21,716,520)**

Recommendation 1: We recommended that the Under Secretary for Health, within a year, evaluates the Veterans Health Administration's (VHA) aortic valve, coronary stent, and thoracic graft purchases; studies the feasibility of establishing national contracts and Blanket Purchase Agreements; and where indicated, initiates national contracts and Blanket Purchase Agreements.

Management agreed with this recommendation. On March 4, 2010, the coronary stent purchases workgroup released a Request for Information with a response due date of

March 18, 2010. The request is expected to identify coronary stents available in the commercial market and responses will be evaluated to determine the viability of establishing a national contract. VHA projects a national contract for these purchases will be established by May 2011.

Meanwhile, the group working to standardize aortic valve and thoracic graft purchases has been meeting biweekly to explore the feasibility of establishing a national contract. To gain a thorough understanding of the complexities of these devices, this workgroup identified sites throughout VA currently using aortic valves and thoracic grafts based on most recent purchases. The workgroup is currently drafting a survey to be completed by those sites to compile data on devices, manufacturers, and surgeon preferences. VHA expects to establish a national contract for aortic valves by December 2011. Plans to establish a thoracic graft national contract are on hold pending results of the survey.

By December 2011, VHA plans to make a final determination on the feasibility of establishing national contracts for all the purchases under review. OIG will close Recommendation 1 upon review of the final determination.

- ***Audit of Veterans Health Administration's Government Purchase Card Practices*** **[Report No. 07-02796-203, 9/11/08] (Total Monetary Benefit—$799,997[1])**

Recommendation 2: We recommended the Under Secretary for Health provide approving officials refresher training on using the revised Approving Official Checklist to ensure cardholders maintain adequate documentation supporting purchases.

Management agreed with this recommendation. On February 18, 2010, the Deputy Under Secretary for Health Operations and Management mandated that all purchase card approving officials receive refresher training on the revised approving official checklist. The revised checklist will require cardholders to maintain adequate documentation to support purchases. Each Veterans Integrated Service Network (VISN) is required to submit written certification to the National Purchase Card Manager indicating that all approving officials in the government purchase card program received the required training. The planned completion date was March 31, 2010, but the Department has not yet provided proof of completion. The OIG will close the recommendation upon receipt of documentation showing full compliance with the training requirement.

- ***Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreement*** **[Report No. 08-00477-211, 9/29/08] (Total Monetary Benefit—$59,800,000[2])**

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[1] The monetary benefit associated with this report covers recommendations 1-3 with a combined total monetary benefit of $799,997. Recommendations 1 and 3 are closed.

[2] The monetary benefit associated with this report also covers multiple recommendations. Recommendations 1-4 have a combined monetary benefit of $47.4 million, and recommendations 6-7 have a combined monetary benefit of $12.4 million.

Recommendation 1: We recommended that the Under Secretary for Health ensure that Veterans Integrated Service Networks establish standardized written procedures for monitoring full-time equivalent-based and per-procedure clinical service sharing agreements.

Recommendation 2: We recommended that the Under Secretary for Health establish VISN-level oversight controls to ensure that Contracting Officers' Technical Representatives (COTRs) are effectively monitoring contractor performance under the terms of the sharing agreement before certifying invoices for payment.

Recommendation 3: We recommended that the Under Secretary for Health implement procedures to ensure that COTRs verify that Medicare-based sharing agreement charges are accurately calculated prior to certifying contractor invoices.

Recommendation 4: We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop performance monitoring training for COTRs that specifically addresses clinical sharing agreements.

Recommendation 6: We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop training for VISN contracting officers on negotiating per-procedure sharing agreements with Medicare-based charges.

Recommendation 7: We recommended that the Under Secretary for Health implement oversight mechanisms to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component charges from contract rates, as required by VA policy.

Management agreed with all recommendations. In December 2009, the Office of Acquisition, Logistics, and Construction Acquisition Academy delayed the launch of the updated COTR training designed to improve clinical sharing agreement monitoring to allow VHA to develop additional education modules. On March 23, 2010, VHA indicated the additional modules are still under development. VHA expects to submit the additional modules to the Acquisition Academy by March 31, 2010, for final approval. OIG will close Recommendations 1, 2, 3, 4, 6, and 7 upon receipt of documentation showing COTRs completed the training.

4. Number of Recommendations Implemented Between January 5, 2009–March 31, 2010.

During the period January 5, 2009–March 31, 2010, VA implemented 824 recommendations deemed acceptable by the OIG.

Office of Inspector General
Department of Veterans Affairs
Office of Audits and Evaluations
Non-Published Products
May 1, 2010 - September 30, 2010

Management Letters Issued that Were Not Disclosed to the Public

As part of our nationwide Benefits Inspection Program for evaluating VA Regional Office (VARO) claims processing operations, we published two Management Advisory Letters during this reporting period.

May 27, 2010 – The Office of Inspector General (OIG) sent a Management Advisory Letter to the Director, Eastern Colorado Health Care System (ECHCS) in Denver, Colorado, regarding the delays we identified in returning veterans' claims folders to the Denver VARO. ECHCS's untimely return of veterans' claims folders upon completion of compensation and pension (C&P) medical examinations resulted in claims processing delays because VARO staff could not associate claims-related mail with veterans' claims folders. We recommended the ECHCS Director develop procedures to ensure the prompt return of veterans' claims folders to the Denver VARO upon completion of C&P medical examinations, or when the ECHCS staff cancels examinations, or when the ECHCS no longer requires the claims folders.

August 16, 2010 – OIG sent a Management Advisory to the Director, VA Compensation and Pension Service, VA Central Office, concerning the delays in completing final rating decisions for mental competency determinations. Veterans Benefits Administration policy states staff should take immediate rating action to determine a beneficiary's competency immediately at the end of the 65-day due process period for which incompetency is proposed. Our inspection of seven VAROs revealed Regional Office managers lack a standard definition of "immediate." For our inspections, and in the absence of a definition of "immediate," we allowed 14 calendar days after the 65-day due process period to determine if staff timely completed a competency decision. We considered this a reasonable period in which to control, prioritize, and finalize these cases. At these VAROs, we determined 36 percent of cases reviewed exceeded our 14-day goal, with timeliness delays ranging from 17 to 852 days. We recommended the VA C&P Service establish a clear standard for timely completion of final competency determinations and reduce the risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds.

Office of Inspector General
Department of Veterans Affairs
Office of Investigations
Non-Published Products
May 1, 2010 - September 30, 2010

Advisory Memorandums Issued that Were Not Disclosed to the Public

May 5, 2010 – OIG investigated and substantiated that two employees misused travel funds. OIG found that one employee asked for and received a reimbursement for an expense that he did not incur. The second received mileage reimbursements for which she was not entitled, used travel advances without authorization for personal expenditures, and violated Public Transit Fare Benefits program when she failed to reduce her monthly benefit by the amount that she did not use. OIG suggested that both employees be issued bills of collection and that they receive training on travel regulations.

July 27, 2010 – OIG investigated and substantiated that an employee's close personal relationship with a subordinate created the appearance that he gave her preferential treatment; however, OIG found no instances of actual preferential treatment. OIG suggested that the employee be counseled on avoiding actions that create the appearance of violating ethical standards, receive ethics training, and formally recuse himself from any future personnel matters concerning the subordinate.

Office of Inspector General
Department of Veterans Affairs
Office of Investigations
Non-Published Products
October 1, 2010 – March 31, 2011

Advisory Memorandums Issued That Were Not Disclosed to the Public

- October 5, 2010 – The Office of Inspector General (OIG) investigated and substantiated that a Medical Center's time and attendance records did not accurately reflect hours worked by a physician; that the physician, at times, treated non-VA patients at the affiliate during her VA duty hours; and that the physician shared nightly on-call duties, treating VA and non-VA patients. OIG suggested that the Medical Center Director ensure that time and attendance records accurately reflected hours worked and that the Director confer with Regional Counsel to determine if VA and the affiliate needed a written agreement to protect VA's interests on occasions when VA physicians treated non-VA patients during their VA duty hours and when they shared on-call duties with non-VA physicians. We found that the subject worked the required number of hours during her tour of duty, but the hours were not accurately reflected in the electronic time and attendance records.

- October 14, 2010 – OIG investigated and substantiated that an employee accepted a gift from a prohibited source when she, as a travel planner, gave her personal reward point account number to a hotel representative when scheduling official travel for colleagues. This resulted in her receiving reward points for which she was not entitled. OIG suggested that the employee avoid giving her personal information when booking official travel for others; that she provide her supervisor a monthly summary of her rewards account to identify any reward points improperly given to her as a result of official travel by staff and take appropriate steps to have them removed; and that the employee take refresher ethics, travel card, and travel policy training.

- December 14, 2010 – OIG investigated and substantiated that an employee's close friendship with a subordinate created the appearance of preferential treatment; however, OIG found no instances of actual preferential treatment. OIG found that their closer-than-arms-length relationship was problematic, so OIG suggested that the employee take ethics refresher training and be formally removed from the subordinate's supervisory chain.

- January 4, 2011 – OIG investigated and substantiated that an employee's close personal relationship with a subordinate created the appearance that she gave him preferential treatment; however, OIG found no instances of actual preferential treatment. OIG found that their closer-than-arms-length personal relationship was problematic and that her and her subordinate's personal use of VA-issued equipment went beyond that of limited personal use. OIG suggested that the employee be counseled on avoiding actions that created the appearance of violating ethical standards; that the employee and her subordinate receive policy and ethics refresher training; and that the employee recuse herself from any future personnel matters concerning the subordinate.

Office of Inspector General
Department of Veterans Affairs
Office of Audits and Evaluations
Non-Published Products
October 1, 2010 - March 31, 2011

Office of Inspection General Attestations Listed on the Internet But Not Published on the Internet:

- March 17, 2011 – The Office of Inspector General (OIG) is required to review VA's FY 2010 Performance Summary Report to the Director, Office of National Drug Control Policy (ONDCP), pursuant to ONDCP Circular, *Drug Control Accounting*, dated May 1, 2007, and as authorized by 21 U.S.C. § 1703(d)(7). We reviewed whether VA has a system to capture performance information accurately and if that system was properly applied to generate the performance data reported in the Performance Summary Report. Based upon our review and the criteria of the Circular nothing came to our attention that caused us to believe that VA does not have a system to capture performance information accurately and the system was not properly applied to generate the performance data reported in the Performance Summary Report in all material respects.

- March 21, 2011 – ONDCP requires VA to submit an annual Detailed Accounting Submission, as authorized by 21 U.S.C. § 1704(d) and ONDCP Circular, *Drug Control Accounting*, dated May 1, 2007, to ONDCP. In our review of VA's submission, nothing came to our attention that caused us to believe that management's assertions are not fairly stated in all material respects based on the criteria set forth in the Circular.

Audits Issued by the OIG Contractor that Were Not Disclosed to the Public:

- November 10, 2010 – We contracted with an independent accounting firm, Clifton Gunderson LLP, to perform the FY 2010 Independent Auditor's Report on Special-Purpose Financial Statements. They provided the opinion that the FY 2010 special-purpose financial statements present fairly, in all material respects, the financial position of VA as of September 30, 2010, and its net costs and changes in net position in conformity with generally accepted accounting principles and with the requirements of Chapter 4700 of the Treasury Financial Manual (TFM). They found no material weaknesses in internal control over the financial reporting process for the special-purpose financial statements, and our tests of compliance with the TFM Chapter 4700 requirements disclosed no instances of noncompliance that are required to be reported under Government Auditing Standards and the Office of Management Budget Bulletin No. 07-04, as amended.

Office of Inspector General
Department of Veterans Affairs
Office of Audits and Evaluations
Non-Published Products
October 1, 2010 - March 31, 2011

Management Letters Issued by the OIG Contractor that Were Not Disclosed to the Public:

- January 13, 2011 - We contracted with an independent accounting firm, Clifton Gunderson LLP, to perform the FY 2010 audit on VA's Consolidated Financial Statements. As part of that audit, the contractor provided an Information Technology (IT) Management Letter to the VA Chief Information Officer, addressing material weaknesses in this area. The IT Management Letter summarized their comments and suggestions regarding the deficiencies. The current year audit identified that while weaknesses were corrected in some locations, they still continue to exist in other areas. This is evidenced by the continued existence of previously identified IT weaknesses at VA facilities. Many of these weaknesses may be attributed to ineffective implementation and enforcement of an agency-wide information security program and ineffective communication from VA management to the individual field offices. These are included in the audit report issued on November 10, 2010, on the financial statements of VA.

Office of Inspector General
Department of Veterans Affairs
Office of Investigations
Non-Published Products
April 1, 2011 – September 30, 2011

Advisory Memoranda

April 7, 2011 – The Office of Inspector General (OIG) investigated and substantiated that a senior official did not exercise sound judgment and gave the appearance of preferential treatment when he hired his immediate staff and later withheld key information when recommending one staff member for a limited term executive position. OIG found that four of the staff members had misconduct or performance-related problems at Federal agencies previously employing them and that pre-employment checks were insufficient or not done. OIG also found that two of the staff members failed to disclose pertinent information concerning their former Federal employment on the forms they completed as part of the VA employment process. OIG suggested that it be emphasized to the senior official that even the appearance of preferential treatment diminished his position and authority as a senior leader, and OIG provided information for action as deemed necessary.

May 9, 2011 – OIG investigated and substantiated that an employee failed to properly include an applicant on a certificate of eligibles for a recruitment action; however, the applicant was later hired using another appointment authority. OIG also found that Human Resources (HR) staff members were not always responsive to requests for records relevant to OIG investigations, and OIG suggested that HR staff be instructed to ensure that their responses are complete and accurate. OIG provided the information for action as deemed necessary.

May 30, 2011 – OIG investigated and substantiated that an employee's actions gave the appearance of violating ethical standards when she signed a form authorizing a recruitment action that was later used to appoint her son to a VA position. The Office of General Counsel could not establish that the employee was a qualified public official—a key element in determining whether an action constitutes nepotism—and OIG recognized that her actions may have been ministerial in nature. OIG suggested that the employee have no future involvement in any personnel actions concerning her son to avoid an appearance of violating ethical standards.

June 28, 2011 – OIG investigated and substantiated that a Human Resources Officer engaged in a conflict of interest when he signed as the authorizing official on personnel actions leading to his own monetary gain. OIG recognized that the employee's act of signing these personnel actions may have been ministerial in nature and that the actions were approved by his supervisors, prior to the employee signing them as part of an administrative process. OIG suggested that management put a mechanism in place to avoid future occurrences of Human Resources Officers signing their own personnel actions.

Office of Inspector General
Department of Veterans Affairs
Office of Investigations
Non-Published Products
April 1, 2011 – September 30, 2011

Management Implication Notification

August 18, 2011 – While investigating the theft of nearly $200,000 worth of diabetic test strips by a former VA Pharmacist, we discovered systemic managerial and physical control weaknesses that facilitated the theft. Based on our observations, we recommended to VA to limit access to the warehouse; maintain an access log; provide additional security for costly or easily stolen items; install overt cameras; and implement a loss detection procedure.

Office of Inspector General
Department of Veterans Affairs
Office of Audits and Evaluations
Non-Published Products
April 1, 2011 – September 30, 2011

Management Letters Issued by Office that were Not Disclosed to the Public:

April 20, 2011 – As part of the Consolidated Financial Statement Audit, we provided the Chief Financial Officer with a Financial Management Letter. This letter, issued by the independent accounting firm, Clifton Gunderson LLP, identifies internal control deficiencies in addition to the material weakness and significant deficiencies described in the auditor's report. These deficiencies, though not required to be reported in the auditor's report, still require management's attention.

Office of Inspector General
Department of Veterans Affairs
Office of Investigations
Non-Published Products
October 1, 2011, to March 31, 2012

Advisory Memoranda:

October 27, 2011 – The Office of Inspector General (OIG) investigated and substantiated that managers failed to provide a VA employee his performance plan within 60 days after the beginning of the appraisal period for 5 consecutive years and that they failed to provide him interim progress reviews for 4 years as required by VA policy. OIG also found that the Office of Human Resources gave a senior official ambiguous advice in reference to calculating performance-based cash awards. OIG suggested that the managers receive refresher training on VA performance policy and that they adhere to that policy. OIG also suggested that senior officials seek advice from the Office of General Counsel and the Office of Human Resources to clarify what was permissible when calculating amounts for performance-based awards.

November 9, 2011 – OIG investigated and substantiated that a senior official and human resources (HR) employees improperly applied the Veterans Recruitment Appointment (VRA) hiring authority when they used it to disregard the rating and ranking scores assigned to applicants on an open general announcement certificate in order to select preferred applicants for VA positions and when they failed to apply VRA rules equally to all VRA eligible applicants on the certificate. OIG suggested that the senior leader and HR employees receive additional HR training to ensure that they apply VRA rules uniformly to all applicants who meet the conditions of VRA rather than apply those rules to only a few.

January 19, 2012 – OIG investigated and substantiated senior officials improperly requested and authorized two relocation incentives by failing to fully document in the request the required factors to consider for the incentives as required by VA policy. The incentives were not improper, but the requirements of VA policy were not met. OIG suggested that human resources staff and senior managers receive training on VA policy concerning the requirements for justifying relocation and recruitment incentives.

February 16, 2012 – OIG investigated and substantiated that medical center senior officials did not always ensure that OIG was immediately notified in cases involving possible or actual felony criminal activities occurring at medical centers. OIG found that poor communication between medical center senior officials and VA police officials most likely contributed to the failure to make timely OIG notifications. Further, OIG found that local medical center policy did not comply with VA policy in that it lacked specific guidance and reference to making such referrals. OIG suggested that it be emphasized to all senior officials the requirement to immediately notify OIG of any possible felony criminal activity and that senior officials review their local policies and add language that mirrors the notification requirements found in Federal regulations and VA policy.

March 7, 2012 – OIG investigated and concluded that a contractor employee failed to report for duty on days she was to report at the VA facility and that the Contracting Officer's Technical Representative (COTR) did not establish and maintain proper time and attendance records for contractor services prior to certifying payment. OIG suggested that the COTR maintain appropriate time and attendance records to comply with the VA contract. OIG also suggested that a VA employee receive refresher training on ethics regulations concerning gifts and gratuities from contractors, since she accepted, and subsequently returned or disposed of, gifts from the contractor employee. OIG further found that a VA physician misused resources when he injected the contractor employee, who was not a VA eligible patient, with prescription medication during their VA tour of duty. OIG suggested that the physician receive refresher training on his roles and responsibilities as a VA physician. OIG also found that medical professionals working at the facility were unsure of their respective chains of command, and OIG suggested that organizational charts be distributed and respective employees informed of their reporting chains of command.

Management Implication Notifications:

January 3, 2012 – We issued a Management Implication Notification to the Veterans Health Administration concerning the possible negative and unintended consequences of VA issued debt notifications during ongoing criminal investigations. During a criminal investigation involving a VA Agent Cashier, who embezzled more than $52,000, and unbeknownst to the Case Agent, VA created a debt in the Agent Cashier's name and mailed a collection notice to her. OIG and the U.S. Attorney's Office became aware of the Department's actions at a bond hearing for Agent Cashier after she was indicted and arrested. This action jeopardized the criminal prosecution of the Agent Cashier. We recommended that VA suspend all administrative attempts to collect debts involving matters referred to the OIG for investigation. If in some situations accounting measures have to be taken to offset fraud losses and balance the accounting records, we recommended development of a specialized account or accounting entry to account for the losses; this action should eliminate the automatic issuance of letters of collection.

February 28, 2012 – While investigating the theft of nearly 6,000 tablets of Oxycotin, Vicodin, Oxycondone, and Clonozepam from the pharmacy at a VA Medical Center (VAMC), we discovered systemic weaknesses in VA systems and management controls that facilitated the theft. Based on our observations, we recommended that the Veterans Health Administration establish a process to review or audit daily transaction reports in the Veterans Health Information Systems and Technology Architecture and match the transactions to dispensing reports from the dispensers. We also recommended that the local VAMC Controlled Substance Coordinator (CSC) conduct the audit because the CSC is not assigned to the pharmacy and does not have access to the pharmacy inventory.

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Reviews Not Published on the Internet:

January 4, 2012 – Review of Top 25 Travelers – At the request of Senator Charles Grassley and the Chairman and Ranking Member of the Senate Committee on Veterans' Affairs, we reviewed the VA's top 25 travelers for the period January 1, 2010, through August 2010. We found the travel expenses for VA's top 25 travelers totaled approximately $1.3 million (of the $240 million VA spent on travel during that same period) for 580 completed expense reports for the time period January 1, 2010, through August 31, 2010. The top 25 travelers were employees of 4 VA organizations: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), the Office of Information and Technology (OIT), and the Office of Acquisition, Logistics, and Construction (OALC). We verbally discussed our results with officials from VA's Office of Management, VHA, VBA, OIT, and OALC. Management agreed with our results.

March 23, 2012 – Review of Construction Costs for the New Orleans VA Medical Center (VAMC) – At the request of Congressman Bill Johnson, Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, we reviewed information related to the construction of the New Orleans VAMC. Specifically, the request asked for a review of the financing and budgeting for construction for the New Orleans VAMC and to review plans to remove fuel tanks buried at the construction site. Our review did not identify any substantive issues with VA's stewardship of the expenditures.

Evaluations Conducted That Were Not Disclosed to the Public:

October 6, 2011 – Review of Allegations of Excessive Billing for Foreign Medical Services at the Denver, Colorado, VAMC – We received allegations that numerous claims over the last 15 years involved expenses for injuries were miscoded as service-connected. The complainant was unable to provide evidence or specific information to verify allegations.

October 12, 2011 – Review of Allegations of Abuse in Beneficiary Travel for Physical Therapy Appointments at New Orleans, Louisiana, VAMC – We received allegations that 10 physical therapy patients have been committing travel benefits fraud. The complainant alleged the patients are allowed to walk-in for physical therapy without a scheduled appointment and alleges that they may be receiving travel benefits inappropriately. Our review indicated the beneficiary travel claims were processed under VHA guidelines.

November 16, 2011 – Review of Allegations on Payroll Processing at Atlanta, Georgia, VAMC – We received allegations of payroll processing errors resulting from the conversion to the Defense Civilian Pay System (DCPS). The complainant stated that many employees, including physicians, wage grade, and nurses are not being paid correctly because of system errors within VA's Personnel Accounting Integrated Data system and Veterans Health Information Systems and Technology Architecture rolling into DCPS. Our review indicated that there were errors in payroll when the two systems reconciled payroll data, however the VAMC had controls in place to identify and correct the problems, ensuring all employees were paid correctly and on time.

January 9, 2012 – Review of Alleged Mismanagement of Staffing Contracts for VA's National Security Operations Center (NSOC) Public Key Infrastructure (PKI) Program, Washington, DC – We received allegations that the NSOC hired 20 full-time equivalent employees to perform PKI support duties in duplication of an existing contract. Our review found there was a slight duplication of effort, but it was part of a scheduled transition plan as the existing contract ended.

January 25, 2012 – Review of Alleged Contracting Irregularities for the Leadership VA Program, Washington, DC – We received allegations that Office of Human Resources and Administration officials obtained consulting services from a contractor to redesign the Leadership VA program before a task order was obligated and awarded. Our review indicated the consulting services were ordered from a valid, current contract for such services.

January 27, 2012 – Review of Alleged Unauthorized Destruction of Claims Folder Documents, Atlanta, Georgia – We received allegations that unknown VA Regional Office employees intentionally discarded 60 pages of evidence that the complainant submitted for her claim. Our review of the claims folder could not identify any documentation that was missing. When asked for copies of what was submitted, complainant refused to provide copies.

February 17, 2012 – Review of Alleged Contract Funding Mismanagement in VHA's Office of Business Oversight (OBO) – We received allegations that VA funds/contracts were misused within the VA's Office of Business Oversight, in particular, with two of its services, the Internal Controls Service (ICS) and the Management Quality Assurance Service (MQAS), which are located in Austin, TX. The allegations were: MQAS transferred excess funds to ICS at the end of the fiscal year to keep from having to return the money, and ICS used those funds on contract services that were not needed, were a waste of funds, or produced no value. Our review concluded the OBO Director had legitimately authorized the transfer of excess funds from MQAS to ICS. MQAS transferred the funds because it had a surplus due to unfilled positions and travel not taken during a time of budget uncertainties and continuing resolutions. ICS used the majority of the funds for contractor services to test and provide narrative descriptions of VA internal control processes needed to comply with Office of Management and Budget Circular A-123 and Circular A-127.

Management Letters Issued That Were Not Disclosed to the Public:

March 1, 2012 – Review of Fiscal Year (FY) 2011 VA Purchases Made on Behalf of the Department of Defense (DoD) – VA's Office of Acquisition and Logistics notified its contracting activities to discontinue purchases on behalf of DoD by May 21, 2009. Despite this, we found one purchase made under an existing MOU where VA purchased an X-ray machine for the DoD. We determined VA had effective policies, procedures, and management controls in place to ensure the contracting officer complied with Defense procurement requirements when placing the X- Ray machine delivery order. In response to our review, the Deputy Assistant Secretary for Acquisition and Logistics has stated that in the future, the National Acquisition Center (NAC) will not accept delivery orders for equipment purchases for DoD facilities. Any pending or future requests will be returned to DoD for action. On January 21, 2012, the NAC's National Contract Service Director sent an e-mail advising his staff of the Deputy Assistant Secretary's decision. Finally, information on the NAC's website was also revised to advise DoD customers they must submit their purchase requests to the Defense Logistics Agency.

December 16, 2011 – Fiscal Year 2011 Federal Information Security Management Act Information Technology (IT) Management Letter – We contracted with an independent accounting firm, Clifton Gunderson LLP, to perform the 2011 audit on VA's Consolidated Financial Statements. As part of that audit, the contractor provided an IT Management Letter to the VA Chief Information Officer addressing material weaknesses in this area. The IT Management Letter summarized their comments on identified deficiencies and made suggestions regarding the deficiencies. Many of these weaknesses may be attributed to ineffective implementation and enforcement of an agency-wide information security program and ineffective communication from VA management to the individual field offices. These are included in the audit report issued on November 10, 2011, on the financial statements of VA and posted on the OIG public website.