Office of Inspector General
Semiannual Report to Congress

October 1, 2000 - March 31, 2001

FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended March 31, 2001. The OIG is dedicated to help ensure that veterans and their families receive the care, support, and recognition they have earned through service to their country. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

OIG oversight of major VA programs resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. Overall, OIG audits, investigations, and other reviews identified $2.5 billion in monetary benefits, for an OIG return on investment of $112 for every dollar expended.

Our criminal investigations place a priority on safety and security at VA facilities. This coupled with proactive initiatives has resulted in increases in the number of investigations conducted, which has resulted in significant increases in the numbers of arrests made by OIG special agents. During the period, the office concluded 322 investigations resulting in 373 judicial actions and over $26 million recovered or saved. Investigative activities resulted in the arrests of 215 individuals who had committed crimes involving VA programs and operations or on VA facilities. Most significant was the conclusion of a 5-year investigation in which a former VA medical center (VAMC) nurse was convicted of three counts of first degree murder, one count of second degree murder, four counts of assault with intent to commit murder, and one count of assault with intent to commit bodily injury. The nurse was convicted of killing and/or assaulting veteran patients during the time of her VAMC employment. She was sentenced to four consecutive life sentences without parole.

Our audit oversight of VA, the second largest Department in the Federal Government, focused on determining how programs can work better, while improving service to veterans and their families. For example, an audit presented opportunities to better use $1.33 billion by establishing a streamlined Veterans Health Administration (VHA)-wide process to fill prescriptions written by veterans' private physicians, and increase revenues by $284 million by increasing the pharmacy co-pay level for priority group 7 veterans. Also, an audit of Veterans Benefits Administration's (VBA) income verification match found that opportunities exist for VBA to: significantly increase the number of

potential overpayments recovered by $806 million through greater efficiency and effectiveness; ensure better program integrity and identification of program fraud; and improve delivery of services to beneficiaries. Monetary benefits of this type can be redirected to programs that can improve or increase services to veterans.

Our Office of Healthcare Inspections focuses on quality of care issues in VA, which operates the largest health care system in the United States. This included a proactive review of VHA's missing patients program. Healthcare inspectors also provided oversight of the VHA's Office of Medical Inspector and the newly created Office of Research Compliance and Assurance activities, and reviewed the adequacy of VHA's responses to allegations of inadequate health care delivery and management.

The OIG's ongoing Combined Assessment Program (CAP) evaluates the quality, efficiency, and effectiveness of VA facilities. Through this program, auditors, investigators, and healthcare inspectors collaborate to assess key operations and programs at VAMCs on a cyclical basis. The CAP reviews completed during this 6-month reporting period highlighted numerous opportunities for improvement in quality of care, management controls, and fraud prevention. Through increased or restructured resources, I am committed to extending this program to enable more frequent oversight of VA activities.

I look forward to continued partnership with the Secretary and the Congress in improving service to our Nation's veterans.

RICHARD J. GRIFFIN
Inspector General

INSPECTOR GENERAL

VA OIG CASE YIELDS MURDER CONVICTION

Once described as a top-notch nurse who shined during medical emergencies, Kristen H. Gilbert was found guilty in Federal court for the murder of four veterans who were under her care at the Department of Veterans Affairs (VA) Medical Center in Northampton, Massachusetts. An extensive investigation by members of the VA Office of Inspector General, the Massachusetts State Police and the U. S. Attorney's Office, resulted in Ms. Gilbert being tried for capital murder in the deaths of four veterans and the attempted murder of three other veterans.

SUSPICIONS ARISE

Ms. Gilbert worked at the VA Medical Center from March 1989 through February 1996. Co-workers became suspicious because of the high number of deaths that occurred during her shift on a 30-bed acute-care medical unit. Sixty-three deaths occurred on the ward between January 1, 1995 and February 19, 1996. Ms. Gilbert was on duty when 37 of those patients died – many of them following emergency codes she called for cardiac arrest.

Staff noticed that emergency codes were often called when Ms. Gilbert's extramarital boyfriend, a member of the hospital's security staff, was on duty and was involved in the code call. None

Bruce Sackman, Special Agent in Charge, VA OIG Northeast Field Office, speaks at a press conference at the U.S. District Court House in Springfield, MA following the conviction of Gilbert. Standing behind Sackman are (l to r): U.S. Attorney Donald K. Stern; Massachusetts State Police Detective Kevin Murphy; VA OIG Special Agent Steven Plante; and Assistant U.S. Attorney Ariane D. Vuono.

Union News. SPRINGFIELD

Today's forecast
High 43, Low 20
See weather, Page A2

TUESDAY, MARCH 27, 2001 50¢

Gilbert's life spared

VERDICT AT A GLANCE

Among three aggravating and 13 mitigating factors in determining whether Kristen Gilbert should live or die, the jury decision was:

■ UNANIMOUS: All 12 jurors agreed several mitigating factors could spare Gilbert's life, including the adverse impact of her execution on her children and other family members.

■ DIVIDED: Only 3 agreed she was an asset to the VA and community and the crimes were not committed in a particularly heinous manner. Only 2 agreed her character and background

Ex-nurse sentenced to prison

By FRED CONTRADA and STEPHANIE BARRY
Staff writers

SPRINGFIELD – The first Massachusetts jury in more than a generation to wield the power of life and death spared convicted serial killer Kristen H. Gilbert from execution yesterday for the sake of her children and her family.

In a decision hailed as repre[illegible] the voice of the communi-

Nancy Cutting, widow of murder victim Kenneth D. Cutting, watches as her son, Jeffrey D. Cutting, right, embraces VA OIG Special Agent, Steven J. Plante, following the announcement that Gilbert was sentenced to four consecutive life terms in prison with no possibility of parole.

were called when he was off duty. Described by some of her co-workers as an excellent emergency nurse, Gilbert was pictured in court as a thrill seeker who sent patients into cardiac arrest for the excitment of responding to emergencies in front of her boyfriend.

EXPEDITIOUS DEATHS

The seven veterans listed in the charges had chronic diseases but none had life-threatening conditions. Five of the seven had no history of heart disease. In one of the cases for which she was convicted, Gilbert murdered a veteran following her request to leave early to meet her boyfriend should the particular patient under her care die. Within an hour, the veteran in question was dead and his body removed to the morgue. She left by the hour she requested.

BOMB THREAT

Prior to her trial for murder, Gilbert served a 15-month sentence in a Federal prison in Danbury, Connecticut for telephoning a bomb threat to the VA hospital in September 1996. The threat

was described as her attempt to hinder the investigation of the suspicious deaths at the Northampton Medical Center.

> ***"In the end what this case is about is a defendant who took advantage of the system in which patients placed their trust in the hands of a caregiver...and committed cold-blooded murder."***
>
> William M. Welch
> Assistant U.S. Attorney

TRIAL OUTCOME

Following the 12-week trial, a Federal jury took 12 additional days to find Gilbert guilty of first degree murder in the deaths of Henry R. Hudon, 35, Kenneth D. Cutting, 41, and Edward S. Skwira, 66; of second degree murder in the death of Stanley J. Jagodowski, 66; and with assault with intent to kill Angelo F. Vella, 68, and Thomas P. Callahan, 60. She was found innocent of the attempt to kill Francis F. Marier, 72. Although they survived Gilbert's murder attempt, Vella, Callahan, and Marier all subsequently died.

PROSECUTOR EXCERPTS

The following are excerpts from the opening statement of U.S. Attorney William M. Welch III before a federal jury went into deliberations to consider whether former nurse Kristen H. Gilbert should be executed for killing veterans at a Northampton hospital:

WELCH: It is time for justice. For seven months Kristen Gilbert coldly and quietly moved through the corridors of the V.A. Medical Center in a nurse's uniform leaving behind her a trail of death and distraught families. In that wake of destruction, she defiled a trust, the most sacred trust that exists between a nurse and a patient in order to make her murders succeed.

It is time to consider what is a just punishment for these most horrendous crimes. ...

We are here so that you understand why a death sentence is the only just punishment in this case. You will speak as the unified voice of the community's conscience, and through your verdict may express the community's outrage at these most horrific crimes. ...

There are some murders committed so coldly and callously, some murders that defile such basic fundamental core human values of the sanctity and dignity of human life that the only just punishment can be one of death. ...

These murders committed by this defendant were done not just once, not twice, but four separate times. And they were committed with careful planning and thinking about the particular drug to use so that she could murder again and again and again undetected. And she knew in committing these murders that she would take advantage of the vulnerability of these victims and that sacred sense of trust that exists between a nurse and a patient in order to make her murders succeed. ...

Ultimately the value of this defendant's life, the circumstances of these murders show that no humanity (exists) behind that mask ... behind that face it is dark, it is empty, it is evil. ...

The same jury that convicted her of the killings spared her life by recommending life in prison with no parole. The judge sentenced her to four consecutive life sentences, assuring that she will spend the rest of her natural life in Federal prison.

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HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended March 31, 2001. The following statistical data highlights OIG activities and accomplishments during the reporting period.

DOLLAR IMPACT	**Dollars in Millions**
Funds Put to Better Use	$2,459.2
Dollar Recoveries	$24.4
Fines, Penalties, Restitutions, and Civil Judgments	$16.3

RETURN ON INVESTMENT	
Dollar Impact ($2,499.9) / Cost of OIG Operations ($22.3)	112 : 1

OTHER IMPACT	
Arrests	215
Indictments	201
Convictions	172
Administrative Sanctions	233

ACTIVITIES

Reports Issued	
Combined Assessment Program	10
Audits	8
Contract Reviews	28
Healthcare Inspections	7
Administrative Investigations	5
Investigative Cases	
Opened	398
Closed	322
Hotline Activities	
Contacts	8,324
Cases Opened	529
Cases Closed	530

OFFICE OF INVESTIGATIONS

Overall Focus

This semiannual period the Office of Investigations achieved major increases in the number of investigative cases initiated and concluded. These investigations have resulted in the highest number of judicial actions ever achieved for this office. During the period, the office concluded 322 investigations resulting in 373 judicial actions and over $26 million recovered or saved. Investigative activities resulted in the arrests of 215 individuals who had committed crimes involving VA programs and operations or on VA facilities. In addition, the office realized monetary benefits of over $13 returned or saved by the Government for each dollar spent. Investigative emphasis was placed on safety and security at VA medical centers (VAMCs) and working hand in hand with VA police we assisted in over 30 arrests of individuals who committed crimes at VAMCs. Additionally, over 300 investigations were initiated in the benefits fraud area based on computer matching results which indicated that individuals were fraudulently diverting VA funds. During this semiannual period, many significant cases were brought to successful conclusions to include the nurse Gilbert conviction noted in the front of this report. Examples of other cases follow.

Veterans Health Administration

In a major drug diversion investigation, four VAMC pharmacy technicians were arrested and charged with conspiracy and theft of Government property after a VA OIG investigation disclosed the technicians were involved in the diversion of prescription drugs from a VAMC outpatient pharmacy. Investigation showed the employees routinely withdrew prescription drugs from the VA pharmacy drug vault and diverted the drugs to a veteran who was reselling them. The technicians admitted that for a 1-year period, each individual stole from 300 - 2,000 pills a week that had a street value in excess of $250,000.

Veterans Benefits Administration

Three individuals, a veterans' service officer, a registered nurse, and the owner of a nursing company, were convicted and sentenced to imprisonment for their participation in a conspiracy to defraud VA. A VA OIG investigation disclosed the three individuals devised a scheme whereby veterans would submit paperwork to obtain VA pension benefits by reporting unreimbursed medical expenses from the nursing company. Nursing company expenses were created solely to offset each beneficiary's income thereby maximizing VA benefits; the reported nursing company expenses had nothing to do with the level of care being provided. The nursing company then hired a friend or relative of each VA beneficiary to serve as a caregiver, who in many cases provided little or no care to the veterans.

In another investigation, a former VA regional office (VARO) employee and her associate were indicted by a Federal grand jury on multiple counts of theft, mail and wire fraud, and conspiracy. The indictment is the result of an investigation by VA OIG which determined that over a 3-year period the employee, in her capacity as a veterans' service officer, created a false veteran payee within VA data systems, subsequently causing VA to issue benefit checks in the name of a fictitious veteran to an address controlled by her associate. The employee then negotiated the checks. As a result, monetary loss to the Government exceeds $229,700. Further judicial actions are pending in this case.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $2.47 Billion

Audits and evaluations were conducted which focused on performance results, while improving service to veterans. During this reporting period, 18 performance, financial, and Combined Assessment Program (CAP) audits, evaluations, and reviews as well as 28 contract reviews identified opportunities to save or make better use of $2.47 billion. The Office of Audit returned $256 for every dollar spent on performance, financial, and CAP audits, evaluations, and reviews. Contract reviews returned $30 in monetary benefits for every dollar spent.

Veterans Health Administration

The following are examples of major health care related audits. Our audit of Veterans Health Administration's (VHA) pharmacy co-payment levels and restrictions on filling privately written prescriptions for priority group 7 veterans found that VHA can reduce the cost of providing prescriptions to priority group 7 veterans about $284 million by increasing the pharmacy co-pay level from the current $2 for each 30-day prescription supply to $10, and about $1.33 billion by filling prescriptions written for enrolled veterans by private physicians. Another audit, requested by the Under Secretary for Health of the Health Eligibility Center (HEC), found that income verification matching procedures of VHA did not provide reasonable assurance that income verification matches include only self-reported income from veterans

Veterans Benefits Administration

Our audit of Veterans Benefits Administration's (VBA) Income Verification Match (IVM) found that opportunities exist for VBA to: significantly increase the number of potential overpayments recovered by $806 million through greater efficiency and effectiveness; ensure better program integrity and identification of program fraud; and improve delivery of services to beneficiaries.

Office of Management

The audit of the Department's Consolidated Financial Statements for Fiscal Years (FYs) 2000 and 1999 resulted in an unqualified opinion. The report on internal control and compliance with laws and regulations reported that VA management demonstrated commitment to addressing management control weaknesses and had made progress towards improving weaknesses concerning information technology security controls, Treasury reconciliations, and Housing Credit Assistance program accounting. However, opportunities exist for further improvement. The report discusses two material weaknesses concerning: (i) information technology security controls and (ii) integrated financial management system; and identified three other reportable conditions concerning: (i) the need to improve application programming and operating system change controls; (ii) business continuity and disaster recovery planning; and (iii) operational oversight and three internal control matters.

Contract Review and Evaluation

During the period, we completed 28 contract reviews – 18 preaward and 10 postaward reviews. These reviews identified monetary benefits of $32 million resulting from contractor actual or potential overcharges to VA.

OFFICE OF HEALTHCARE INSPECTIONS

During this reporting period, CAP reviews occupied approximately 75 percent of the Office of Healthcare Inspections' (OHI) resources. In addition, OHI focused on active oversight of the 124 Hotline cases sent to VHA program offices and the VHA medical inspector. In 11 of these cases, OHI was not satisfied with the VHA response and recommended that they receive further study. The reporting period also saw the conviction and sentencing to life in prison of a VA nurse charged with murdering patients at a VAMC. OHI staff worked diligently as clinical team members/consultants to the Office of Investigations in order to locate and develop evidence sufficient for the conviction.

Program Review

A major program review of this period was conducted in follow up to a preliminary assessment of VHA's missing patient policies and search procedures that we conducted in FY 1999. The review assessed the adequacy of VHA's policies and procedures for assuring the safety and security of impaired or otherwise high-risk patients who may elope or wander from their VA treatment settings, sometimes with tragic results. While we found that VHA managers had increased their efforts to locate missing patients, we also validated our preliminary conclusions that VHA managers could improve their procedures and practices to safeguard against future tragic incidents. We made recommendations to strengthen existing missing patient policies and procedures and to promote the safety of all VA patients.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

The Hotline program provides an opportunity for employees, veterans, and other concerned citizens to report fraud, waste, abuse, and mismanagement. The identification and reporting of issues such as these are integral to the goal of improving the efficiency and effectiveness of the Government. During the reporting period, the Hotline received 8,324 contacts. We opened 529 cases, and closed 530 cases which contained 151 substantiated allegations. Hotline staff responded to 90 inquiries received from members of the Senate and House of Representatives. The cases we opened led to 33 administrative sanctions against employees and 71 corrective actions taken by management to improve VA operations and activities. Our reviews identified: (i) employees who abused time and leave and violated ethical conduct standards; (ii) VA facilities with poor fiscal controls; (iii) several instances of misconduct by medical staff in the care and treatment of veteran patients; and (iv) problems in VBA operations with a number of compensation and pension cases that warranted corrective action by management.

Follow Up on OIG Reports

The Operational Support Division tracks implementation actions on issued audits, inspections, and reviews with over $2.9 billion of actual or potential monetary benefits as of March 31, 2001. Of this amount, $1.2 billion is resolved as VA officials have agreed to implement the recommendations, but have not yet done so. In addition, $1.7 billion relates to unresolved contractor reviews awaiting resolution by VA contracting officers, and an unresolved VHA audit on pharmacy co-payment levels and restrictions on filling privately written prescriptions for priority group 7 veterans with VHA deferment on concurrence or non-concurrence with the

recommendations pending more focused attention and direction by VHA's National Leadership Board. After obtaining information that showed VA officials had fully implemented corrective actions, the Division took action to close 58 internal reports and 248 recommendations with a monetary benefit of $486 million.

Status of OIG Reports Unimplemented for Over 3 Years

VA management officials are required to provide the OIG with documentation showing the completion of corrective actions taken on OIG reports. In the majority of cases, program offices provide us with the actions required to implement the reports in a reasonable period. However, we are concerned about seven OIG reports that were issued in FY 98 and earlier that remain unimplemented. VHA has four reports (one report issued in each of FYs' 94, 96, 97, and 98), and VBA has three reports (one report issued in FY 97 and two reports issued in FY 98).

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

Background

In one form or another, American governments have provided veterans benefits since before the Revolutionary War. VA's historic predecessor agencies demonstrate our Nation's long commitment to veterans.

The Veterans Administration was founded in 1930, when Public Law 71-536 consolidated the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers.

The Department of Veterans Affairs was established on March 15, 1989, by Public Law 100-527, which elevated the Veterans Administration, an independent agency, to Cabinet-level status.

Mission

VA's motto comes from Abraham Lincoln's second inaugural address, given March 4, 1865, "to care for him who shall have borne the battle and for his widow and his orphan." These words are inscribed on large plaques on the front of the VA Central Office building on Vermont Avenue in Washington, DC.

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

VA Central Office
810 Vermont Avenue, NW, Washington, DC

Organization

VA has three administrations that serve veterans:

- Veterans Health Administration (VHA) provides health care,
- Veterans Benefits Administration (VBA) provides benefits, and
- National Cemetery Administration (NCA) provides interment and memorial services.

To support these services and benefits, there are six Assistant Secretaries:

- Management (Budget, Finance, Acquisition and Materiel Management),
- Information and Technology,
- Policy and Planning,
- Human Resources and Administration (Equal Opportunity, Human Resources Management, Administration, Security and Law Enforcement, and Resolution Management),

- Public and Intergovernmental Affairs, and
- Congressional and Legislative Affairs.

In addition to VA's Office of Inspector General, other staff offices providing support to the Secretary include the Board of Contract Appeals, the Board of Veterans' Appeals, the Office of General Counsel, the Office of Small and Disadvantaged Business Utilization, the Centers for Minority Veterans and for Women Veterans, and the Office of Employment Discrimination Complaint Adjudication.

Resources

While most Americans know that VA exists, few realize that it is the second largest Federal employer. For FY 2001, VA employed approximately 205,900 employees and had a $47.5 billion budget. There are an estimated 25 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state of the union, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 188,000 of VA's employees work in the health care system. Health care is funded at $20.6 billion, approximately 43 percent of VA's budget in FY 2001. VHA provides care to an average of 57,000 inpatients daily. During FY 2001, slightly more than 41 million episodes of care are estimated for outpatients. There are 172 hospitals, 781 outpatient clinics, 135 nursing home units, 206 Vietnam veterans centers, and 43 domiciliaries.

Veterans benefits are funded at $26.1 billion, almost 55 percent of VA's budget in FY 2001. Over 11,800 VBA employees provide benefits to veterans and their families. About 2.6 million veterans and their beneficiaries receive compensation benefits valued at $20 billion. Also, over $3 billion in pension benefits are provided to veterans and survivors. VA life insurance programs have 4.4 million policies in force with a face value of over $556 billion. Almost 250,000 home loans will be guaranteed in FY 2001, with a value of almost $30 billion.

The National Cemetery Administration currently operates and maintains 119 cemeteries and employed over 1,400 staff in FY 2001. Operations of NCA and all of VA's burial benefits account for approximately $323 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 86,400 estimated for FY 2001. Approximately 349,000 headstones and markers will be provided for veterans and their eligible dependents in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General (OIG)

Background

VA's OIG was administratively established on January 1, 1978, to consolidate audit, investigation, and related operations into a cohesive, independent organization. In October 1978, the Inspector General Act (Public Law 95-452) was enacted, establishing a statutory Inspector General (IG) in VA.

Role and Authority

The Inspector General Act of 1978 states that the IG is responsible for: (i) conducting and supervising audits and investigations; (ii) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of VA; and (iii) keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action.

Organization

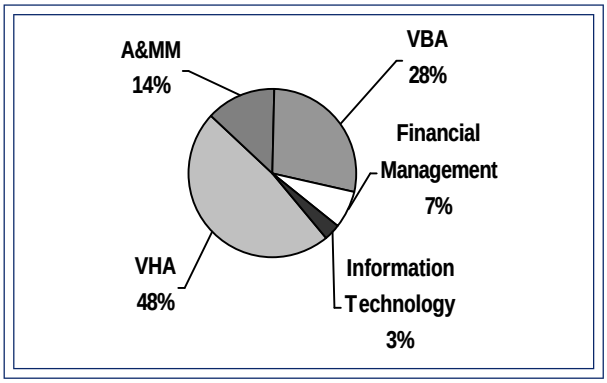
Allocated full time equivalent (FTE) for the FY 2001 staffing plan was as follows:

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	5
Investigations	108
Audit	166
Management and Administration	52
Healthcare Inspections	34
Total	**369**

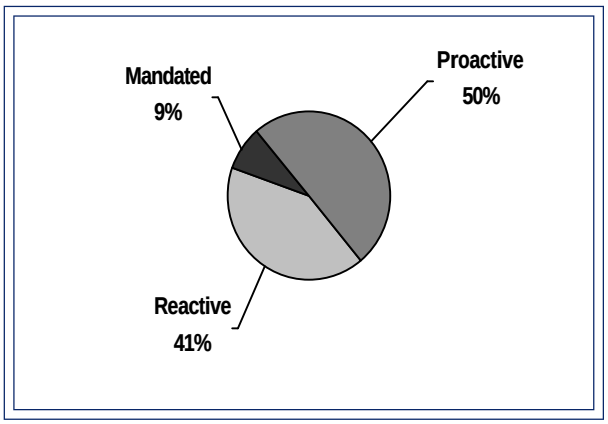
In addition, 24 FTE are reimbursed for a Department contract review function.

FY 2001 funding for OIG operations is $48.9 million, with $46.3 million from appropriations and $2.6 million through reimbursable agreements. Approximately 75 percent of the total funding is for salaries and benefits, 5 percent for official travel, and the remaining 20 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

The percent of OIG resources, which have been devoted during this semiannual reporting period to VA's major organizational areas, are indicated in the following chart.



The following chart indicates the percent of OIG resources which have been applied to mandated, reactive, and proactive work.



Mandated work is required by law and the Office of Management and Budget (OMB); examples are our audits of VA's consolidated financial statements, follow up activities, and Freedom of Information Act information releases.

Reactive work is generated in response to requests for assistance received from external sources concerning allegations of fraud, waste, abuse, and mismanagement. Most of the work performed by the Office of Investigations is reactive.

Proactive work is self-initiated, focusing on areas where the OIG staff determines there are significant issues; some healthcare inspections and most audits fall into this category.

TechWorld, home to the VA Office of Inspector General

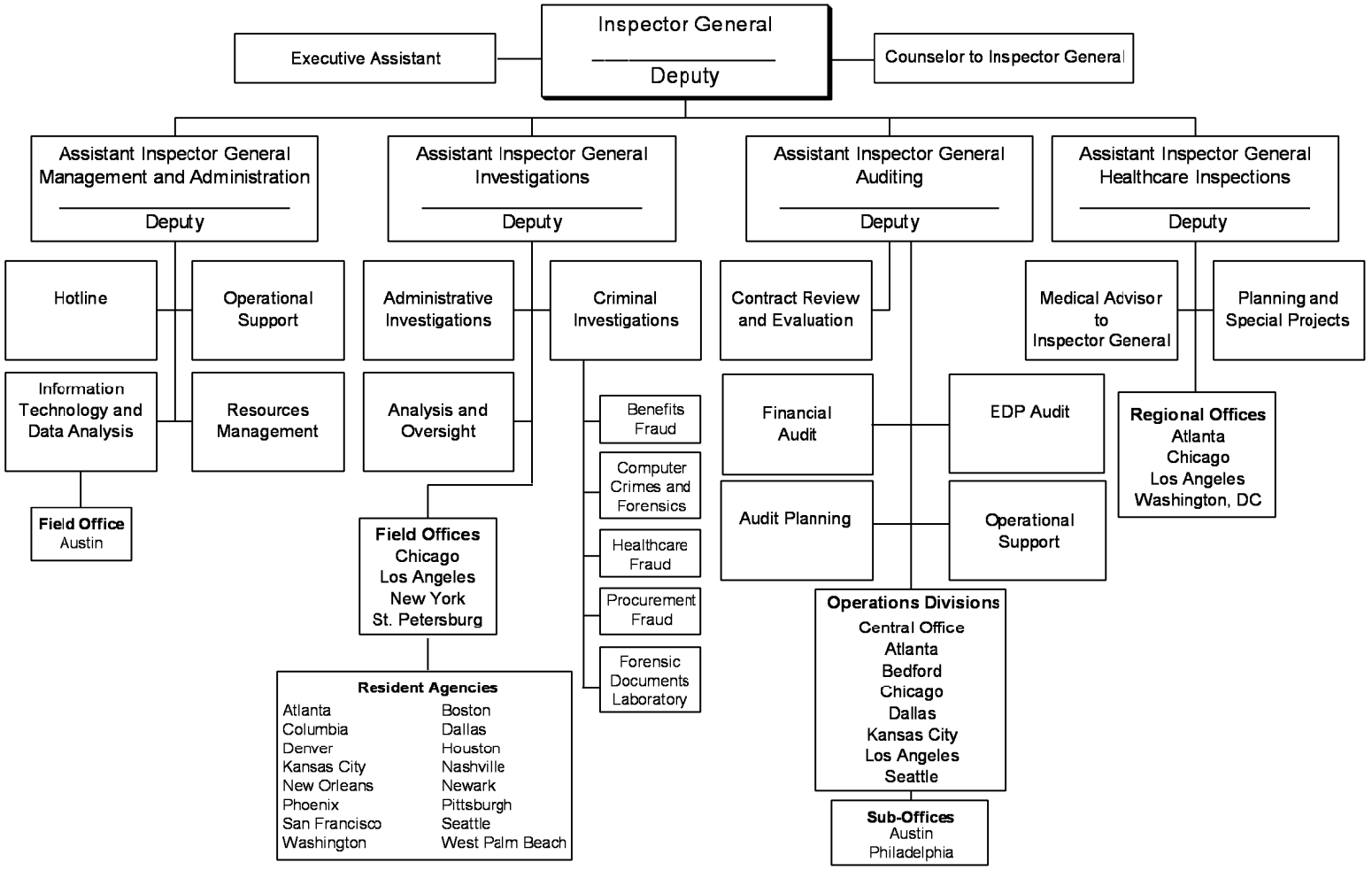
OIG Mission Statement

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

In performing its mandated oversight function, the OIG conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter fraud, waste, abuse, and mismanagement. The OIG's oversight efforts emphasize the goals of the National Performance Review and the Government Performance and Results Act (GPRA) for creating a Government that works better and costs less. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer driven and results oriented.

The OIG will keep the Secretary and the Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, the staff of the OIG will strive to be leaders and innovators, and perform their duties fairly, honestly, and with the highest professional integrity.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL



COMBINED ASSESSMENT PROGRAM

Combined Assessment Program Overview - Medical

The Combined Assessment Program (CAP) is part of the OIG's effort to ensure that quality health care service is provided to our Nation's veterans. CAP reviews provide cyclical oversight of VA medical facility operations; focusing on the quality, efficiency, and effectiveness of service provided to veterans.

The CAP combines the skills and abilities of the OIG's major components to provide collaborative assessments of VA medical facilities. The OIG team consists of representatives from the Offices of Healthcare Inspections, Audit, and Investigations. They provide an independent and objective assessment of key operations and programs at VAMCs on a recurring basis.

Healthcare inspectors conduct proactive reviews to evaluate care provided in VA health care facilities and procedures for ensuring the appropriateness and safety of patient care. The facilities are evaluated to determine the extent to which they are contributing to VHA's ability to accomplish its mission of providing high quality health care, improved patient access to care, and high patient satisfaction. Their effort includes the use of standardized survey instruments.

Auditors conduct a review to ensure management controls are in place and operating effectively. Auditors assess key areas of concern which are derived from a concentrated and continuing analysis of VHA, Veterans Integrated Service Network (VISN), and VAMC databases and management information. These areas include patient management, credentialing and privileging, agent cashier activities, data integrity, and the medical care cost fund.

Special agents conduct fraud and integrity awareness briefings. The purpose of these briefings is to provide key staff located at VAMC with insight into the types of fraudulent activities that can occur in VA programs. The briefings include an overview and case-specific examples of fraud affecting health care procurements, false claims, conflict of interest, bribery, and illegal gratuities. Special agents also investigate certain matters which have been referred to the OIG by VA employees, members of Congress, veterans, and others.

The following is a summary of the nine medical CAP reports completed during the period October 1, 2000 through March 31, 2001. (See Appendix A for listing of CAP reviews issued during the period.) During these on-site CAP visits, the Office of Investigations conducted 35 fraud and integrity briefings for approximately 1,200 employees.

Our reviews identified the following areas requiring the attention of VHA management:

- Staffing.
- Compliance with VHA clinic waiting time goals.
- Documentation of physician-patient encounters and current procedural terminology codes in patient medical records.
- Employee morale.
- Maintenance and cleanliness of health care system facilities.
- Controlled substances documentation in the medical records.
- Clinic and pharmacy waiting times.

- Physicians credentialing, privileging, and background checks.

- Quality management.

- Compliance with VHA's national pain management strategy.

- Oversight of the community nursing home program.

- Means testing to determine eligibility for VA services.

- Supply inventory management.

- Negotiation and administration of clinical service contracts.

- Accountability over controlled substances.

- Controls over the Government purchase card program.

Combined Assessment Program Overview - Benefits

In FY 2001, we expanded our CAP program services to include coverage of the VBA programs. These reviews are similar to CAPs of medical facilities but focus on the delivery of benefits to veterans and their dependents.

Auditors conduct a review to ensure that management controls are in place and working effectively. Healthcare inspectors and investigators assess key areas of concern derived from a concentrated and continuing analysis of VBA, VA regional office (VARO), and management information. These areas may include compensation and pension claims processing, loan guaranty service, vocational rehabilitation and counseling service, fiduciary service, fraud prevention and detection, and information security. During the reporting period we issued one CAP report on the delivery of benefits.

VARO Boston, MA

We concluded that the VARO's administrative activities were generally operating satisfactorily and management controls over benefits delivery were generally effective. However, to improve compensation and pension claims processing, we made the following recommendations to VARO management: (i) ensure the veterans service center staff timely review incoming claims and initiate required claims development, and make reasonable efforts to determine proper addresses when VA mail sent to beneficiaries is returned as undeliverable; and (ii) implement overpayment prevention practices.

We also identified opportunities for management to improve the automated information system and records security. We recommended the VARO management ensure that: (i) a high-level risk assessment is completed; (ii) security awareness and ethics training are conducted annually; (iii) Benefits Delivery Network (BDN) multiple user identification codes are eliminated; (iv) physical security is improved over BDN terminals logged on to the BDN shell; (v) BDN security logs are reviewed and violations addressed; (vi) access to the station's network server is controlled; and (vii) claims files of veteran-employees are identified and properly secured.

VARO management corrected many of these areas during our review. The Director concurred with the recommendations and provided acceptable implementation plans.

OFFICE OF INVESTIGATIONS

Mission Statement

Conduct investigations of criminal activities and administrative matters affecting the programs and operations of VA in an independent and objective manner, and assist the Department in detecting and preventing fraud and other violations.

The Office of Investigations is responsible for conducting criminal and administrative investigations affecting the programs and operations of VA. The office consists of three divisions.

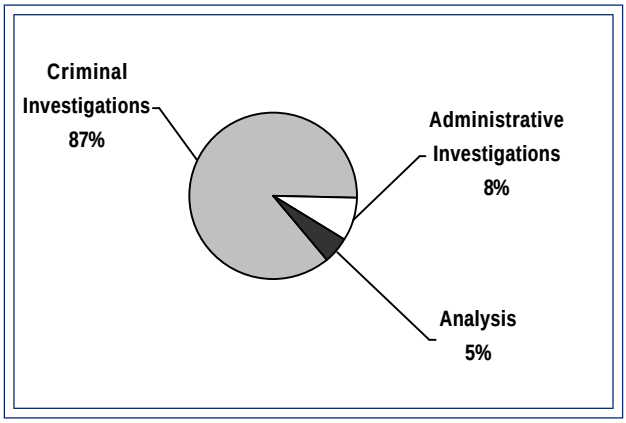
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible for operation of the forensic document laboratory.

II. Administrative Investigations Division - The Division is responsible for investigating allegations, generally against high-ranking VA officials, concerning misconduct and other matters of interest to the Congress and the Department.

III. Analysis and Oversight Division - The Division is responsible for the oversight responsibilities of all Office of Investigations operations through a detailed, recurring inspection program. The Division is the primary point of contact for law enforcement communications through the National Crime Information Center, the National Law Enforcement Telecommunications System, and the Financial Crimes Criminal Enforcement Network.

Resources

The Office of Investigations has 108 FTE allocated to the following areas.



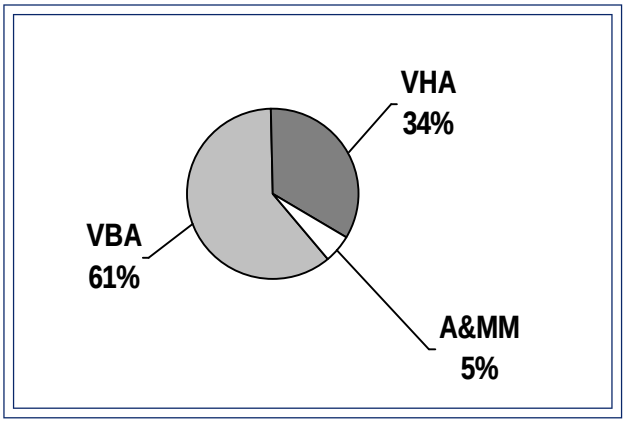
I. CRIMINAL INVESTIGATIONS DIVISION

Mission Statement

Conduct investigations of criminal activities affecting the programs and operations of VA in an independent and objective manner, and assist the Department in detecting and preventing fraud and other criminal violations.

Resources

The Criminal Investigations Division has 94 FTE for its headquarters and 20 field locations. These individuals are deployed in the following program areas:



Overall Performance

Output

- 322 investigations were concluded during the reporting period.

Outcome

- Arrests - 215
- Indictments - 201
- Convictions - 172
- Monetary benefits - $26.7 million ($16.3 million - fines, penalties, restitutions, and civil judgements; $6.4 million - efficiencies/funds put to better use; and $4.0 million - recoveries)
- Administrative sanctions - 192

Cost Effectiveness

- The average cost of conducting the 322 closed investigations was $4,415. Each investigation averaged a return of $59,783, resulting in approximately $13 returned for every $1 spent.

Timeliness

- Work days from receipt of allegation to initiation of an investigation averages 45 days.
- Average work days from initiation of investigation to referral to an assistant U.S. attorney was 220 days.

Customer Satisfaction

- Customer satisfaction survey forms were provided to each prosecutor upon referral of an investigation for criminal prosecution. All ratings received were 5.0 out of a possible 5.0 (5.0 means highly satisfied and 1.0 means dissatisfied).

Following are summaries of some of the investigations conducted during the reporting period by VA component. We discuss VHA, VBA, Board of Veterans' Appeals, and Office of Human Resources and Administration. This is followed by the OIG forensic document laboratory summary.

Veterans Health Administration

Fraud and other criminal activities committed against VHA include actions such as patient abuse, theft of Government property, drug diversion, bribery/kickback activities by employees and contractors, false billings, and inferior products.

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value. Working closely with VA police the office has placed an increased emphasis on crimes occurring at VA facilities throughout the nation to help ensure safety and security for those working in or visiting VA medical centers.

Suspicious Patient Deaths/Murder

- A former VAMC nurse was convicted of three counts of first degree murder, one count of second degree murder, four counts of assault with intent to commit murder, and one count of assault with intent to commit bodily injury. This conviction resulted from a 5 year investigation by VA OIG and state police. The jury deliberated 12 days before reaching its decision. The former VAMC nurse was convicted of killing and/or assaulting patients

by injecting them with a lethal dose of epinephrine during the time of her VAMC employment from 1995 to 1996. She was sentenced to life in prison without parole.

- A physician pleaded guilty in a county court to killing one of his patients, a 19-year-old at a university hospital, in January 1984. The guilty plea for aggravated murder was the result of a review of hospital records conducted by VA OIG special agents who were investigating the doctor's role in the deaths of veteran patients at a VAMC. Suspicions were aroused when a review of the university hospital patient's medical records disclosed similarities to the deaths of the veterans, with documentation in both cases reflecting elevated potassium levels resulting from injections given prior to death. The doctor admitted in court to injecting the university hospital patient with a deadly dose of potassium while he was employed as an intern at that hospital. The doctor previously pleaded guilty in Federal court to killing three patients at a VAMC as well as attempting to kill other patients both in the U.S. and in Africa. The doctor was subsequently sentenced to three consecutive life terms in prison for his involvement in the VAMC deaths. Pursuant to the guilty plea for the patient's death, the doctor was sentenced to life in prison that will run concurrently with his Federal sentence.

Employee Integrity

Theft/Diversion of Pharmaceuticals

- A former VAMC pharmacy technician pleaded guilty to theft of Government property and conspiracy. A second individual, who owned and operated a private pharmacy, pleaded guilty to similar charges. Three other VAMC pharmacy technicians, who were also indicted on multiple counts of theft and conspiracy, are awaiting further judicial action. The guilty pleas were the result of a joint investigation by the VA OIG and the U.S. Food and Drug Administration (FDA), Criminal Investigations Division. The investigation disclosed that, for approximately 3 years, the four VAMC employees conspired to remove large amounts of non-controlled pharmaceutical drugs from the VAMC pharmacy and exchanged these drugs for cash with the private pharmacy owner, who then sold them to the public. Loss to the Government exceeded $1.3 million.

- Three VAMC pharmacy technicians were arrested and charged with conspiracy and theft of Government property after a VA OIG investigation disclosed the three technicians, along with a fourth technician and a veteran, were involved in the diversion of prescription drugs from the VAMC outpatient pharmacy. The fourth technician and the veteran previously were arrested on the same charges. Investigation showed the employees routinely withdrew a prescription anti-anxiety drug from the VA pharmacy drug vault and diverted the drug to the veteran who was reselling it. The diverted pharmaceuticals were valued at approximately $100,000. The technicians admitted for a 1 year period, each person stole from 300 - 2,000 pills a week that had a street value of approximately $250,000.

- A VA pharmacy technician was arrested on felony charges of possession of diazepam (Valium) with intent to distribute. The individual was in possession of 1,000 tablets of Valium that she stole from a VAMC. The arrest was made as a result of information obtained from a co-conspirator who was previously arrested. This is a joint investigation involving VA OIG, FDA, Drug Enforcement Administration, state police, and a state narcotics task force.

- A former VA registered nurse was sentenced to 24 months' probation and ordered to pay restitution to VA. The individual was previously convicted of one count each of fraudulent acquisition of a controlled substance and theft of public property. An investigation disclosed the individual diverted 12,842 mg of morphine and 1,540 mg of percocet for his personal use while employed at a VAMC.

- A former VAMC nurse entered into an agreement for pre-trial diversion after admitting she stole VA pharmaceuticals. A joint VA OIG and VA police investigation revealed the former employee stole controlled narcotics, meperidine (Demerol) and morphine, over an 18-month period. The employee admitted to injecting these narcotics on a daily basis which she obtainedby failing to give VA patients their full dosage, or removing the narcotics from vials and then replacing the same amount with saline solution. The stolen VA pharmaceuticals had an approximate street value of $215,000. The employee voluntarily entered a drug treatment program for chemical dependency.

- A former VAMC pharmacy technician pleaded guilty to theft of Government property and conspiracy, pursuant to a plea agreement. The individual's guilty plea resulted from a joint VA OIG investigation with the FDA which determined that over the past 3 years, the individual and two co-workers conspired to divert large amounts of noncontrolled pharmaceutical drugs from the VAMC pharmacy where they were employed. The trio then exchanged the drugs for cash from a fourth individual who sold the drugs to the public from his privately owned pharmacy. The co-conspirators and the pharmacy owner are awaiting further adjudication. Loss to the Government is over $1.3 million.

Theft and Embezzlement

- A VAMC accounting technician pleaded guilty to a criminal information charging him with embezzling public money. A joint investigation by the VA OIG and VA police disclosed the individual had U.S. Treasury checks wrongfully issued in his name, taking advantage of his position to defraud the veterans' co-payment refund program of more than $7,500. He proceeded to cash the checks and use the money to pay personal debts. The individual subsequently confessed to the scheme during the course of the investigation. A sentencing date is pending.

- A former VA employee pleaded guilty to a felony theft charge and was subsequently sentenced to 2 years' probation and ordered to pay $5,000 in restitution. A VA OIG investigation determined the individual, who served as treasurer of the VA employees' association, misappropriated over $10,000 from the association account into her personal bank account. The investigation also determined the individual had purchased numerous computer accessories and other items for her personal use using the Government purchase card.

- A VAMC health care technician was arrested and charged with three felony counts of forgery and one felony count of theft by deception. A joint investigation by the VA OIG and VA police disclosed that, on three occasions, the employee entered the room of an elderly veteran patient who resided at the VAMC's extended care center while the patient was sleeping and removed blank checks from his checkbook. The employee then forged and negotiated the checks, resulting in a loss of $4,500 to the veteran. At the time of the theft, the employee was out on bond for a separate criminal narcotics charge.

- A former VAMC student trainee and his brother were both indicted for conspiracy to commit credit card fraud. The indictment followed a joint investigation between the VA OIG and U.S. Postal Inspection Service regarding allegations the student trainee was fraudulently obtaining credit cards using the names and personal information of VA employees. The individual would generally use convenience checks to withdraw funds from these credit card accounts. The checks were deposited into the bank accounts of both brothers. Approximately $43,000 in fraudulent charges was made on the credit card accounts.

Theft of Government Property

- A former VAMC medical administration service lead clerk pleaded guilty to one count of theft of Government property. Investigation determined the individual had instructed a fee basis contractor that

had been overpaid by VA to refund the VAMC by making two checks, totaling $5,424, payable to himself in care of VA. The individual then deposited the funds in his girlfriend's bank account and proceeded to use the money for his own use.

- Three individuals employed at a VAMC canteen and one VAMC homeless program employee were each charged for unlawfully removing Government property from the VAMC canteen warehouse and retail store. The charges were the result of a joint VA OIG and VA police investigation into the theft of canteen products. A recent internal VAMC canteen audit identified that an estimated loss of $216,000 occurred during calendar year 2000.

Workers' Compensation Benefits Fraud

A former licensed practical nurse at a VA medical and regional office center was sentenced to 6 months' home detention with electronic monitoring, 60 months' probation, and ordered to pay jointly with her husband $37,479 in restitution to the Department of Labor, Office of Workers' Compensation Programs. Her husband was sentenced to 60 months' probation and ordered to make the joint restitution. The nurse previously had been indicted on one count of false statements to obtain Federal workers' compensation benefits. Her husband had been indicted on charges of aiding and abetting. A VA OIG investigation disclosed the two failed to disclose the wife's involvement in her husband's aluminum siding and windows business while she received workers' compensation benefits for an inability to work due to an injury. At the 4-day trial, the nurse and her husband were each found guilty of their respective charge. At the time of the guilty verdict, the nurse's employment was terminated.

Credit Card Fraud

- An individual formerly employed as a VAMC grounds maintenance supervisor was arrested and charged with theft of Government property. A joint investigation by the VA OIG and VA police disclosed the individual, using his assigned Government credit card, wrongfully purchased items solely intended for personal use. The individual confessed to his acts during the course of the investigation, relinquished the items purchased that were still in his possession, and resigned from his employment. A trial date is pending.

- A VAMC clerk pleaded guilty to charges of larceny and was sentenced to 5 years' suspended sentence, 5 years' probation, ordered to pay $7,284 restitution, serve 100 hours' community service, and submit to drug evaluation and counseling. A joint investigation by the VA OIG, VA police, and General Services Administration OIG disclosed the individual misused a Government fleet service credit card to make unauthorized purchases of $7,280.

False Statements

A VAMC pipe-fitter, who also served as vice-president of the local American Federation of Government Employees union, was charged with one count of forgery of records and one count of uttering or publishing false records. A joint investigation by the VA OIG, VA police, and Federal Bureau of Investigation (FBI) disclosed the individual and other union members devised a scheme, alleging that a VA police detective fabricated evidence against another VAMC employee by altering a witness' written statement relating to an alleged assault that took place at the VAMC. As evidence in the scheme, union members provided the VA OIG with witness statements which contained inconsistent signatures and alleged the detective had forged one of the statements. Investigation disclosed the VA detective did not forge or otherwise alter evidence. The VA OIG forensic laboratory determined the forged signature was actually authored by the pipe-fitter.

Other Employee Misconduct

An individual pleaded guilty to a four count indictment charging her with committing bank fraud. An investigation disclosed the individual opened a credit union account which she used to deposit over $34,000 in stolen and forged checks belonging to a disabled veteran living in a VA nursing home.

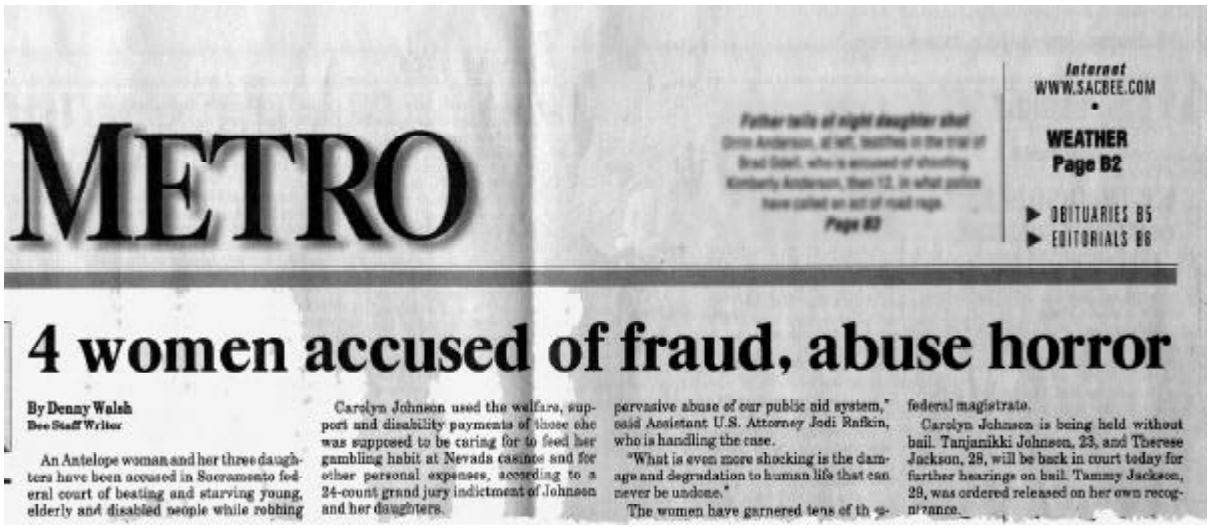
Abuse of Veterans by Caregivers

Four individuals were indicted and charged with fraud, witness tampering, and illegal possession of a firearm. Three of the individuals were arrested pursuant to the indictment and the fourth individual was already in custody. A joint investigation by the VA OIG; Social Security Administration (SSA) OIG; Bureau of Alcohol, Tobacco, and Firearms; U.S. Postal Inspection Service; and local authorities disclosed the individuals engaged in a scheme to commit fraud, make false claims, and embezzle funds belonging to VA and SSA benefits recipients who were deemed incompetent to handle their own affairs. The individual already in custody, a caretaker for incompetent veterans, used her position to misappropriate VA and SSA benefits payments intended for her wards, as well as to engage in other fraudulent activities. Two of her wards, a veteran judged incompetent to handle his own affairs and another ward in receipt of SSA benefits, died while in her care. The caretaker had a prior conviction for elder abuse. Search warrants executed on the caretaker's residence and the residences of her three daughters disclosed evidence of illegal firearms possession and evidence that fraud had been committed. Another disabled veteran in her care, who was to be a witness in the criminal investigation, was taken into protective custody by VA OIG and county adult protection services employees after it was alleged that the caretaker had abused him in order to prevent his testifying against her. The disabled veteran was taken to a VA urgent care clinic where an examination corroborated witness accounts that the caretaker recently had beaten the veteran. The caretaker allegedly instructed the disabled veteran to make false statements to the grand jury, resulting in the witness tampering charges filed against her.

Theft/Diversion of Pharmaceuticals (non-employee)

- An individual was sentenced to time served, 2 months' supervised release, and to pay a $200 special assessment. The individual previously had

The Sacramento Bee, Wednesday, October 4, 2000



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4 women accused of fraud, abuse horror

By Denny Walsh
Bee Staff Writer

An Antelope woman and her three daughters have been accused in Sacramento federal court of beating and starving young, elderly and disabled people while robbing

Carolyn Johnson used the welfare, support and disability payments of those she was supposed to be caring for to feed her gambling habit at Nevada casinos and for other personal expenses, according to a 24-count grand jury indictment of Johnson and her daughters.

pervasive abuse of our public aid system," said Assistant U.S. Attorney Jodi Rafkin, who is handling the case.

"What is even more shocking is the damage and degradation to human life that can never be undone."

federal magistrate.

Carolyn Johnson is being held without bail. Tanjanikki Johnson, 23, and Therese Jackson, 28, will be back in court today for further hearings on bail. Tammy Jackson, 29, was ordered released on her own recognizance.

pleaded guilty to two counts of obtaining a controlled substance by fraud, deceit, or forgery. A VA OIG investigation disclosed the individual stole a prescription pad from a VAMC emergency room doctor, forged a doctor's prescription, and obtained 120 narcotic tablets from the pharmacy. The individual also stole a prescription pad and doctor's name stamp from another VAMC physician and used these items to forge another prescription for 120 additional narcotic tablets.

- Two VA patients were each sentenced to 60 months' probation. This sentence resulted from a 3-month undercover joint investigation by VA OIG and VA police that disclosed the two patients sold their prescription narcotics, primarily percocet and morphine, to VA employees and others.

Possession of Illegal Drugs on VAMC Property

Two individuals pleaded guilty to one count each of illegally distributing heroin after being arrested and indicted on charges of distributing heroin on VAMC grounds. The guilty pleas resulted from a joint investigation by the VA OIG, VA police, and FBI into heroin distribution schemes operating on VAMC grounds. The investigation disclosed the two individuals, both of whom were in the VAMC methadone maintenance treatment program, sold heroin to fellow patients enrolled in the program. One individual was sentenced to 12 months' imprisonment and 3 years' probation. The second individual was sentenced to 24 months' imprisonment and 3 years' probation.

Theft of Government Property

- An individual who operated as a medical equipment dealer was arrested and charged with dealing in stolen property. A joint investigation by the VA OIG, FDA, and local police disclosed the individual knowingly engaged in a scheme to purchase medical equipment stolen from a VAMC. He then arranged to broker the stolen merchandise through his medical supply company, selling the stolen items to a Medicare recipient and billing Medicare for the cost. The stolen property was recovered and the investigation is continuing.

- Five individuals were arrested and charged with participating in a scheme to steal U.S. Treasury checks from the U.S. mail. A joint investigation by the VA OIG, U. S. Postal Inspection Service, U. S. Secret Service, and local agencies disclosed that a Postal Service employee stole checks before they could be delivered to the addressees. Accomplices manufactured fraudulent identification documents in order to cash the stolen checks. The thefts included payroll checks issued to VAMC employees.

Theft of Other Property

- An individual was arrested on charges of conducting a fraudulent scheme and identity theft. The individual was found to be in possession of computer equipment purchased using the personal identifying information of several VA employees. The individual's boyfriend was also arrested and charged with possession of stolen property. A search of the couple's apartment uncovered multiple credit cards in various names and counterfeit retail gift certificates.

- A VAMC detective advised that his office had received complaints from a number of employees that personal credit cards had been stolen from their workspaces. During preliminary inquiries, the detective identified a female as one of several subjects involved in the credit card thefts and requested VA OIG assistance. The VA OIG special agents and the U.S. Secret Service joined in the investigation. Subsequent inquiries determined the stolen cards were used to purchase cigarettes and other items at local retail stores. A store employee who conducted one of the transactions involving a stolen credit card advised that she personally knew the female who had made the purchase and identified the subject by name. Based on the information received, the detective obtained an arrest warrant for the individual charging her with theft. The individual was subsequently arrested.

- The nephew of a quadriplegic veteran who resides at a VAMC spinal cord injury unit was arrested based on a criminal complaint charging him with bank fraud. A joint investigation by the VA OIG and VA police disclosed the nephew obtained the veteran's personal identification number to his automated teller machine card while assisting the veteran with a financial transaction. The nephew later stole the card from the veteran's room at the VAMC and used it to steal more than $5,000 from the veteran's bank account. Further judicial actions are pending.

- An individual was indicted on one count of wire fraud after being arrested pursuant to statements he made and evidence that was disclosed when a search warrant was executed on his residence. The search warrant disclosed evidence that he had hacked into a computer system that ran the telephones at a number of locations, including a VAMC. A joint investigation by the VA OIG, General Services Administration OIG, U.S. Secret Service, and a state electronic crimes task force disclosed the individual gained access to toll free numbers that he sold to others for use in making long distance calls. Approximately 17 telephone systems were hacked. The total loss to all affected companies was more than $341,000, with a loss of more than $11,600 to VA.

Apprehension of Fugitives

- In response to a request for assistance from VAMC authorities, VA OIG initiated a project to address drug trafficking and related problems. The VAMC police identified a number of potential subjects. A routine background inquiry on one subject determined he was wanted for a probation violation. VA OIG special agents tracked the individual, a former VAMC residential patient, to an adult group home. After coordinating the warrant with the local police, OIG agents and the local police apprehended the subject without incident.

- VA OIG special agents in cooperation with VAMC police and the U.S. Marshal's Service conducted a review of outstanding arrest warrants issued for individuals who had committed crimes at a VAMC. One of the individuals was wanted for failure to appear in two cases in connection with assaulting a VA police officer and disorderly conduct. The agents located and apprehended him.

Misappropriation of Union Funds

An individual formerly employed as secretary-treasurer for an American Federation of Government Employees union office located at a VAMC was sentenced to 3 years' probation and ordered to pay $192,000 restitution. The individual previously pleaded guilty to a three count criminal information charging that he participated in a conspiracy to commit mail fraud, submitted a false personal income tax return, and possessed a firearm in a Federal facility. A joint investigation by the VA OIG, Department of Labor, and Internal Revenue Service (IRS) disclosed the individual issued union checks to himself and third parties for their personal benefit. He then made false statements in annual reports to the Department of Labor to conceal the misappropriation of funds. Total amount of misappropriated funds was approximately $190,000.

Procurement Fraud

A medical supply company pleaded guilty to a criminal information charging it with introducing into interstate commerce a misbranded medical device, failing to furnish appropriate notifications to the FDA, and submitting false reports to the FDA with respect to a medical device. As part of the sentencing, which occurred simultaneously, the company was ordered to pay a criminal fine of $29.4 million, civil penalties of $30.6 million, and was placed on probation for a period of 3 years. A joint investigation by the VA OIG, FDA, Department of Health and Human Services OIG, Defense Criminal Investigative Service, and FBI disclosed the company manufactured and

distributed a glucose monitoring system that had known defects that would cause glucose meters to display problematic readings. The company admitted that it failed to describe the two defects in its submissions for FDA clearance to market the blood glucose monitors. VA purchased more than $346,000 worth of the defective products for use in the VA health care system.

Contract Fraud

- An individual, who operated as owner and president of a medical lab company, pleaded guilty to a 24-count indictment charging her with misrepresenting the company as a Government contractor, mail fraud, making false statements to the Government, and bankruptcy fraud. She had previously been arrested after a joint investigation by the VA OIG, FBI, Defense Criminal Investigative Service, Army Criminal Investigative Division, and U.S. Agency for International Development disclosed she made false statements to the Government certifying that medical products were made in the U.S. The company had been awarded a $64,000 VAMC contract based on the false claim that the company was an authorized distributor of medical products for another health care firm. That false statement resulted in default of the contract and monetary loss to VA. The company failed to provide products, failed to provide proper amounts of the products, and failed to provide the products in a timely manner that ultimately had an adverse effect on patient care. Further fraudulent activities included misrepresenting personnel from the company as Government officials and making false statements that resulted in duplicate payments and contractual defaults.

- A criminal information was filed in U.S. District Court charging the co-owner of a construction company with conspiracy to fraudulently use the U.S. mail for personal gain and with making false statements to the Government. A joint investigation by the VA OIG, Small Business Administration, and Naval Criminal Investigative Service disclosed the individual, whose companies contracted with VA and the U.S. Navy to perform construction work on facilities, defaulted on a number of the contracts and used the mail to divert hundreds of thousands of dollars in payments that were designated for numerous sub-contractors. The actions of this individual and another co-owner of the construction company resulted in a $3.2 million loss suffered by a bonding company when the contracts were defaulted. The investigation further disclosed the individual made false statements to the Government by certifying to the Small Business Administration that he was the sole owner of the construction company. Judicial actions are pending against other individuals involved in the conspiracy.

Travel Benefits Fraud

- A VAMC outpatient was arrested on charges that he received travel benefits to which he was not entitled. A joint investigation by the VA OIG and local police disclosed the individual provided a fictitious residential address to VA indicating that he lived farther from the VAMC than he actually did, in order to obtain increased travel reimbursements in cash. Total loss to VA was more than $12,000 through the submission of more than 340 fraudulent travel vouchers.

- An individual was arrested and pleaded guilty to charges of grand theft after a joint investigation by the VA OIG and VA police disclosed that he filed fraudulent travel reimbursement vouchers. Investigation showed the individual submitted travel vouchers for travel to a VAMC, claiming that he lived farther away from the VAMC than he actually did, in order to obtain more than $5,700 in travel reimbursement benefits to which he was not entitled.

- An individual entered a guilty plea to one count of theft by taking and was sentenced to 6 months' imprisonment, 114 months' probation, and ordered to pay probation fees and restitution of $29,600. The sentencing was the result of a joint

investigation by VA OIG and local police that disclosed the individual, a VAMC outpatient, filed false documents in order to receive travel benefits to which he was not entitled. The individual provided fictitious residential addresses to VA alleging that he lived farther from the VAMC than he actually did, in order to obtain increased travel reimbursements in cash. The total loss to VA was in excess of $27,100 through the submission of 657 fraudulent travel vouchers.

Veterans Benefits Administration

VBA provides wide-reaching benefits to veterans and their dependents including pension and compensation payments, home loan guaranty services, and educational opportunities. Each of these benefits programs is subject to fraud by those who wish to take advantage of the system. For example, individuals submit false claims for service connected disability, third parties steal pension payments issued after the unreported death of the veteran, individuals provide false information so that veterans qualify for VA guaranteed property loans, equity skimmers dupe veterans out of their homes, and educational benefits are obtained under false representations. The Office of Investigations spends considerable resources in investigating and arresting those who defraud the benefits operations of VA.

Death Match Project

An ongoing proactive project is being conducted by the VA OIG Information Technology and Data Analysis Division in coordination with the Office of Investigations. The match is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for veterans who have passed away. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. To date the match has identified in excess of 700 possible cases. Over 330 investigative cases have been opened. Investigations have resulted in the actual recovery of $2.1 million, with an additional $6 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $9.5 million. To date, there have been eight arrests on these cases with several additional cases awaiting judicial actions.

Employee Misconduct

Theft and Embezzlement

A former VARO employee and her associate were indicted on multiple counts of theft, mail and wire fraud, and conspiracy. The indictment is the result of a joint investigation by VA OIG and U.S. Postal Inspection Service. The investigation determined that over a 3-year period the employee, in her capacity as a veterans' service officer, created a false veteran payee within VA data systems, subsequently causing VA to issue benefit checks in the name of a fictitious veteran to an address controlled by her associate. The employee then negotiated the checks. As a result, monetary loss to the Government exceeds $229,700.

Procurement Fraud

An individual was sentenced to 5 months' home confinement, 5 years' probation, and was ordered to pay more than $117,000 restitution. The individual previously had pleaded guilty to converting money belonging to VA to his own use. A VA OIG investigation disclosed the individual operated as the pastor of a church and the president of a corporate affiliate of the church, a nonprofit corporation whose purpose it is to improve the quality of life in the church's neighborhood. In August 1996, the corporation applied for a $500,000 "VA homeless providers and per diem" grant, to be used to provide transitional housing and vocational skills to homeless veterans. The corporation's grant application was approved and

in January 1997, VA forwarded $200,000 as the first disbursement of grant funds. The money was to be used for specific purposes which included the purchase and rehabilitation of a building in the neighborhood which was to become a skills center. The investigation determined the building was never purchased and the individual used $117,094 of the grant funds for purposes unrelated to the project, including channeling a portion of the funds into his for-profit real estate business.

Loan Guaranty Program Fraud

Loan Origination Fraud

- A disbarred attorney was sentenced to 27 months' imprisonment, 5 years' probation, and ordered to pay $981,711 restitution to his victims after pleading guilty to a criminal information charging him with mail fraud. A joint investigation by the VA OIG and FBI disclosed he engaged in a scheme to defraud while acting as the closing attorney on real estate purchase and sale transactions. This scheme involved both VA guaranteed loans and non-VA loans. Prior to each closing, the mortgage companies mailed or wired the loan proceeds to the closing attorney. The monies were deposited into the attorney's escrow account. Subsequent to each real estate closing, the attorney mailed documents to the mortgage companies certifying that the loan proceeds had been properly disbursed. The investigation disclosed that for a number of years the attorney delayed paying off mortgages and used the money to pay business and personal expenses. As he closed new loans the money was used to pay off old mortgages. In some instances, the attorney paid the monthly loan payments so the mortgagees would not realize that there were two loans against their property. The scheme was discovered when the attorney's business declined and he was unable to pay off some of the later mortgages. The total theft is more than $936,900.

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Tuesday, February 13, 2001

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Three guilty of defrauding homeowners

By Denny Walsh
Bee Staff Writer

Three people were found guilty Monday by a Sacramento federal judge of scamming desperate homeowners facing foreclosure.

Raymond Hall, 69, of Citrus Heights, and Richard Buschman,

ated the money, she said.

Ultimately, the victims' worst fears were realized – the homes were lost through foreclosure and their credit was destroyed.

"While the victims' losses were not that great compared to other white-collar crimes," she said, "these defendants preyed on very

- Two real estate agents and another individual were found guilty of 10 counts of mail fraud and 1 count of equity skimming. A joint investigation by the VA OIG and FBI disclosed the three defendants promised homeowners facing foreclosures they could stop the foreclosures and salvage their credit ratings by transferring their homes to trusts controlled by the defendants. The defendants rented the properties back to the homeowners or other individuals without paying the outstanding mortgages. The defendants used the rent money they collected for personal expenses. Five of the homeowners had loans guaranteed by VA. Losses to VA in the foreclosures were approximately $150,000. Sentencing is pending.

Property Management Fraud

An individual was sentenced to 60 days' incarceration, 3 years' probation, ordered to complete the court's larceny program, and to complete 16 hours' of community service each month for the term of her probation. The sentence was the result of a joint investigation by the VA OIG and local law enforcement authorities, which

disclosed the individual broke into, and took wrongful possession of, VA foreclosed properties and then leased them to unsuspecting victims.

Other Loan Guaranty Fraud

- Three individuals involved in a loan guaranty fraud scheme pleaded guilty to making false statements to the Government. The first individual worked for a mortgage bank, the second individual operated as a real estate closing attorney, and the third was a property appraiser. All three admitted to taking part in a scheme where property values were deliberately inflated in order to raise the amount of the loan so that delinquent credit debts of the borrower could be paid off. These loans were subsequently insured by the Government, including VA.

- Two individuals each pleaded guilty to a five-count criminal information charging them with bankruptcy fraud, equity skimming, conspiracy, false use of a Social Security number, and making a false statement in a bankruptcy filing. A joint investigation by the VA OIG, Department of Housing and Urban Development, and FBI disclosed the two operated an equity skimming scheme involving hundreds of loans. To stall foreclosure on the properties, the individuals filed bankruptcies in multiple states using fraudulent names and Social Security numbers. Loss to the Government exceeds $3 million. Sentencing is scheduled.

Beneficiary Fraud

Accounting for over 60 percent of the VA OIG investigative case inventory, fraud associated with VA's benefits payments programs leads to numerous arrests and judicial actions. The following are a sampling of these cases conducting during this semiannual period.

Dependency and Indemnity Compensation Benefits Fraud

- An individual pleaded guilty to three counts of theft of Government property. An investigation by the VA OIG disclosed the individual, the daughter of a VA beneficiary, failed to disclose her mother's death to VA and continued to allow VA Dependency and Indemnity Compensation (DIC) benefits to be issued. The individual received and negotiated 53 U.S. Treasury checks totaling $53,393 and deposited the funds into a personal bank account for her own use.

- The daughter of a VA DIC benefits recipient was arrested after a VA OIG and U.S. Postal Inspection Service investigation disclosed she diverted VA benefit payments. Investigation revealed the individual failed to notify VA of the death of her mother. After the mother's death, the individual contacted VA and switched the benefits payment to a direct deposit. For more than 10 years, the individual carried on this fraud causing a loss to VA of $105,276.

- An individual was sentenced to 18 months' imprisonment, 3 years' probation, and ordered to pay $159,348 restitution to VA. The individual had previously pleaded guilty to an indictment charging her with felony theft of Government funds after a VA OIG investigation disclosed that from November 1980 to September 2000, she negotiated U.S. Treasury checks payable to her deceased mother-in-law. The individual failed to notify VA of her mother-in-law's death, forged forms to continue the payments, and converted the money to her own use.

- An individual was arrested pursuant to a criminal complaint charging her with theft of VA benefits. A VA OIG investigation disclosed the individual failed to notify VA of her grandmother's death and continued for more than 6 years to divert DIC benefits checks mailed to her grandmother as

surviving spouse of a deceased veteran. During the course of the 6-year period, the individual completed two marital status questionnaires sent to her grandmother by VA, signing her grandmother's name on both questionnaires in order to continue to receive the DIC checks. Loss to VA was more than $93,000 in benefits wrongfully diverted by the individual.

- The wife of a veteran pleaded guilty to felony charges of first degree arson, insurance fraud, and theft of Government funds. The charges were the result of a joint VA OIG, state insurance fraud agency, and state fire marshal's office investigation. The individual admitted to deliberately setting her home on fire in order to benefit from insurance proceeds and fraudulently receiving VA DIC benefits. The individual is still under investigation for the death of her first husband, a veteran who died in a suspicious house fire. She was sentenced to 10 years imprisonment and ordered to pay fines totaling $6,225.

- An individual was sentenced to 21 months' confinement, 36 months' probation, and ordered to pay $34,400 restitution after pleading guilty to two counts of theft of Government property. The sentencing was a result of a joint investigation by VA OIG and SSA OIG which disclosed the individual failed to report his mother's death to VA and SSA. For more than 20 months after his mother's death, the individual continued to allow VA and SSA benefit payments to be electronically deposited into a joint checking account that he shared with his mother. He used these payments for his personal use.

- An individual was charged in a 10-count criminal indictment with theft of VA benefits. A joint investigation by the VA OIG and SSA disclosed that an anonymous tip indicated the individual was receiving VA benefits to which she was not entitled. Investigation disclosed the individual, who was receiving VA DIC benefits as surviving spouse of a deceased veteran, remarried in 1990 and failed to notify VA. The receipt of DIC benefits terminates upon remarriage. In addition to receiving DIC benefits, the individual also received medical benefits through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) program. Due to her failure to notify VA of her remarriage, she received $81,322 in DIC benefits and approximately $5,000 in CHAMPVA benefits to which she was not entitled.

- An individual pleaded guilty to one count of theft of Government funds. A joint investigation by the VA OIG and FBI disclosed the individual failed to report her mother's death to VA and continued to receive VA compensation benefits checks mailed to her mother, the beneficiary and widow of a veteran. For more than 8 years after her mother's death, the individual forged her mother's signature on the benefits checks and diverted $86,709 for her own personal use.

Pension Benefits Fraud

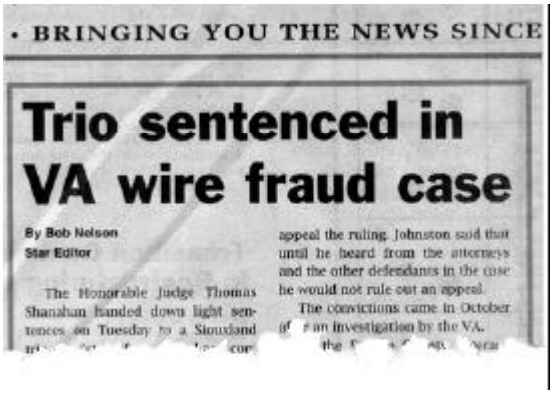
- An individual who previously pleaded guilty to a one count criminal information charging her with fraudulent acceptance of VA benefit payments was sentenced to 60 months' probation and ordered to pay $19,770 in restitution. A VA OIG investigation disclosed the individual, who was entitled to benefits as the widow of a veteran, failed to disclose that she had worked while receiving VA benefits. When she knowingly failed to report her earnings to VA while receiving the benefits, an overpayment of more than $19,200 was created.

- An individual was arrested, indicted and subsequently pleaded guilty to charges of theft and forgery. A joint investigation by the VA OIG and local police disclosed the individual engaged in a scheme to steal a VA pension benefits check of $19,728 from a veteran's mail. The individual duped a local businessman into assisting her with negotiating the stolen check and with his assistance she opened several bank accounts to divert the stolen funds.

- An individual pleaded guilty to one count of wire fraud after a VA OIG investigation uncovered the individual failed to disclose to VA the death of his roommate, a veteran in receipt of VA pension benefits, and continued to allow the benefits to be deposited into a joint checking account bearing both of their names. Through this scheme, the individual diverted more than $51,800 in VA benefits to which he was not entitled.

- Three individuals, a county veterans' service officer, a registered nurse, and the owner of a nursing company, were convicted and sentenced for their participation in a conspiracy and wire fraud scheme to defraud VA. The veterans service officer was sentenced to 1 year probation and ordered to pay $104,500 restitution. The two remaining individuals were each sentenced to 6 months' home confinement, 2 years' probation, ordered to pay $104,500 restitution, and assessed fines and penalties totaling $21,000 each. A VA OIG investigation disclosed the three individuals devised a scheme whereby veterans and widows would submit paperwork to obtain VA pension benefits by reporting unreimbursed medical expenses from the nursing company. Nursing company expenses were created solely to offset each beneficiary's income thereby maximizing VA benefits; the reported nursing company expenses had nothing to do with the level of care being provided. The nursing company then hired a friend or relative of each VA beneficiary to serve as a caregiver, who in many cases provided little or no care. Veterans and caregivers were instructed to have the caregiver slip their nursing company's pay back to the veterans' service officer under the table. The jury determined VA's loss to be $104,500.

South Sioux City Star
Thursday, January 11, 2001



· BRINGING YOU THE NEWS SINCE

Trio sentenced in VA wire fraud case

By Bob Nelson
Star Editor

The Honorable Judge Thomas Shanahan handed down light sentences on Tuesday to a Siouxland

appeal the ruling. Johnston said that until he heard from the attorneys and the other defendants in the case he would not rule out an appeal.

The convictions came in October of an investigation by the VA.

- An individual was indicted on two counts of false statements, 12 counts of wire fraud, and 15 counts of mail fraud. A VA OIG investigation disclosed the individual had been receiving VA widow's pension benefits since 1990 as surviving spouse of a deceased veteran. VA regulations provide that remarriage disqualifies eligibility to such benefits. The investigation disclosed that in applying for the benefits, the individual falsely certified that she had not remarried when, in fact, she had remarried 1 month after the death of the veteran. Also, the VA OIG forensic laboratory determined the individual altered the veteran's original death certificate in order to have it falsely state that she was his wife. Subsequent to the false application, she filed yearly certifications stating that she had remained a widow. As a result of the scheme, the individual received more than $56,600 to which she was not entitled.

- A veteran pleaded guilty to four counts of wire fraud. A joint investigation by the VA OIG and Department of Health and Human Services determined the veteran devised a scheme to hide his employment from VA while collecting VA pension benefits. Using an alias and a false Social Security number, the veteran received benefits to which he was not entitled. Loss to VA is approximately $25,000.

Education Benefits Fraud

- An individual was sentenced to 27 months' imprisonment and ordered to pay $17,000 restitution. The individual used another person's

identity and transcripts to gain admission to a college graduate program, then used his own identity to obtain education benefits from VA. The individual was not eligible for admission to the graduate program on his own because his grades were too low, therefore he defrauded VA into providing educational benefits that he would not otherwise be entitled to. This was a joint investigation with the VA OIG, FBI, SSA, and a local police department.

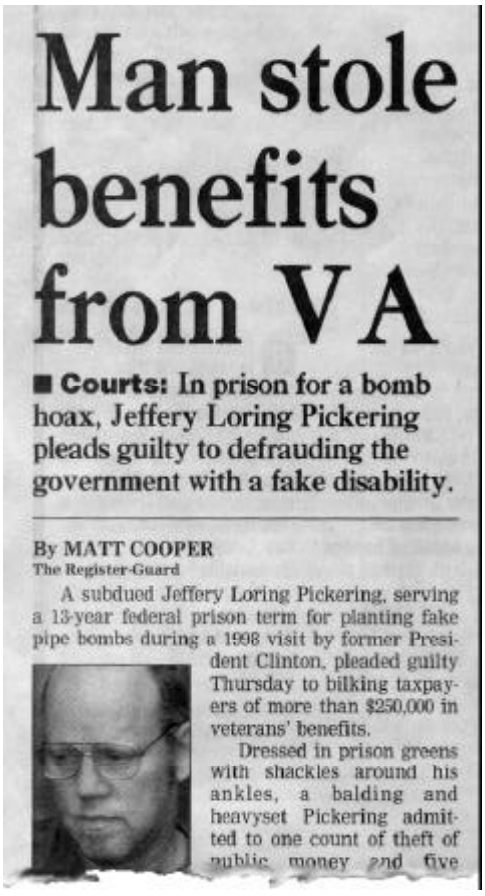
- An individual who was employed as a contract employee for the U.S. Postal Service was indicted on charges of obstruction of correspondence and unlawful possession of letters containing VA checks. A joint investigation by the VA OIG and U.S. Postal Inspection Service disclosed the individual conspired to divert 27 VA educational benefits checks totaling $14,000.

Compensation Benefits Fraud

- An individual was sentenced to 5 years' probation and ordered to pay $16,780 restitution after being indicted on charges of receiving benefits to which he was not entitled. A VA OIG investigation disclosed the individual, a veteran formerly employed as a civilian aircraft mechanic, collected disability benefits based on a declaration made to VA that he was not employed and could not obtain future employment due to service-related disability. He was in fact continuously employed when he made the statements. Based on his declaration of unemployability, VA increased his benefits by approximately $1,000 per month resulting in a loss to the Government of more than $16,700.

- A veteran pleaded guilty to five counts of wire fraud and one count of theft of public money. The plea resulted from a joint investigation by VA OIG and FBI which disclosed the veteran made numerous misrepresentations to VA relative to his military duties, injuries received, and traumatic events he witnessed while serving in the U.S. Marine Corps during the Vietnam War. The veteran claimed these events caused him to develop post-traumatic stress disorder for which he was rated 100 percent disabled. The VA OIG forensic laboratory identified the veteran's handwriting on a falsified entry in his service medical record. The false entry intended to show the veteran had sustained a shrapnel wound during combat, when in fact, no such event occurred. Loss to VA was more than $262,000. An earlier investigation of the veteran by the FBI and U.S. Secret Service into threats made against former President Clinton resulted in a guilty plea to possession of explosive devices. The veteran is presently serving a 13-year prison sentence on those charges. Sentencing relative to the guilty plea has been scheduled.

The Register-Guard, Eugene, OR
Friday, February 23, 2001



Man stole benefits from VA

■ **Courts:** In prison for a bomb hoax, Jeffery Loring Pickering pleads guilty to defrauding the government with a fake disability.

By MATT COOPER
The Register-Guard

A subdued Jeffery Loring Pickering, serving a 13-year federal prison term for planting fake pipe bombs during a 1998 visit by former President Clinton, pleaded guilty Thursday to bilking taxpayers of more than $250,000 in veterans' benefits.

Dressed in prison greens with shackles around his ankles, a balding and heavyset Pickering admitted to one count of theft of public money and five

- The brother of a deceased veteran was indicted on one count of theft of Government funds. A joint investigation by the VA OIG and U.S. Postal Inspection Service disclosed that for almost 4 years the brother had assumed the deceased veteran's identity to obtain VA disability compensation benefits. The loss to VA was $93,601.

- An individual was sentenced to 15 months' imprisonment, 36 months' supervised release, and ordered to pay $53,096 restitution. The individual, a veteran, previously pleaded guilty to charges of scheming to defraud VA by providing false information with regard to his employment history. In 1996, VA awarded the individual 100 percent unemployability benefits based on his certification that he had not been employed since 1994 due to service-connected injuries. A joint investigation by the VA OIG and IRS Criminal Investigations Division disclosed the individual owned a construction company and worked as a carpenter, performing physical labor during the time that he was collecting benefits for unemployability. As a result of the scheme, the individual received more than $50,000 in benefits to which he was not entitled.

- An individual was arrested on charges of submitting false claims, theft, and providing false statements. A VA OIG investigation disclosed the individual, a veteran alleging 100 percent disability for blindness, bolstered his claim for VA compensation, claiming to be completely blind when his visual impairment was found to be far less severe. From December 1995 to August 1999, the individual submitted false statements and documents which caused VA to issue compensation payments based on his 100 percent blindness claim, creating an overpayment of more than $62,300. The individual pleaded guilty to the charges and sentencing is pending.

- An individual pleaded guilty to one count of making false and fraudulent statements. A joint investigation by the VA OIG and VA police disclosed the individual engaged in a scheme to defraud VA of $194,198 in benefits payments. The individual submitted false claims and made false statements to VA physicians, representing that he was severely disabled, wheelchair bound, and in need of aid and attendance from a care giver, when, in fact, he was able to walk and was not as severely disabled as he represented.

Fiduciary Fraud

- An individual who operated as a fiduciary for her veteran husband pleaded guilty to theft of Government funds. A VA OIG investigation disclosed the individual, as fiduciary, was responsible for the management of benefit payments distributed by VA. When her husband died in February 1997, the individual failed to notify VA, causing benefits payments in excess of $130,000 to continue to be deposited into a jointly held bank account. She then used these benefits for her own use.

- An attorney was indicted and charged with one count each of false statements, theft, and misappropriation by a fiduciary. The indictment was the result of a VA OIG investigation that disclosed the individual, appointed by the state court to act as financial guardian for an incompetent veteran, failed to provide an accounting of disbursements of the veteran's benefits to VA. It was later determined that $29,000 in VA compensation benefits was missing from the veteran's account.

- An individual was sentenced to 8 months' imprisonment, 3 years' probation, and ordered to pay $130,568 restitution to VA. The individual previously pleaded guilty to one count of theft of Government funds following a VA OIG investigation. The investigation determined she was the fiduciary for her veteran husband and responsible for the management of benefit payments distributed by VA, however she failed to notify VA when her husband died in 1997. The benefits payments continued to be deposited into a joint bank account and the individual used these benefits for her own use.

Theft of Benefits

- An individual was indicted and charged with 98 counts of forgery and theft. A joint VA OIG and SSA OIG investigation determined that, over a 5-year period, the individual cashed both VA and SSA benefits checks issued to a deceased veteran. The total loss to the Government is estimated at more than $69,400 with VA's loss estimated at more than $33,800. The individual was arrested prior to the indictment and a criminal trial is scheduled.

- An individual was arrested after being charged in a 26-count indictment with bank fraud, mail fraud, and the theft of 13 U.S. Treasury checks. A joint investigation by the VA OIG and U.S. Secret Service disclosed that checks reported missing by VA beneficiaries living in the same geographical area were all found to have been deposited into the individual's bank account. After depositing the checks into his account, the individual requested that his account be closed and a refund check be mailed to him. Copies of the checks were obtained and revealed the alleged signature of each beneficiary along with the individual's signature. The VA OIG forensic laboratory confirmed the individual authored the handwriting on the checks. The 13 checks that were diverted totaled more than $48,200.

Other Benefits Fraud

- An individual was sentenced to 21 months' incarceration, 3 years' supervised release, and ordered to pay restitution of $62,000. A joint investigation by the VA OIG, Department of Health and Human Services OIG, and Department of Education OIG disclosed the individualenlisted in the U.S. Army on two separate occasions, fraudulently using the assumed identity of another individual. The individual sustained injuries while on active duty and, following his military discharge, applied for and received VA service-connected benefits under this false identity. The individual continued to use this false identity to obtain Social Security disability benefits and Department of Education benefits.

- A veteran who was rated with a 100-percent service-connected disability and his wife each pleaded guilty to one count of theft of Government funds. A VA OIG investigation disclosed the veteran's daughter was injured in an automobile accident and had her medical bills paid by the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The daughter was also covered by a private insurance carrier that was ultimately responsible for the medical bills. The veteran's wife disputed who should receive the reimbursement payment from the private insurance company, so the company issued a $21,792 check payable to the veteran's wife and CHAMPVA and sent the check to the veteran's wife. The veteran and his wife then procured a "CHAMPVA" rubber stamp, falsely endorsed the check, and deposited the funds into their personal bank account. They subsequently withdrew the money for personal use. Sentencing is pending.

- The wife of a veteran pleaded guilty to one count of misprision of a felony in connection with her role in conspiring to fake her husband's death and cover up her husband's identity, identifying him to others as another individual and not her husband. A joint investigation by the VA OIG, SSA OIG, and Defense Criminal Investigative Services disclosed the woman conspired with her husband's mother and brothers to fake her husband's death and then illegally enrich themselves by applying for and receiving VA and SSA benefits totaling over $300,000 as a result of the faked death. The woman's husband was a U.S. Marine who faced charges of child molestation in a military court. He faked his own death in order to avoid those charges, but subsequently was charged with additional molestation charges for which he received a sentence of 45 years' imprisonment.

- An individual who formerly served as a national service officer with the Disabled American Veterans was sentenced to 3 years' supervised

probation and was ordered to pay restitution of $500. The individual previously had pleaded guilty to a criminal information charging him with illegally soliciting and receiving funds from a veteran. A VA OIG investigation disclosed the individual solicited the funds from the veteran as payment for providing assistance in the preparation of a claim for VA service connected disability benefits.

- An individual pleaded guilty after being arrested and indicted on charges of theft of VA and SSA benefits, false statements, and Social Security fraud. A joint investigation by the VA OIG and SSA OIG disclosed the individual, who received VA and SSA benefits based on his unemployment status, obtained employment using his nephew's Social Security number and did not report the employment to VA or SSA. The scheme resulted in a loss to the Government of more than $16,000 in benefits that were wrongfully collected.

- An individual was sentenced to 4 months' home detention, 60 months' probation, and ordered to pay more than $63,000 in restitution after pleading guilty to the fraudulent acceptance of VA benefits. A VA OIG investigation disclosed the individual failed to report to VA the death of his mother, and continued for almost 10 years to allow VA to electronically deposit the benefits into a jointly held bank account.

- A veteran was sentenced to 18 months' imprisonment, 36 months' probation, and ordered to pay $33,242 in restitution to the Government after pleading guilty to one count of wire fraud. A joint investigation by a benefits fraud task force comprised of investigators from the VA OIG, SSA OIG, and U.S. Postal Inspection Service disclosed the individual was involved in identity fraud and filing false claims with VA, SSA, and the Office of Workers' Compensation Programs.

Work-Study Program Fraud

- Two individuals were arrested pursuant to an indictment charging them with conspiracy to submit false claims to the Government. A VA OIG investigation disclosed that one of the individuals, a former VA work-study program participant at the Congressional Medal of Honor Society, submitted claims for payments for an 11-month period when in fact she did not work at the Society. She was aided in the scheme by her sister who was employed as a secretary by the Society. The sister intercepted contracts and claims forms issued by VA and furnished them to her sister, who completed and returned them to VA via the U.S. mail. Total loss to the Government was more than $5,000. A trial date is pending.

- An individual was arrested and charged with one count of fraud in excess of $2,500, a third degree felony. Subsequently, this individual pleaded guilty and was sentenced to 24 months' probation and ordered to make VA restitution of $5,829. A VA OIG investigation disclosed the individual, a veteran participating in a VA education work-study program, forged his supervisor's initials and filed fraudulent time sheets to claim work he did not perform in order to receive benefits to which he was not entitled.

Credit Card Fraud

A two-count criminal complaint was filed charging an individual with one felony count and one misdemeanor count of theft of Government property. The charges were filed as a result of a VA OIG investigation that disclosed the individual used her assigned Government credit card to purchase furniture, dental services, concert tickets, electronic items, and a vacation travel package for her personal use. The individual then submitted false invoices giving the appearance that the goods and services were purchased for veterans. Total charges on the card were $3,593.

Office of Human Resources and Administration

Support to VA Central Office

A former VA Central Office (VACO) contract security guard pleaded guilty to one count of theft for his role in the theft of VA computers. The individual was sentenced to 18 months' probation, ordered to pay $3,000 restitution to VA, and perform 40 hours' community service. A joint investigation by the VA OIG, VA police, and FBI disclosed the individual's role as the person responsible for the thefts of computers and computer-related equipment from VACO. Since the individual's arrest and departure from VACO employment, no additional thefts of computers have occurred.

OIG Forensic Document Laboratory

The OIG operates a nationwide forensic document laboratory service for fraud detection that can be used by all elements of VA. The types of requests routinely submitted to the laboratory include handwriting analysis, typewriting analysis, ink and paper analysis, analysis of photocopied documents, and suspected alterations of official documents.

There were a total of 27 reports issued during this semiannual period.

Laboratory Cases for the Period

Requester	Cases Completed
OIG Office of Investigations	7
VA Regional Offices	17
Office of Security and Law Enforcement	1
Other	2
TOTAL	**27**

The following are examples of completed laboratory work:

- VA OIG investigated an individual who was employed as a baggage handler for a major airline that transports U. S. Treasury checks through the mail. The forensic laboratory analysis determined the individual forged the payee signatures of 13 individuals on checks with a total value of over $48,000. The forensic analyst prepared court exhibits documenting the forgeries. Testimony during the trial by the laboratory director played a major role in the jury finding the individual guilty of the charges filed against him.

- VA OIG investigated an individual who was a VAMC registered nurse. The criminal investigation determined that during a 2½ year period, the nurse made false entries on narcotic sign out sheets and diverting narcotic drugs for personal use. Hundreds of false entries were revealed as a result of a forensic analysis which identified the nurse as the author of the false entries. Prosecution is pending.

- A VARO submitted a case to determine if a medical record was created on the date that appeared on the document. The record was used by a veteran to show justification to VA for a service connected disability which would have entitled the veteran to additional VA benefits. The laboratory examinations determined the record was fraudulent and resulted in a VA savings of over $47,000.

- The VARO in Manila, Philippines submitted two cases to the laboratory in which the surviving spouse of deceased veterans submitted medical records referencing their deceased husbands as documentation in support of additional VA benefits. The records were purportedly created in the 1940's and 1950's. It was requested that laboratory examinations determine if the records were genuine. In both cases, analysis determined the records were not genuine and the VARO turned down the requests for additional VA benefits. This resulted in a VA savings of over $54,000.

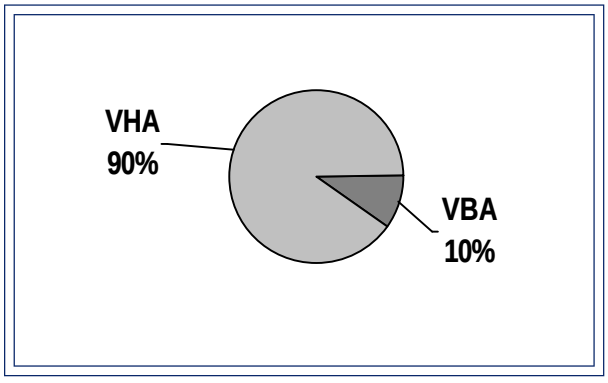
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

Mission Statement

Independently review allegations and conduct administrative investigations generally concerning high ranking senior officials and other high profile matters of interest to the Congress and the Department.

Resources

The Administrative Investigations Division has nine FTE assigned. The following chart shows the percentage of resources utilized in reviewing allegations by program area.



Overall Performance

During the reporting period, the Division closed 25 cases.

Output

- During the reporting period, five reports with recommendations and seven advisory memoranda were issued, including an advisory memoranda on a case not yet closed due to other open issues. Fourteen cases resulted in administrative closures. Additionally, at the end of the reporting period, the Division had four draft reports completed and referred to the Department for comment.

Outcome

- VA managers agreed to take administrative actions against eight high-ranking officials, and five corrective actions to improve operations and activities as a result of these investigations, to include issuing a bill of collection and providing guidance to field facilities.

Timeliness

- The average time from receipt of an allegation to initiation of an investigative case, for all cases initiated during the reporting period, was 35 calendar days. The average time from initiation of an investigative case to case closure (or issuance of a draft report), for all cases closed (or with draft reports issued) during the reporting period was 107 calendar days.

Customer Satisfaction

- The average rating on customer satisfaction surveys returned during the reporting period was 4.75 out of a possible 5.0 (5.0 means highly satisfied and 1.0 means dissatisfied).

The Administrative Investigations Division reports discussed below address serious issues of misconduct against high-ranking officials and other high profile matters of interest.

Veterans Health Administration

Acquisition and Use of Cellular Telephone

An administrative investigation substantiated that a VHA Central Office senior official, and senior officials at a VAMC, agreed to an arrangement that resulted in the misappropriation of funds to purchase a cellular telephone and telephone service. The VHA official requested one of the VAMC officials, a personal friend of his, to acquire a cellular telephone for him. The VAMC paid for the telephone and monthly telephone service, in exchange for the periodic transfer of central office-controlled travel funds to the medical center. The arrangement was a misappropriation of funds because a VAMC appropriation was used to pay an expense that should have been paid from another appropriation. We also substantiated that the VHA official did not exercise prudence in the use of the telephone, including using it for personal long-distance and frivolous calls. Monthly telephone bills over a 2-year period averaged over $230. VHA management agreed with our recommendations to take appropriate administrative action against the senior officials involved, terminate the arrangement, and review the VHA official's telephone records and bill him for improper calls made. As a result of another recommendation, VHA management took appropriate administrative action against another senior official, who also improperly obtained a cellular telephone from a field facility. *(Improper Acquisition and Use of Cellular Telephone, VHA Central Office, Washington, DC, 00-00700-23, 12/19/00)*

Use of Government Vehicles, Other Property, and Official Time

An administrative investigation substantiated that, on several occasions over a 4-year period, a VA Domiciliary Director misused Government vehicles by allowing community organization representatives to transport property and non-VA individuals in them, or drive them, for unofficial purposes. During some of these occasions, the Director also misused other VA property by lending items to the community organizations for unofficial purposes, and misused subordinates' official time by directing them to participate in unofficial community activities. The Director was an officer in one of the recipient organizations which created a conflict of interest. Although the Director's intent was to improve the facility's relations with the local community, we concluded he created a risk for substantial Government liability. VHA officials agreed with our recommendations to take appropriate administrative action against the Director, and to issue guidance to field facilities regarding the proper use of official resources for community activities. *(Use of Government Vehicles, Other Property, and Official Time, VA Domiciliary, White City, Oregon, 00-01137-18, 11/30/00)*

Nepotism Issue

An administrative investigation substantiated that a VAMC senior official violated the Federal nepotism statute and regulation, which restricts the employment of relatives, and engaged in a prohibited personnel practice, by advocating her sister for a position at the medical center. The senior official initiated a conversation with the former medical center director, who was also the selecting official, during which she discussed her sister's prior experience and qualifications. The senior official also initiated one or more conversations with the then Deputy General Counsel to discuss issues relevant to the timing and outcome of an Office of General Counsel final opinion on the matter. We also substantiated that the senior official improperly approved an award affecting her sister's compensation. In addition, other circumstances surrounding the sister's hiring strongly suggested the senior official's influence. For example, the senior official had a strong motive

to facilitate her sister's hiring, in that the sister wanted to be reunited with her spouse, who had recently accepted employment in the local area. In addition, the senior official and the former medical center director took no initiative to have the propriety of the sister's employment subjected to a legal review, suggesting they hoped it would not be challenged. Finally, although the sister was virtually tied with another candidate for the position, characterized as a "crucial" one, neither the former director nor the promotion panel chairman ensured that the candidates' relative qualifications were thoroughly assessed, suggesting the sister's selection was a foregone conclusion. Regarding our recommendation that appropriate administrative action be taken against the senior official, the Acting Chief Network Officer concurred that the circumstances surrounding the selection and appointment of the sister, and the approval of a monetary award for her, warranted corrective action. However, the Acting Chief Network Officer is awaiting a General Counsel opinion before fully implementing this recommendation, to determine the appropriate basis for the action. Further, regarding our recommendation that a bill of collection be issued to recoup salary money paid to the sister, the Acting Chief Network Officer is again waiting receipt of the General Counsel opinion. In response to our recommendation that appropriate administrative action be taken against the former medical center director for appointing the sister after the senior official advocated her consideration for employment to him, the Acting Chief Network Officer informed us the former director retired after our report was issued. *(Nepotism Issue, VA Medical Center, Philadelphia, Pennsylvania, 98-01138-13, 1/02/01)*

Various Issues

Advisory memoranda were issued to management officials, advising them of administrative investigation findings not warranting formal recommendations. For example, we advised a medical center director that a physician at his facility examined two non-VA patients off-station, improperly using a minimal amount of his VA duty time to do so. We also advised VHA management in Central Office that they needed to discuss with a senior official how to improve morale among his subordinates, and deal with the subordinates' concerns related to a perceived special relationship between the senior official and another employee. In another instance, we advised VHA management that a facility director authorized the use of Veterans Canteen Service funds for an inappropriate purpose, improperly accepted a gift, and misused a Government vehicle. However, we noted that in each instance, the director either acted in good faith based on guidance provided to him, or immediately attempted to mitigate the wrongdoing. Another advisory memorandum informed VHA management that a senior official was using a Government vehicle to regularly drive to a temporary duty site, when use of his private vehicle was less expensive. We advised a medical center director that a national union official stationed at his facility was accumulating frequent flyer miles, but not redeeming them for subsequent official travel, thereby reducing travel costs to the Government. Finally, we advised VHA management that a facility director improperly approved the transfer of general post funds to reimburse the facility's operating budget for previously purchased items. The above investigative findings were referred to management for their information and whatever action they deemed appropriate. *(various unnumbered memoranda)*

Veterans Benefits Administration

Vehicle Use Issue

An administrative investigation substantiated that a VBA Central Office official misused a Government vehicle to attend personal medical appointments on

six occasions over a 14-month period. The official told us she once had permission to use the vehicle, and then continued to do so to minimize her time away from the office during the workday. We also substantiated that the official's attendance records did not reflect that she was on leave while at her medical appointments. VBA officials agreed with our recommendations to take appropriate administrative action against the official, and correct her time and attendance records. *(Attendance, Personnel, and Vehicle Issues, VBA Headquarters, Washington, DC, 00-02176-9, 10/30/00)*

Resource Misuse Issue

An administrative investigation substantiated that a VARO high level official improperly approved the use of Government-rented vehicles and, in one instance, subordinates' official time, to provide VA employees and their spouses transportation to and from entertainment activities incidental to a VBA training conference. The misuse of these resources violated the standards of ethical conduct for employees of the executive branch, appropriations law, and VA travel policy. VBA officials agreed with our recommendation to take appropriate administrative action against the high level official. *(Resource Misuse Issue, VA Regional Office, Phoenix, Arizona, 00-01829-63, 3/28/01)*

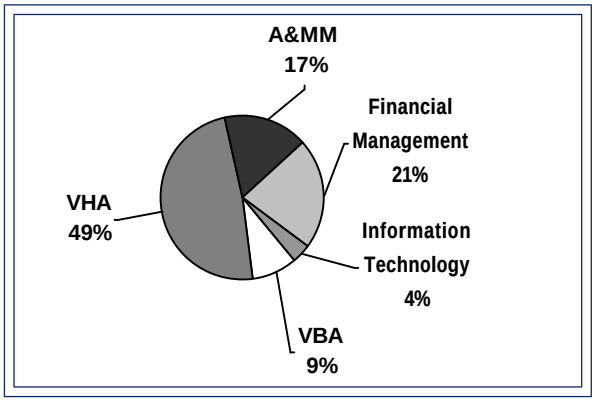
OFFICE OF AUDIT

Mission Statement

Improve the management of VA programs and activities by providing our customers with timely, balanced, credible, and independent financial and performance audits and evaluations that address the economy, efficiency, and effectiveness of VA operations, and that identify constructive solutions and opportunities for improvement, and to conduct preaward and postaward reviews to assist contracting officers in price negotiations and to ensure reasonableness of contract prices.

Resources

The Office of Audit had an average 148 FTE assigned in VA Central Office and 10 operating divisions throughout the country during the 6-month period covered by this report. The following chart shows the allocation of resources utilized in auditing each of VA's major program areas.



In addition, the Office of Audit's Contract Review and Evaluation Division had 24 FTE authorized for reimbursement under an agreement with the VA Office of Acquisition and Materiel Management. This Division conducts preaward and postaward reviews of certain categories of VA contracts.

Overall Performance

Output

- We issued 18 performance, financial, and CAP audits, evaluations, and reviews for an output efficiency of 1 report per 4.1 FTE during this 6-month period. We also issued 28 contract review reports (18 preaward contract reviews and 10 postaward reviews), for an output efficiency of about 3.1 reports per FTE for the 6-month period.

Outcome

- Recommendations were made to enhance operations and correct operating deficiencies with monetary benefits identified totaling $2.438 billion. In addition, contract reviews identified monetary benefits of $32 million associated with the performance of preaward and postaward contract reviews.

Cost Effectiveness

- We achieved a return of $256 in monetary benefits for every dollar spent on performance, financial, and CAP audits, evaluations, and reviews during this 6-month period. We also achieved a return of $30 in monetary benefits for every dollar spent on contract reviews. Additionally, contracting officers sustained 63 percent of our recommended better use of funds during negotiations.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations was 4.5 on a scale of 5, for reports issued during the period. The average customer satisfaction rating achieved for contract reviews was 4.8 out of a possible 5.

Audits completed during the period identified opportunities to improve services to veterans, and identified savings that could be used to increase service. The following summarizes some of the audits completed during the reporting period organized by VA component: VHA, VBA, and Office of Management. This is followed by an assessment of the validity and integrity of the data used to evaluate GPRA performance.

Veterans Health Administration

Resource Utilization

Issue: Pharmacy co-payment levels.
Conclusion: VHA can reduce the cost impact of providing prescriptions to priority group 7 veterans, make additional resources available for veterans health care, and enhance the delivery of prescriptions services to veterans.
Impact: Better use of $1.33 billion and cost avoidance of $284 million.

The audit was conducted to: (i) quantify the number of priority group 7 veterans that use the Florida/Puerto Rico Veterans Integrated Service Network's (VISN 8) health care facilities for the purpose of filling prescriptions written by their private physicians, and (ii) evaluate the process used by VA medical facilities to fill prescriptions written by private sector physicians.

The audit found that VHA needs to increase the pharmacy co-payment levels for priority group 7 veterans who currently pay $2 for each 30-day supply of prescription drugs filled. Generally, veterans in priority group 7 are not being treated for service connected disabilities and have incomes above the limits needed to qualify for free care. Although a VHA workgroup had recently recommended raising the co-pay level to $5, we believe a $10 co-pay level is supported by prescription cost data and is more in-line with private sector medical insurance coverage. A $10 co-pay level will allow VHA to increase its annual pharmacy co-pay collections VA-wide from $75 million in FY 1999 to over $567 million in FY 2001. This will provide the opportunity to recover a greater proportion of the average direct cost of each prescription, which we estimate to be approximately $20 per fill.

The audit also found that VHA needs to streamline its current process of filling prescriptions written by enrolled veterans' private physicians. Our review showed that the pharmacy benefit is the health care service that the majority of priority group 7 veterans want. We believe that the processes VHA uses to restrict pharmacy services to only those veterans for whom it provides direct medical care is inefficient. Veterans with Medicare eligibility and/or private insurance coverage who choose to be treated by private non-VA health care providers must frequently submit to duplicate exams, tests, and procedures by VHA simply in order to receive their prescriptions. VA medical centers frequently end up spending more on scarce clinical resources to "re-write" prescriptions than the actual cost of the prescriptions. The costs of re-examining veterans in order to fill the privately written prescriptions are significant and in FY 1999 totaled as much as $879 million VHA-wide. For FY 2001, we estimate the VHA-wide costs for re-examining these veterans will increase to $1.33 billion.

The Under Secretary for Health provided comments that agreed with our concerns about the inefficiencies associated with the current system of filling privately written prescriptions for priority group 7 veterans. The report remains unresolved based on VHA deferment on concurrence or non-concurrence with the recommendations pending more focused attention and direction by VHA's National Leadership Board. *(Audit of VHA Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans, 99-00057-4, 12/20/00)*

Issue: VAMC Clarksburg management.
Conclusion: Action is needed to address significant management deficiencies and control weaknesses that have adversely impacted the facility's administration of construction contracts, purchase card program activities, and Government vehicles.
Impact: Improved management of the medical facility.

We conducted a limited scope review of construction contracts, purchase card program activities, and the administration of Government vehicles. Review work performed supported an investigation assessing Hotline allegations that focused upon the actions of specific VA employees working in facility management operations, certain construction contractors, and local vendors. Significant management deficiencies and control weaknesses were identified that impacted the administration of construction contracts, the purchase card program, and Government vehicles.

Supervision over facility management operations was ineffective and resources available to support acquisition functions were inadequate. Overall, we found little management control over facility management operations. The review identified major deficiencies in the current management of construction contracts. Key deficiencies included performance of unauthorized construction, authorization of contractor work performance before the award of a contract, contract modifications outside the scope of original contracts, contract awards lacked or did not adequately justify determinations of price reasonableness, and certain modifications lacked support for increasing project costs. We also found that prior year funds were used inappropriately and several construction projects experienced unexplained and significant performance delays while controls over other construction contract progress payments were non-existent.

Our review of purchase card transactions identified a number of control weaknesses that showed that the facility paid excessive prices for services and staff continually split work requirements to circumvent competition requirements. Purchase card reconciliations were not performed timely.

We found that the administration of Government vehicles was inadequate and accountability over vehicles in the facility's inventory could not be assured. As a result, top management's attention is needed to assure the integrity and accountability over the facility's construction program, purchase card expenditures, and vehicle property management. The Acting Director concurred with the report recommendations and provided appropriate implementation actions.*(Review of Selected Construction Contracts, Purchase Card Activities, and Vehicle Administration at VAMC Clarksburg, WV, 99-01685-10, 1/25/01)*

Issue: Research program at VA greater Los Angeles healthcare system.
Conclusion: Major financial and administrative deficiencies have been corrected.
Impact: Improved stewardship of research assets and resources.

At the request of VHA management, we evaluated controls in the research program to provide independent assurance that deficiencies previously identified by VHA reviewers had been corrected. We concluded the major deficiencies in financial and administrative operations had been identified and effectively corrected. To illustrate, current managers:

- Ended the practice of using grant funds "earmarked" for specific research protocols to pay expenses that were not related to those protocols and implemented procedures to ensure that funds were used only for their intended and authorized purposes.

- Implemented the computerized research management system, which provided managers and principal investigators (PIs) reliable information needed to control research accounts.

- Reduced research service staffing and implemented procedures to ensure that temporary employees were released when their appointments ended.

- Established controls to prevent PIs from spending more funds than they had in their protocol accounts and began collecting reimbursements from PIs whose overspending had been improperly covered by appropriated research funds.

We also concluded the healthcare system former top management had not provided adequate oversight of research service and did not establish effective controls to ensure that they received reliable information on research operations. The former top managers were aware of many of the deficiencies and had initiated some corrective actions, but they did not follow through to ensure that these actions were effectively implemented. The current management implemented stronger oversight controls, with the main control being the establishment of a research budget subcommittee responsible for monitoring research financial operations.

VA Greater Los Angeles Healthcare System
Los Angeles, CA

To further strengthen oversight, we recommended the healthcare system Chief Executive Officer implement procedures for conducting periodic reviews of research operations to ensure that controls continue to be effective and that the past deficiencies will not recur. The Chief Executive Officer concurred with the recommendation and provided an acceptable implementation plan. (*Evaluation of Financial and Administrative Controls in the Research Program at the VA Greater Los Angeles Healthcare System, 99-00191-2, 10/12/00)*

Program Management

Issue: Health Eligibility Center.
Conclusion: VHA income verification matching procedures do not provide reasonable assurance that income verification matches include only self-reported income from veterans.
Impact: Assuring program integrity.

We conducted an audit of the income verification matching process used by the VA Health Eligibility Center (HEC) to establish patient eligibility for VA health benefits. The Under Secretary for Health requested an audit to determine whether corrective actions taken by VHA would provide reasonable assurance that: (i) VHA has established a system to ensure that only self-reported income is included in future matches with the IRS and SSA; and (ii) VHA and the HEC have purged their electronic files and paper records of all federal tax information (FTI) not supported by self-reported income.

We conducted reviews of the means test (MT) process at 13 VAMCs that showed: (i) MTs were not signed or could not be located in 17 percent of the cases reviewed for calendar year 2000; and (ii) the HEC did not purge all unauthorized FTI from its electronic files and paper records. These conditions occurred because: (i) VHA had not implemented our 1999 recommendation to centralize means testing to the HEC; (ii) VHA and

the HEC had not developed a process to filter unsigned MTs prior to conducting the income verification matches with IRS and SSA; and (iii) the HEC relied on inaccurate information reported in VHA's signed MT review. As a result, the HEC did not purge FTI from its files for all cases in which VAMCs did not have signed MTs.

Pending implementation of our 1999 recommendation to expedite centralized means testing to the HEC, we recommended the Under Secretary for Health establish a process that would provide positive assurance that a signed MT supports all MT information. We further recommended the HEC purge all FTI that is not supported by a signed MT. Implementation of the recommendations would provide reasonable assurance that only self-reported income is matched with the IRS and SSA, and provide VHA the ability to bill for about $15.3 million in services provided to non service-connected veterans. The Under Secretary for Health concurred with the recommendations and provided acceptable action plans. *(Audit of the Department of Veterans Affairs Health Eligibility Center, Atlanta, Georgia, 00-02165-54, 3/26/01)*

Veterans Benefits Administration

Fraud Detection

Issue: VBA's income verification match (IVM).
Conclusion: VBA's IVM results can be enhanced with better use of staff resources, increased recovery of beneficiary overpayments, and referral of program fraud cases to the OIG.
Impact: Deterrence of fraud and cost avoidance of $806 million.

The purpose of the audit was to review the effectiveness of VBA's IVM in completing required benefit payment adjustments and identification of program fraud. The audit found that opportunities exist for VBA to: (i) significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered; (ii) better ensure program integrity and identification of program fraud; and (iii) improve delivery of services to beneficiaries.

The following key findings were identified: (i) VBA needs to increase the oversight and tracking of the IVM process; (ii) the claims examination process could be made more effective; (iii) IVM related debts need to be established; (iv) waivers of IVM related debts should not be granted when fraud is identified; (vi) recoveries could be increased by reducing the number of unmatched records; (vii) referrals to VA OIG for fraud need to be increased; and (viii) the IVM process represents a potential material weakness area that should be monitored by the Department. We found the potential monetary impact of these findings to the Department was $806.3 million. Of this amount, we estimated potential overpayments of $773.6 million associated with benefit claims that contained erroneous Social Security numbers, or some other inaccurate key data elements. The remaining $32.7 million is related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimated that $299.8 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation.

As a result of these findings, we recommended that the Under Secretary for Benefits: (i) increase program oversight of the results of IVM actions completed; (ii) eliminate review of Section 306 and protected pension cases; (iii) eliminate review of IVM cases with income discrepancies of less than $500 *(Repeat recommendation from 1996 OIG report;* (iv) complete necessary validation of beneficiary identifier information in the Compensation and Pension master record *(Repeat*

recommendation from 1990 OIG report); (v) assure that accounts receivable are established to recover IVM related debts from beneficiaries; (vi) assure that waivers of IVM related debts are not granted when fraud is identified; (vii) refer potential fraud cases to the OIG based on the referral process that has been established; and (viii) report the IVM for consideration as an internal high priority area that needs monitoring.

Our review results showed that effective national oversight and tracking of the IVM process was needed to adequately address VA's significant program risk for benefit overpayments and fraud associated with unreported beneficiary income.

Our review confirmed that the IVM process is resulting in significant payment recoveries by individual VAROs. However, VBA has not tracked the results of the matching process to assure the productivity of the case reviews and the appropriateness of VARO actions in establishing accounts receivable. The effectiveness and efficiency of the IVM process has also been adversely impacted, because VBA did not implement program enhancements recommended by the OIG in prior reports that would have provided the opportunity for more effective use of staff resources and increased recovery of benefit overpayments.

The VBA Deputy Under Secretary for Management concurred with the report recommendations and provided appropriate implementation actions. *(Audit of VBA's IVM Results, 99-00054-1, 11/8/00)*

Office of Management

VA's Consolidated Financial Statements

Issue: VA's Consolidated Financial Statements for FYs 2000 and 1999.

Conclusion: Audit resulted in an unqualified audit opinion, but points out that significant control weaknesses and noncompliance items still remain.

Impact: Improved stewardship of VA assets and resources.

Our report contains the OIG audit opinion, an assessment of VA's internal control structure, and compliance with laws and regulations. The OIG contracted with the independent public accounting firm Deloitte & Touche LLP, to perform the audit. The independent auditors' report provided an unqualified opinion on VA's FY 2000 consolidated financial statements. We agreed with the auditors' opinion and conclusions in the related report on the Departments' internal control over financial reporting and compliance with laws and regulations.

The auditors' Report on Internal Control discusses material weaknesses concerning: (i) the need to improve application programming and operating system controls; (ii) business continuity and disaster recovery planning; (iii) operational oversight; and (iv) other matters. These internal control weaknesses expose VA to significant risks and vulnerabilities. In this report, we also reaffirmed our prior recommendations and included recommendations addressing these weaknesses and the reportable conditions.

Additionally, the report states information technology security controls continues to be a material weakness and discusses integrated financial management system controls as a new material weakness. The report indicates the management control weaknesses are not in compliance with OMB Circulars A-123, "Management Accountability and Control"; A-127, "Financial Management System"; and A-130, "Management of Federal Information Resources."

The auditors' Report on Compliance with Laws and Regulations discusses the Department's

noncompliance with Federal Financial Management Improvement Act requirements concerning material weaknesses in internal controls over financial reporting. VA is not in full compliance with the requirements of OMB Circulars A-123, A-127, and A-130. Therefore, it is the auditors' and OIG's shared opinion that these weaknesses, in the aggregate, result in significant departures from certain of the requirements of OMB Circulars A-123, A-127, and A-130, and show instances of substantial noncompliance with the Federal financial management systems requirements under the Act. Except for these noncompliances, the report concludes that for the items tested, VA complied with those laws and regulations materially affecting the financial statements.

The Assistant Secretary for Financial Management stated appropriate offices have reviewed the report and concur with the reported findings and recommendations. *(Audit of VA's Consolidated Financial Statements for Fiscal Years 2000 and 1999, 00-01702-50, 2/28/01)*

Issue: Public Law 104-208, Federal Financial Management Improvement Act of 1996.
Conclusion: Correction of noncompliance items is in-process.
Impact: Improved stewardship of VA assets and resources, and better, more timely management information.

Correction is in-process for items shown in our report on VA's consolidated financial statements as being noncompliant with Public Law 102-208 requirements. VA has taken a number of steps to establish a comprehensive information system security program. The Department's target completion date is FY 2003. Corrective action was substantially completed on housing credit assistance program financial system noncompliance items reported in our report on VA's FY 1999 consolidated financial statements.

In our report on VA's FY 2000 consolidated financial statements, we added one new item - noncompliance with OMB financial management system requirements. VA is in the process of developing and testing a replacement core financial management and logistics system. Roll-out is presently scheduled to begin April 2003.

Regarding previously reported noncompliance with managerial cost accounting requirements, VA's National Cemetery Administration completed testing and converting system data during FY 2000 and will be fully implemented in FY 2001. VHA's target implementation is expected to be in FY 2002, permitting the cost system to be modified to include allocated costs such as accrued annual leave and judgment fund costs.

Preaward Contract Reviews

Issue: Federal Supply Schedule vendors' best prices.
Conclusion: Contractors can offer better prices to VA.
Impact: Potential better use of $11.5 million.

- Preaward reviews of seven medical equipment and supply companies' offers resulted in potential savings of $9,096,561.

- Preaward review of two diagnostic test kit and reagent manufacturers' offers resulted in potential savings of $2,246,595.

- Preaward review of a wheelchair manufacturer's offer resulted in potential savings of $212,160.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $824,592.

We completed reviews of three proposals for scarce medical specialists' services and concluded that the contracting officer should negotiate reductions of $824,592 to the proposed contract costs.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Postaward audits and surveys disclosed overcharges.
Impact: Recovery of $18.3 million.

- We completed four Public Law 102-585 compliance reviews at pharmaceutical companies. Three of the four companies agreed to pay $7,612,299 to VA. VA is issuing a bill of collection to the fourth company. We also made recommendations to all of the companies reviewed suggesting ways they could improve their policies and procedures so that the Government and the company could be assured that its systems were producing accurate Federal Ceiling Prices.

- A pharmaceutical and medical supply company agreed to pay $5,822,656 related to pricing disclosures that were not accurate, complete, and current during negotiations leading to two Federal Supply Schedule contracts with VA.

- We completed a review of a pharmaceutical prime vendor. Recoveries amounted to $4,234,671.

- A medical equipment and supply company paid $580,000 to VA for contract overcharges. The company had failed to provide accurate, complete, and current discount and pricing information to the VA contracting officer during contract negotiations.

- A pharmaceutical manufacturer agreed to pay $18,296 for overcharges related to violations of the price reduction clause in their Federal Supply Schedule contract.

Implementation of GPRA within VA

The OIG has a significant role to play in informing both VA and Congress on issues concerning efforts to implement the Government Performance and Results Act of 1993 (GPRA). As background for our efforts in this area, it is relevant to note that VA was an OMB-designated pilot agency for performance measurement. As such, VA began establishing performance measures for its programs and operations in FY 1992.

In FY 1998, at the request of the Assistant Secretary of Policy and Planning, we initiated a series of audits to examine the integrity of the data used for GPRA reports. This ongoing project involves a series of audits to evaluate the validity, reliability, and integrity of the data used to evaluate GPRA performance. During this 6-month reporting period, we assessed the accuracy of the foreclosure avoidance through servicing.

Foreclosure Avoidance through Servicing Ratio

The audit was conducted to determine whether VBA officials accurately reported the foreclosure avoidance through servicing ratio. This was one in a series of audits assessing the accuracy of data used to measure VA's performance in accordance with the GPRA. To assess the accuracy of VBA's computation of the ratio for FY 1998, we attempted to verify each of the five components of the computation. We found that four of the five components were accurate, but we could not verify the fifth component because supporting

documentation was not available. Accordingly, we could not attest to the accuracy of the ratio reported in VA's annual accountability report. During our audit, VBA activated a new computer system which will retain appropriate supporting documentation. Since this should correct the only material deficiency we identified, we did not make any formal recommendations.

Current Status

As part of our ongoing assessment to validate the accuracy and reliability of VA's performance measures in accordance with GPRA, the OIG is auditing one VHA performance measures and one VBA performance measure. These measures are:

VHA Performance Measures: Prevention index.

VBA Performance Measure: Rehabilitation rate.

We will issue reports on each performance measure as audits are completed. GPRA related audit reports issued to date include:

Review of Implementation of VHA's Strategic Plan and Performance Measurements, 5R1-A19-026, 2/6/95.

Review of Implementation of National Cemetery Service's Strategic Plan and Performance Measurements, 5R1-B18-082, 7/6/95.

Review of Implementation of VBA's Strategic Plan and Performance Measurements, 5R1-B18-100, 8/25/95.

Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the GPRA, 8R5-B01-147, 9/22/98.

Accuracy of Data Used to Measure Claims Processing Timeliness, 9R5-B01-005, 10/15/98.

Accuracy of Data Used to Measure Percent of Veterans with a Burial Option, 9R5-B04-103, 5/12/99.

Accuracy of Data Used to Count the Number of Unique Patients, 9R5-A19-161, 9/20/99.

Accuracy of Data Used to Compute the Foreclosure Avoidance through Servicing Ratio, 99-00177-14, 11/16/00.

OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

Promote the principles of continuous quality improvement to provide effective inspections, oversight, and consultation to enhance and strengthen the quality of VA's health care programs.

Resources

The Office of Healthcare Inspections (OHI) has 34 FTE assigned to staff headquarters and field operations. OHI inspectors commit all of their staff time to health care inspections and evaluation issues. CAPs occupy approximately 75 percent of OHI resources.

Overall Performance

Output

- We published one VHA program evaluation and six inspection reports during the reporting period.
- We published findings in nine CAP reports.
- We evaluated the adequacy of VHA responses for 124 Hotline cases.

Outcome

- We identified VHA program improvements for monitoring patients who wandered from their treatment areas.
- We made 29 recommendations that focused on improving both clinical care delivery management efficiency and holding responsible staffs accountable for their actions.
- We followed up on 11 Department responses to Hotline allegations because not all of the issues appeared to be satisfactorily resolved.

Veterans Health Administration

Nationwide Health Care Program Review

Issue: VHA's missing patients policies and procedures.
Conclusion: VHA's missing patients policies and procedures are not sufficiently rigorous to protect cognitively impaired patients.
Impact: Strengthened policies and procedures that promote the safety of all VA patients.

This review was in follow up to our preliminary assessment of VHA's missing patient policies and patient searches conducted in FY 1999. In that review, we concluded VHA managers needed to improve the monitoring of high-risk patients and their patient search procedures to reduce adverse incidents. We also concluded clinical managers needed to assess and record factors that can help define patients' elopement risks. We recommended VHA managers evaluate the effectiveness of existing missing patient policies and search procedures. VHA officials informed us they were reluctant to act on our preliminary work because we based our conclusions on a small number of incidents that occurred over a several year period.

Therefore, we expanded the scope of our review to fully assess the adequacy of VHA's missing patient policies and patient search procedures. We contacted all 142 VAMCs and health care systems and visited 11 VAMCs to assess VHA's response to the issue of missing patients and the adequacy of internal controls.

We found VHA managers: (i) recognized the need for guidelines and safety measures for protecting cognitively impaired or otherwise high-risk patients; (ii) begun to re-assess the manner in which they approached safety initiatives and alternatives for monitoring patients who were at high risk for eloping or wandering from their treatment settings; (iii) implemented innovative programs and creative procedures to address the safety needs of their patients; (iv) increased their efforts to locate missing patients; (v) could improve their procedures and practices to safeguard against potential future tragic incidents; and (vi) need to revise policy to require clinicians to conduct elopement/wandering risk assessments for hospitalized patients, provide formal education and training regarding missing patient search procedures, and report missing patients consistently among all VAMCs.

We made recommendations to strengthen existing missing patient policies and procedures and to promote the safety of all VA patients. The Under Secretary for Health concurred with our recommendations and provided responsive implementation plans. *(Evaluation of Veterans Health Administration Missing Patient Policies and Procedures, 00-00282-12, 11/30/00)*

Healthcare Inspections

Issue: Training requirements for the transport of hazardous or infectious materials.

Conclusion: VAMC employees had not received the required Department of Transportation training on packaging and transport of hazardous or infectious materials.

Impact: Increased nationwide awareness of training requirements.

While conducting a CAP review at the VAMC Sioux Falls, SD, we learned the Federal Aviation Administration (FAA) cited the facility for not documenting the training provided to employees in packaging and transporting laboratory specimens and hazardous or infectious materials. The FAA sanctioned the facility from future mailings until VA employees complied with all policies and procedures. The FAA informed us that these procedures have been required for some time, however they have just begun to enforce them.

VA Medical/Regional Office Center
Sioux Falls, SD

We found VHA's Diagnostic Healthcare Group had recently taken appropriate steps to inform VHA facilities about the FAA inspection process and had purchased the training materials. Therefore, we did not make any formal recommendations. We suggested: (i) VHA provide written guidance to VA facilities regarding the Department of Transportation training requirement and FAA inspection process; and (ii) VHA managers need to conduct periodic reviews of VHA hazardous materials policies to ensure compliance with the prescribed FAA regulations. *(Letter Report, Department of Transportation Inspection of Department of Veterans Affairs Clinical Laboratories, 2000-02096-5, 10/5/00)*

Issue: Administration and management of psychiatry service and psychiatric patients.

Conclusion: Numerous opportunities for improvement exist in the management of psychiatry service.

Impact: Improved care to patients.

Several VAMC employees alleged managers fostered and perpetuated a climate of discrimination against psychiatric patients, psychiatrists, and psychiatry as a clinical specialty. We concluded: (i) cursory examinations of some psychiatric patients resulted in delayed treatment and could have been interpreted by some patients as prejudicial; (ii) the psychiatry service physician on-call schedule had adversely affected clinic appointment availability and psychiatrist attendance at treatment team meetings; and (iii) patients rights were being violated on the inpatient psychiatry unit.

We made recommendations aimed at improving the management and administration of the psychiatry service and quality of care provided to psychiatric patients. The Director concurred with our recommendations and provided adequate implementation plans. *(Healthcare Inspection – Multiple Allegations Regarding Psychiatry Service Management and Patient Care Issues, Department of Veterans Affairs Medical Center, San Juan, Puerto Rico, 99-01260-7, 11/15/00)*

Issue: Resident competence.
Conclusion: Senior VAMC managers were aware of the complications caused by a resident and had suspended his surgical privileges on three occasions.
Impact: Strengthened procedures for monitoring residents.

A complainant alleged that a resident, whose clinical privileges had been suspended at the university hospital, was allowed to perform surgery at the VAMC. We confirmed that the resident continued to perform surgery in spite of the fact that his clinical privileges had been previously suspended. Senior managers were aware of the issues involving the resident, and suspended and reinstated his surgical privileges on several occasions during his rotation.

We made recommendations that will strengthen procedures for monitoring and approving residents' progress in completing their rotation, and improve communication between clinical staff. The VISN Director concurred with our recommendations and provided acceptable implementation plans. *(Ophthalmology Resident Competence, Harry S. Truman Memorial Veterans Hospital, Columbia, Missouri, 00-02038-29, 1/23/01)*

Issue: Unauthorized care and treatment.
Conclusion: The VAMC was operating an unauthorized clinic.
Impact: Unauthorized services discontinued.

VA Medical Center, New Orleans, LA

A complainant alleged that VAMC New Orleans was operating a transgender clinic and not following VA policy. Additionally, the complainant alleged this clinic was not an authorized medical clinic and was taking away funds and resources from other authorized clinics. We found the VHA set certain prohibitions against providing patients gender revision care. In essence, VA clinicians cannot carry out any process or procedure involving genital identity revision. We found the VAMC was operating a transgender clinic and that clinic clinicians were providing hormonal therapy to patients.

We recommended discontinuation of the prohibited services and VHA determine whether transgender clinics are operating in other VISNs. The Acting Chief Network Officer concurred with our

recommendations and provided adequate implementation plans.*(Operation of a Transgender Clinic at VAMC New Orleans, Louisiana, 00-02019-31, 1/23/01)*

Issue: Research improprieties.
Conclusion: Clinicians enrolled the patient in a research study without obtaining the proper consent from the guardian.
Impact: Strengthened policies for documenting patients' competency and guardianship status.

John L. McClellan Memorial Veterans Hospital Little Rock, AR

A patient's family alleged that clinicians enrolled the patient in a research study without obtaining consent from the court-appointed guardian. The family made two other allegations concerning the quality of care provided to the patient. We substantiated the allegation that clinicians enrolled the patient in a research study without obtaining the consent of his court-appointed guardian. We did not find that clinicians wasted time in taking the patient to the operating room for emergency surgery. We were unable to reach a conclusion regarding the allegation that clinicians misplaced the patient's advance directive.

We recommended providing training to research nurse coordinators and managers, and ensuring local directives delineate responsibility for documenting a patient's competency and guardianship status. We also recommended the VAMC Director remind employees of the importance of placing guardianship and advance directive documents in the front of patients' current medical records. The Director concurred with the recommendations and provided acceptable implementation plans. *(Healthcare Inspection – Patient Research and Other Health Care Issues, John L. McClellan Memorial Veterans Hospital, Little Rock, AR, 99-01321-47, 3/23/01)*

Issue: Patient care and discharge planning.
Conclusion: The VAMC's admission policy to the nursing home care unit is misguided.
Impact: Strengthened admission and exclusion guidelines.

A complainant contacted the OIG concerning several quality of care issues related to the care and treatment regime of a chronically ill patient. We concluded that neither the patient nor his family objected to the discharge as alleged. Nevertheless, we questioned the appropriateness of the discharge to the patient's home or a community nursing home (more than 100 miles from the medical center). We found that the medical center's nursing home care unit admission policy was misguided. VAMC clinicians, whom we interviewed, all informed us that they understood that admission was precluded to patients receiving continuous positive airway pressure and/or bi-level positive airway pressure therapy. However, no such policy existed in writing. Furthermore, this exclusionary practice would not be consistent with community standards of care.

We recommended the VAMC Director ensure that clinical managers re-evaluate admission policy regarding the admission of continuous positive airway pressure or bi-level positive airway pressure supported patients. The Director concurred with our recommendation. *(Inspection of Allegations Regarding Patient Care and Discharge Planning, Department of Veterans Affairs Central Texas Health Care System, Temple, Texas, 00-01491-57, 3/26/01)*

OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support, and providing products and services that promote the overall mission and goals of the OIG. Strive to ensure that all allegations communicated to the OIG are effectively monitored and resolved in a timely, efficient, and impartial manner.

The Office of Management and Administration is a diverse organization responsible for a wide range of administrative and operational support functions. The Office includes four Divisions:

I. Hotline Division - The Division is responsible for determining action to be taken on allegations received by the OIG Hotline. The Division receives thousands of contacts annually, mostly from veterans, VA employees, and Congress. The work includes controlling and referring many cases to the Office of Investigation, Office of Audit, and Office of Healthcare Inspections or impartial VA components for investigation.

II. Operational Support Division - The Division does follow up tracking of OIG report recommendations; Freedom of Information Act releases; strategic, operational, and performance planning; and IG reporting and policy development.

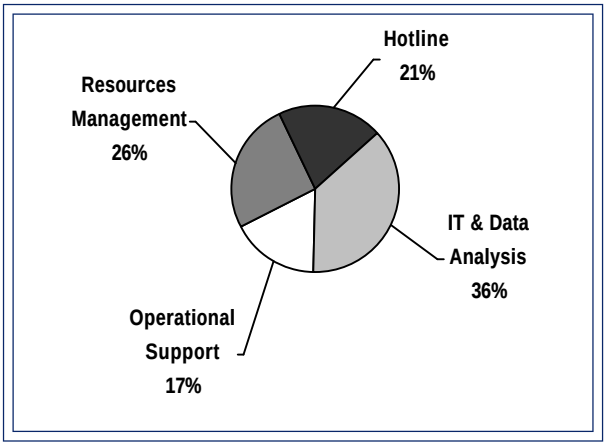
III. Information Technology (IT) and Data Analysis Division- The Division manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements.

The Division also maintains the Master Case Index (MCI) system, the OIG's primary information system for case management and decision-making. The Data Analysis section, located in Austin, TX provides data processing support, such as computer matching and data extraction from VA databases, to the OIG and other VA entities.

IV. Resources Management Division - The Division is responsible for OIG financial operations, including budget formulation and execution, OIG personnel management, and all other OIG administrative support services.

Resources

The Office of Management and Administration has 53 FTE allocated to the following areas.



I. HOTLINE DIVISION

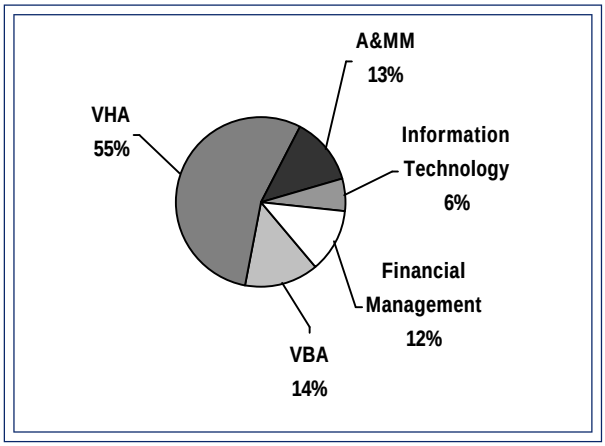
Mission Statement

Ensures that allegations of fraud, waste, abuse, and mismanagement are responded to in an efficient and effective manner.

The Division operates a toll-free telephone service five days a week, Monday through Friday, from 8:30 AM to 4 PM Eastern Time. Phone calls, letters, and e-mail messages are received from employees, veterans, the general public, Congress, General Accounting Office, and other Federal agencies reporting issues of fraud, waste, and abuse. Due consideration is given to all complaints and allegations received; mission-related issues are addressed by OIG or other Departmental staff.

Resources

The Hotline Division has 11 FTE staff positions. The following chart shows the percentage of resources devoted to various program areas.



Overall Performance

During the reporting period the Hotline received 8,324 contacts. Of this number, 529 cases were opened. The OIG reviewed 135 of these and the remaining 394 cases were referred to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 530 cases, of which 151 contained substantiated allegations (28 percent). The Hotline staff opened 12 cases and generated 90 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 33 administrative sanctions against employees and took 71 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled $968,316.

The Hotline Division's most significant leads are referred to other OIG elements. Hotline staff also retain oversight on a number of other cases that are referred to VA program officials for resolution.

The Hotline staff worked with VA program offices on allegations concerning patient care and services, quality of care issues, employee misconduct, outside employment concerns, contracting activities, Government equipment and supplies, time and attendance, and ethical improprieties. Hotline staff also worked with VBA on allegations concerning the payment of compensation and pension to incarcerated veterans, and benefits awarded to veterans and beneficiaries who were not entitled to receive payments.

The following are some examples of Hotline-prompted reviews that were closed during this reporting period.

Veterans Health Administration

Quality of Care

- Prompted by a Hotline inquiry, a VHA review substantiated a veteran's receipt of the wrong medication through the mail. To assure better quality of care, the facility assigned a pharmacist to the mental health clinic and apologized to the veteran for the error.

- A VAMC review substantiated an allegation that staff shortages in the department of surgery led to several delays in scheduling a veteran's knee surgery. The department was placed under new management, staff was hired, and a new program for residents was developed to improve patient services. Additionally, the veteran received his surgery.

- A VHA review substantiated an allegation of slow response by a physician serving as medical officer of the day to a nurse's summons for assistance. In addition, the same physician was found to have transposed entries in the medical records of two patients. When the entries were questioned, the physician refused to correct the records. VAMC management counseled the physician and notified the state professional board. The physician no longer has privileges to practice at the VAMC.

- A VHA review substantiated the allegation of poor communications with a patient's family when a physician hung up on the patient's wife while she was inquiring about her husband's care. VAMC officials completed a formal report of contact regarding the incident and counseled the physician concerning customer relations.

- A VHA review substantiated the allegation that a VAMC administered an HIV test without the knowledge or consent of a veteran. The veteran was admitted to the hospital for a chronic cough and interstitial lung disease, and as a matter of routine, a work-up for pulmonary infectious diseases was warranted. However, there is no documentation of the veteran's consent to or refusal of the HIV test. Management counseled the clinical staff on procedures involving informed consent, including HIV testing.

- A VHA review substantiated the allegation of delay in treatment and poor communication with a patient. A resident physician examined a veteran and planned to schedule a urology consult for him. However, the resident physician and the attending physician thought each other had scheduled the consult for the veteran. Finally, a registered nurse practitioner examined the veteran and scheduled the consult. Management reviewed procedures for scheduling consults to ensure that patients are served properly in the future.

- A VHA review substantiated the allegation of poor communication with a patient. A veteran complained that medical personnel at a VA clinic did not discuss or review medical test results with him. Reviewers found no progress notes in the veteran's medical file showing that care providers discussed or reviewed the test results with him. The chief medical officer reminded all providers to follow-up on and document all abnormal test results and subsequent action to inform the patient.

- A review at a VAMC substantiated the allegation that there was a 21-minute delay in transporting a grounds employee, who is a veteran, to the medical center for treatment in what appeared to be a seizure or a diabetic episode. The review revealed that proper procedures were not followed in transporting all patients, visitors or employees with emergent, questionable, or unknown conditions to the medical center for treatment. Management forwarded guidance on emergency medical responses on facility grounds to all division managers.

- A VHA review substantiated an allegation of staffing shortages at a VA facility, although the

review concluded that patient care was not compromised as a result. The VAMC is monitoring daily staffing and has adopted a policy to suspend surgical admissions, if necessary, when staffing levels are low. An effort to recruit staff is ongoing. In addition, the VAMC took steps to improve such administrative functions as medical transcription that had experienced delays because of the staffing problems.

- A VHA review substantiated the allegation of incorrect treatment. A nurse practitioner placed a medication order to the pharmacy on a computer that another provider was using. As a result, the medication order was placed for the wrong veteran. The nurse coordinator discussed this with the nurse practitioner and used this circumstance in training for all employees on how to avoid similar situations in the future.

- A VHA review substantiated a veteran's allegation that the VAMC delayed his sinus surgery with a series of cancellations beginning in May 2000. As a result, the VAMC has adopted a policy mandating the clinics not cancel scheduled appointments less than 90 days before the appointment. In addition, medical center administrators are reviewing the existing scheduling system to minimize any cancellations. The veteran received the surgery.

- A VHA review determined that there was a breakdown in communications between a patient and his family and the VAMC staff. To decrease the possibility of future communications lapses, the Director had meetings with the cardiology staff to define which care team has responsibility for a patient who is being seen for an outpatient procedure, but who will be subsequently admitted to the VAMC.

- A VHA review substantiated the allegation of inappropriate or incorrect treatment. The review found that an order for medication was written on a medication profile form for the wrong veteran. This error was discovered before any medication was dispensed. Management implemented new procedures for ordering medications.

- A review at a VAMC substantiated poor communications with a patient who thought he was awaiting a liver transplant. The facility failed to inform the veteran that due to serious medical complications, he had not been placed on the transplant waiting list. There was also confusion among his care providers at the facility as to his being placed on the list. The medical complications were resolved and the patient was accepted at the national VA transplant center.

- A VHA review substantiated an allegation of poor communications with a patient's family. The review revealed that an inquiry from the patient's wife about her husband's care was mistakenly handled by an employee in human resources. The VAMC instituted a policy requiring that all telephone calls involving significant issues or complaints about patient care be forwarded to the patient representative to ensure follow up.

- A VHA review substantiated allegations of poor communications with a patient and his family; and delay in the receipt of medical care due to the unavailability of a gastrointestinal specialist. Both the chief, surgical service and chief, medical service have discussed the facility's customer service expectations with staff, and implemented a patient sensitivity training program. In addition, both services initiated processes for coordinating specialists' leave schedules.

- A VHA review substantiated allegations of problems with a VAMC's hearing aid program. Multiple fee basis referrals had been returned unprocessed without informing the facility's audiologists. Management is keeping the audiologists in the communications loop and negotiated a contract with one outside provider rather than using multiple providers.

- A VHA review substantiated an allegation of poor communications with a patient's family. The review found that although VAMC employees acted properly in refusing to release the patient's medical records to his son, it was acknowledged that the

employees should have referred the complainant to the office of release of information for the records he sought. The staff was reminded to refer all such requests.

- A VHA review substantiated poor communications with a patient. The review found the facility failed to notify the patient of his upcoming appointments in a timely manner. The appointment manager was instructed to provide appointment notices more expeditiously.

- A VHA review substantiated a veteran's allegations that a physician misdiagnosed him and prescribed a course of treatment for acid reflux rather than a collapsed lung. When the veteran requested an appointment with his primary care physician, he could not be seen for more than 2 months. The VAMC review showed the misdiagnosis resulted from the physician not reading an x-ray in a timely manner. The contractor employing the physician was requested to check the physician's records for a pattern of missed diagnoses, the incident was referred to the peer review committee, and all emergency room providers were reminded to read x-rays in a timely manner. In addition, providers were requested to keep daily slots open on their calendars for patients requiring immediate attention.

- A VHA review substantiated the allegation of excessive waiting time. The review found the pharmacy was 2 weeks behind inputting new mail-out prescriptions due to staffing and workload issues. This caused a delay in a veteran receiving his prescription. As a result, management hired additional employees and made changes in the processing of prescriptions.

- A VHA review substantiated the allegations of poor communications with a family member and poor documentation. The review found communication lapses occurred between the VAMC and family members of a deceased veteran resulting in numerous death certificates being issued and a delay in funeral services. To correct this situation, management assigned a member of the surgical staff primary responsibility for decedent affairs.

- A VHA review found that a physician who claimed to have discussed a proposed surgical procedure with a veteran, failed to document the discussion in the patient's medical records. Additionally, some information was missing from the signed consent form, such as the patient's name and Social Security number. The physician was counseled on the need to improve documentation.

- A VHA review substantiated a family's perception of poor quality of care and poor communications by VA staff in an extended care unit. Management counseled the staff on the importance of maintaining good and courteous communications with patients and families, particularly in an extended-care ward, and was reminded to promptly report evidence of neglect.

- A VAMC review verified a patient's allegations that dental appointments were cancelled at the last minute. The record showed at least once in the preceding year an appointment had been cancelled because the provider was summoned for jury duty. The director apologized to the veteran for the inconvenience. The VAMC response also indicated the veteran's traumatic brain injury and resulting cognitive distortions may have lead to his perception of poor and unprofessional treatment. The veteran's concerns about communications problems were discussed with all dental clinic staff and customer service training was provided.

Employee Misconduct

- As the result of a Hotline inquiry, a VHA review substantiated the allegations that a VA employee misused official time, misused Government resources, and violated ethical conduct standards. The review found the employee posted numerous bulletin board messages using a Government computer. As a result, the employee was suspended for 14 days without pay.

- A VHA review substantiated the allegation of misuse of Government sources and other violations of ethical conduct standards. The review found that a VA police officer purchased alcohol while in uniform and driving a Government vehicle. The review also found that the VA police supervisor previously reviewed the same allegation and improperly conducted the investigation. Management took action to remove the police officer and suspended the police supervisor.

- A VHA review disclosed communications problems at an outpatient clinic that caused a perception of employee misconduct on the part of two employees involved in a personal relationship. A board of investigation found that clinic employees were not aware that an August 2000 reorganization had realigned the supervisory lines. The board recommended that classes be held to educate the employees about the organizational restructuring. In addition, the board recommended the clinic implement a schedule of daily, monthly, and quarterly meetings to address the clinic's general communications problems.

- A VHA review substantiated the allegation of Privacy Act violations. The review found that a VA employee accessed her ex-husband's medical records without his knowledge or authorization. Management counseled the employee on the serious nature of her action and the potential consequences should there be a recurrence.

Time and Attendance

- Prompted by a Hotline inquiry, a VHA review substantiated timekeeping irregularities. A timekeeper was allowed to post her own time, and the approving official was also the alternate timekeeper. Additionally, the supervisor allowed staff to alter their tours of duty without reflecting a change in the timecards. The facility moved the timekeeper's card to another unit, removed the supervisor's alternate timekeeper duties, corrected the tours of duty for the section, and counseled the supervisor on the correct method of maintaining timecards.

- A VHA review substantiated the allegation that an employee was improperly receiving on-call pay for 8 months. The VAMC took numerous corrective actions and appointed an administrative board to review recommendations related to the findings.

- A VHA review substantiated the allegation of time and attendance irregularities. A former radiology supervisor granted extended lunch periods to a certain employee and allowed the employee to work beyond the tour of duty as compensation. However, the supervisor failed to provide official documentation of time worked outside normal duty hours. Timecards on the employee involved were corrected. The supervisor and staff received instruction on the correct electronic time and attendance policies.

- A VHA review substantiated the allegation that a nurse misreported leave taken and that her husband, a physician, signed the timecard as the approving official. The nurse was charged the appropriate annual leave and admonished, and her husband was counseled about signing any document involving his wife.

- A VHA review substantiated the allegation of time and attendance abuse. The review found that a 20-year VA employee's use of sick leave was excessive when the employee stated that she did not suffer from a major illness of a chronic nature. As a result, the employee received a sick leave restriction letter and a referral to the employee assistance program. Management will continue to review the employee's use of sick leave.

Fiscal Controls

- In response to a Hotline inquiry, a VAMC review found that inadequate staffing caused a backlog of approximately 12,000 possible revised billings. The VAMC review also found that an estimated 4,000 episodes of care could not be billed because VA has not formulated a national policy on resident supervision meeting Health Care Financing

Administration standards. Using figures provided by the facility, it was determined the VAMC had an estimated loss of $712,000 for FY 2000. The VAMC hired additional staff, provided training in coding procedures, and authorized overtime to address the billings backlog.

- A VHA review substantiated the allegation that a veteran was improperly billed for home health care services that were not received. The review found the home health care provider generated the invoice in error. The invoice was retracted, VA files were amended, and a letter of apology sent to the veteran.

- A VHA review substantiated the allegation that the VAMC improperly billed a veteran $4,800 for health care services. The VAMC failed to locate a signed VA form showing that the veteran was aware he would be charged a co-payment. The VAMC cancelled the bill for services and changed procedures for obtaining signed means tests.

- A VHA review found that a VAMC did not process a veteran's health insurance claim in a timely and correct manner. When the facility's billing process was changed, the new process caused delays and errors in processing claims until the staff was fully trained. The VAMC purchased new computer software and implemented training of employees regarding coding and billing procedures.

Patient Safety

- As the result of a Hotline inquiry, a VHA review substantiated the allegations of violation of patient safety protocols, inadequate staff supervision, and poor communication with patient/ family members. The review found: (i) the level of patient supervision and assessment was inadequate for a wheelchair bound patient who was left unattended; (ii) the VAMC did not follow established guidelines regarding the timeliness of the patient's skin assessment; and (iii) the patient's family was not notified of the patient's falls or bruises as they occurred. The director instituted corrective actions.

- A VHA review substantiated the allegation of patient safety violations. The review found a veteran was improperly discharged from a VAMC prior to arrival of his family. As a result, the veteran, who has a history of wandering off, left his room and was found 6 hours later in a waiting room of the hospital.

Government Equipment and Supplies

- As the result of a Hotline inquiry, a VHA review substantiated an allegation that an outpatient clinic employee was conducting outside business using a Government telephone. The employee's supervisor counseled him to refrain from such inappropriate use and will periodically review telephone call logs.

- Prompted by a Hotline inquiry, a VHA review substantiated the allegation of misuse of Government resources. A VA employee misused a Government computer, telephone system, and fax machine for her personal use. As a result, disciplinary action will be determined in concert with the findings of an active board of investigation of a parallel matter and a review of the employee's personnel record.

Contracting Activity

- Prompted by a Hotline inquiry, a VBA review found that a construction contractor on a VA project, in violation of the Davis Bacon Act, did not pay one of its laborers at the prevailing wage rate. The VISN, as contract administrator, ordered the contractor to issue a check to the employee for $2,935.

- A VHA review substantiated the allegation of contract/procurement irregularities. The review found that a veteran encountered problems with a contractor hired by VA to build a wheelchair ramp,

porch lift, and scooter lift for his flat bed truck to accommodate his disability. Management hired a new contractor and is monitoring the situation until the contract has been successfully completed.

Personnel Issues

- Prompted by a Hotline inquiry, a VHA review substantiated the allegation of irregular VAMC personnel practices. The VAMC granted a newly transferred employee relocation expenses, however relocation expenses were not included in the original vacancy announcement. The VAMC has issued a $4,322 bill of collection for the reimbursement of the relocation expenses.

- A VHA review substantiated the allegation of prohibited personnel actions. The review found that a VA physician circumvented normal procedures for posting job vacancy announcements. Management counseled the physician and an administrative officer on the proper procedures for posting announcements.

Ethical Improprieties

- In response to a Hotline inquiry, a VHA review determined that a VA official used official e-mail to solicit gifts from subordinate employees for a newborn grandchild. The official was counseled about the ethics violation and the inappropriate use of VA equipment and he had to attend a special ethics training session.

- A VHA review substantiated an allegation of conflict of interest. The review found two VA employees were accepting meals from agents of prohibited sources. As a result, the employees received written counselings.

Abuse of Authority

As the result of a Hotline inquiry, a VHA review found that an employee had hired her two children for the summer jobs program, creating the perception of a conflict of interest. VAMC management counseled the employee to avoid the appearance of impropriety. Additionally, the director reviewed the summer jobs program to ensure that application procedures are easy to follow and that VA employees are not in a position to hire or supervise family members.

Workers' Compensation

Prompted by a Hotline inquiry, a VISN review found the VAMC failed to properly bill the Department of Labor for workers' compensation claims. Management implemented process changes to improve the program.

Veterans Benefits Administration

Receipt of VA Benefits

- As the result of a Hotline inquiry, a VBA review found that a veteran who was incarcerated in a state prison since 1997, never reported his status change to VA. The VARO reduced the veteran's benefits and created an overpayment of $66,905.

- A VBA review substantiated a veteran's allegation that certain documentation was missing from his VA file. The VARO requested copies of those records from the federal archives and the National Guard.

- A VHA and VBA review at a VAMC and a VARO found that a non-veteran had assumed the identity of a veteran with a similar name in order to receive outpatient medical services. The VAMC terminated medical services for the non-veteran and flagged the veteran's file with a national alert should the non-veteran seek services at another VAMC. The VARO also flagged the claims folders for both the veteran and the non-veteran.

- A VBA review at a VARO substantiated the allegation of erroneously withheld attorney fees of $3,497 from a veteran. The funds were subsequently released to the veteran.

- A VBA review substantiated the allegation that a VARO mishandled and lost a veteran's claim file. The review found the VARO's computer system erroneously reflected that her file was located in the rating activity, when in fact it had been missing for 10 months. The VARO began rebuilding the veteran's claim file and informed her of this action by mail.

- A VBA review found a veteran was improperly receiving benefits for a stepchild who did not reside with her. As a result, the stepchild was removed from the award and the VARO processed an overpayment.

- A VBA review substantiated the allegation of problems with administrative services. The review found that a veteran was improperly billed for a debt resulting from non-payment of a home loan. As a result, the VARO granted the veteran a pre-foreclosure waiver, relieving him of the outstanding debt of $11,952, and will refund monies already paid against the debt.

- A VBA review substantiated the allegation of fiduciary irregularities in the non-payment of a veteran's nursing home bill. The fiduciary was withholding payment until a pending guardianship issue was settled. The VARO authorized the fiduciary to pay the outstanding bill of $15,121 on behalf of the veteran.

- A VBA review found that due to a clerical error the VARO had erroneously notified the VA Debt Management Center of a veteran's death, resulting in the suspension of the veteran's benefits. The VARO reinstated the veteran's benefits and apologized to him for their error.

- A VBA review substantiated fraud in the receipt of DIC benefits. Prior to applying for DIC benefits on her deceased fourth husband (a WWI veteran), a widow married for the fifth time and drew benefits for 29 years until the fraud was reported. The VARO notified the widow of the termination of her benefits back to the inception date, creating an overpayment of $191,690.

- A VBA review of a widow's records revealed that she continued to receive DIC benefits during a 4-year period in which she was remarried. The VARO created an overpayment of $60,284.

Privacy Issues

Prompted by a Hotline inquiry, a VBA review found that a veteran's records were improperly reclassified from a "sensitive" status, although the review did not determine that his personal information had been released. The VARO reclassified the veteran's file to a higher level of security than was used previously, placed it in a locked file, and protected it with a "flash" notice that permits information release only with written consent from the veteran.

National Cemetery Administration

As a result of a Hotline inquiry, a VA national cemetery review found problems with a cemetery's facilities and services. The review found that flat markers were damaged, grass was growing up around the markers, and over 40,000 markers were in need of raising and realignment. The cemetery is currently undergoing extensive renovation.

Board of Veterans' Appeals

Prompted by a Hotline inquiry, a Board of Veterans' Appeals review substantiated the allegation of Privacy Act violations. The Board

published their decisions on the Internet, containing veterans' Social Security numbers and other personal identifiers, such as familial relationship, and words indicating that an address of the veteran may be present. As a result, management revised its procedures for reviewing decisions prior to publication, and discontinued public distribution and sale of yearly decisions on CD-ROM. The Board is also reviewing previously published decisions from 1994 to the present to ensure no further Privacy Act violations.

Outside Organization

Prompted by a Hotline inquiry, a review found that a veterans' service organization improperly solicited donations from the veteran after his legal guardian requested that all solicitations be discontinued. As a result, the organization's vice president has implemented new procedures to preclude this problem from occurring in the future. His organization returned the veteran's initial donation and issued a letter of apology.

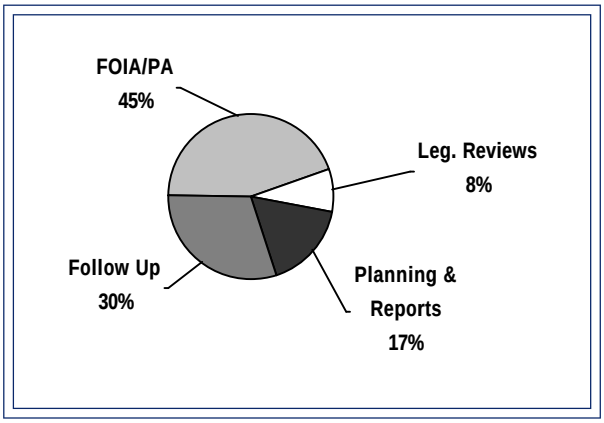
II. OPERATIONAL SUPPORT DIVISION

Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely follow up reporting and tracking on OIG recommendations; responding to Freedom of Information Act (FOIA)/Privacy Act (PA) requests; conducting policy review and development; strategic, operational, and performance planning; and overseeing Inspector General reporting requirements.

Resources

This Division has 9 FTE assigned with the following allocation:



Overall Performance

Follow Up on OIG Reports

The Division is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $2.9 billion of actual or potential monetary benefits as of March 31, 2001. Of this amount $1.2 billion is resolved, but not yet realized as VA officials have agreed to implement the recommendations, but have not yet done so. In addition, $1.7 billion relates to unresolved reviews awaiting contract resolution by VA contracting officers and one audit with VHA deferment on concurrence or non-concurrence with the recommendations pending more focused attention and direction by VHA's National Leadership Board.

The Division is also responsible for maintaining the centralized, follow up system that provides for oversight, monitoring, and tracking of all OIG recommendations through both resolution and implementation. Resolution and implementation actions are monitored to ensure that disagreements

between OIG and VA management are resolved as promptly as possible and that corrective actions are implemented as agreed upon by VA management officials. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

As of March 31, 2001, VA had 68 open internal OIG reports with 163 resolved but unimplemented recommendations, 39 unresolved contract review recommendations that are awaiting contracting officers' decisions, and 3 unresolved recommendations awaiting VHA's National Leadership Board action.

After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close during this period 58 internal reports and 248 recommendations with a monetary benefit of $486 million.

During this period, 100 percent of follow up requests on immediate actions were sent within three months. Also, 100 percent of the initial and the subsequent follow up letters were processed in less than 3 months. In both cases, we met the standard.

Freedom of Information Act, Privacy Act, and Other Disclosure Activities

The Division processes all OIG FOIA and Privacy Act requests from Congress (on behalf of constituents), veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, general public, and subjects/witnesses of inquiries and investigations. In addition, the Division processes official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel, the Department of Justice, and the FBI. These requests require the review and possible redacting of OIG Hotline, healthcare inspection, criminal and administrative investigation, contract audit, and internal audit reports and files. We also process OIG reports and documents to assist VA management in establishing evidence files used to support administrative or disciplinary actions against VA employees.

During this reporting period, we processed 153 requests under the Freedom of Information and Privacy Acts and released 199 audit, investigative, and other OIG reports. In five instances we had no records. Information was totally denied in 3 requests and partially withheld in 93 requests because release would have constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute.

During this period, one FOIA case did not receive a written response within 20 work days, as required. There are no cases pending over 1 year. Our average processing times were 172 work days for complex cases, 31 work days for less complicated requests, and 10 work days for routine matters.

The Information Technology and Data Analysis Division section reports on electronic FOIA activities.

Review and Impact of Legislation and Regulations

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, OMB, and the Department that relate to VA programs and operations. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, we reviewed 30 legislative, 51 regulatory, and 35 administrative proposals.

Status of OIG Reports Unimplemented for Over 3 Years

We require management officials to provide us with documentation showing the completion of corrective actions on OIG reports, including reporting of collection actions until the amounts due VA are either collected or written off. In turn, we conduct desk reviews of status reports submitted by management officials to assess both the adequacy and timeliness of agreed upon implementation actions. When a status report adequately documents corrective actions, the follow up staff closes the recommendation after coordination with the OIG office that wrote the report. If the actions do not implement the recommendation, we request a status update.

The following chart lists the total number of unimplemented OIG reports and recommendations. It also provides the total number of unimplemented reports and recommendations issued in FY 98 and earlier.

VA Office	Unimplemented OIG Reports and Recommendations			
	Total		FY 98 and Earlier (note)	
	Repts	Recoms	Repts	Recoms
VHA	35	106	4	5
VBA	9	50	3	3
A&MM	21	46	0	0
HRA	2	2	0	0
I&T	1	1	0	0
Total	**68**	**205**	**7**	**8**

Office of Acquisition and Materiel Management (A&MM)
Office of Human Resources and Administration (HRA)
Office of Information and Technology (I&T)

(Note): There are two additional 1998 reports not listed in the above "FY 98 and earlier" columns and not listed in the below summaries because they are contractor related reports. One is an A&MM acquisition center report and one is a VHA facilities management report. Both reports are listed in Appendix C on contractor reviews.

We are particularly concerned about the FY 98 and earlier reports that have not been implemented 3 years after being issued. The status and OIG concerns on these FY 98 and earlier reports are summarized as follows.

Veterans Health Administration

Unimplemented Recommendations and Status (FY 98 and Earlier Reports)

Report: *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes, 4R3-A28-016, 1/11/94*
Recommendation: **VHA develop standardized community nursing homes inspection procedures and criteria for approving homes for participation in the program.**
Status: In December 2000, VHA staff indicated a revised draft directive on transmission of information on assaultive patients was in the concurrence process, but they were unable to predict a publication date. VHA staff also indicated another draft would be put into the concurrence process in March 2001, however this did not occur. No planned completion date has been provided.
Concern: The OIG is concerned that this report, which dates back to 1994, has not yet been implemented. The final report showed that inspection procedures varied between VAMCs, appropriateness of community nursing homes inspection team makeup could be improved, and annual reinspections should be conducted more timely. These are still issues which need to be addressed to improve care of veterans.

Report: *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients, 6HI-A28-038, 3/28/96*
Recommendation: **VHA managers should explore network flagging systems that would ensure employees at all VAMCs are alerted when patients with histories of violence present for treatment to their medical centers.**
Status: The title of the implementation project is computerized advisories to reflect the new approach VHA is proposing to develop warnings on repetitively dangerous patients. The draft directive is going through concurrence. VHA will also require a computer approach that is system wide to implement this project. A draft proposal will be presented to the VA information technology advisory council in May 2001. Tied to the implementation of the computer approach and directive is the need for training of staff in the proper use of computerized use of patient flagging as a treatment tool. The final products may not reach the field until 2002.
Concern: The OIG report included recommendations that were meant to strengthen areas that may reduce that incidence of injury associated with violence in inpatient psychiatric units. The original planned completion date was October 1996. A directive provided in 1998 did not address the issue. The OIG believes the new computerized advisory project, when implemented, will close this 1996 recommendation.

Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*
Recommendations: **VHA improve the cost effectiveness of home health services by: (1) establishing guidelines for contracting for such services, and (2) providing contracting officers with benchmark rates for determining the reasonableness of charges.**
Status: VHA provided a 10-page draft directive on purchased skilled home health care and homemaker/home health aide services in July 2000, and again in December 2000, however both drafts did not address recommendation (2). In March 2001, VHA stated another draft directive would be put into the concurrence process in April 2001. No planned completion date has been provided.
Concern: The June 1997 final report showed that contracting for home health services could save at least $1.8 million annually, however the recommendations remain unimplemented. The May 1997, comments to the draft report referred to a pilot project that would implement the recommendations. However, 1½ years later, the December 1998 status update reported that the pilot did not address these recommendations. We are concerned that the last four status updates from the program office reported either delays in planned completion dates or did not provide a planned completion date. As a result, over $5.3 million has been spent on these contracts which could have been avoided. We are also concerned that until this condition is corrected, at least $1.8 million annually is not saved.

Report: *Evaluation of VA Capital Programming Practices and Initiatives, 8R8-A19-061, 1/28/98*
Recommendation: **Develop a policy for VISN-controlled capital investments, including policy on the types of investments subject to capital programming, on dollar thresholds, and on responsibilities for considering alternatives, performing benefit-cost analysis, and meeting other capital programming requirements.**
Status: VHA has written a detailed draft directive on network capital asset planning that will implement the recommendation. The draft directive has been shared with field staff and minor project applications for the FY 2002 operating plan are being prepared in accordance with the draft directive. VHA management may decide to hold the final publication of the directive pending any recommendations for improvement that will result from the General Accounting Office's review of the process which should be completed shortly.
Concern: In FY 1997, VA's capital investment costs were about $1.3 billion. Historically VA has not had a comprehensive capital programming process. The report noted VA did not always

consider alternatives to proposed capital asset acquisitions and did not use benefit-cost analysis to support capital decisions. The original planned completion date was September 1998.

Veterans Benefits Administration

Unimplemented Recommendations and Status (FY 98 Reports)

Report: *Review of VBA's Procedures to Prevent Dual Compensation, 7R1-B01-089, 5/15/97*
Recommendation: **VBA follow up on FYs 1993 through 1996 dual compensation cases to ensure either VBA disability payments are offset or the Department of Defense is informed of the need to offset reservist pay.**
Status: VBA stated a letter was sent to the Director, Defense Manpower Data Center in December 2000, requesting that VA be provided an accurate file of reservist training days. Once the center provides the accurate data, VBA can begin the match. VBA also plans to set up a series of meetings with the manpower data center to further discuss this issue. No planned completion date has been provided.
Concern: The audit's purpose was to determine if VBA's procedures ensured that disability compensation benefits of active military reservists were properly offset from their training and drill pay. It found that 90 percent of the potential dual compensation cases reviewed did not have offsets from their military reserve pay. We are concerned that an estimated $8 million in annual dual compensation payments continue to be made each year because this recommendation has not been implemented.
Report: *Audit of Veterans Benefits Administration SSA/VA Death Match Procedures, 8R4-B01-069, 2/6/98*
Recommendation: **Correct electronic beneficiary data base system errors, and link other electronic beneficiary data bases, where necessary.**
Status: VBA stated they plan to run a one-time match between the beneficiary identification records locator system and the master record to identify the extent of the problem. After the match is completed, VBA will conduct another analysis. Once the extent of the problem is determined, appropriate measures will be implemented. No planned completion date has been provided.
Concern: The IG report found that VBA needed to develop and implement an effective method to identify deceased veteran beneficiaries and terminate their benefits timely. Based on information about veterans' deaths received from SSA, audit sample results showed that only 56 percent of veterans reported by SSA as deceased were, in fact, deceased. VBA benefit awards for 27 percent of the sampled deceased claimants were still running, had incorrect termination dates, or had incorrect suspense dates. The OIG is concerned that approximately $4 million in erroneous payments were made throughout VBA.

Report: *Alleged Improper Reimbursement of Relocation Expenses, VARO San Diego, CA, 8PR-B01-097, 4/17/98*
Recommendation: **The VARO Director should establish a debt and collect the real estate expenses that were improperly paid to a VARO supervisor. The collection should include all withholding tax and relocation income tax allowances paid.**
Status: VBA stated they received an opinion from the VA regional counsel that indicated the individual did not receive proper notice of a hearing to allow salary offset. Regional counsel is in the process of providing the notice and hearing for a salary offset. No planned completion date has been provided.

Concern: A review at a VARO substantiated an allegation that a supervisor improperly claimed and was reimbursed real estate expenses not incidental to a transfer to a new duty location. The report recommended a debt be established to collect the real estate expenses, including all withholding tax and relocation income tax allowances improperly paid to the employee. A final accounting found the debt was $19,352.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

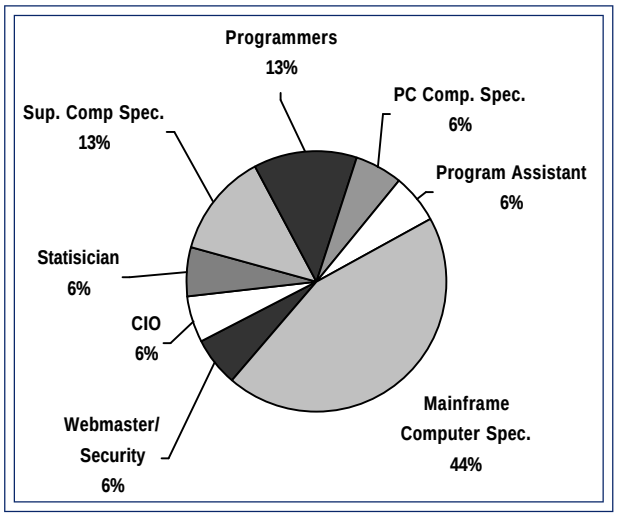
Mission Statement

Promote OIG organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of OIG information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to this database, VA databases, and electronic mail by all authorized OIG employees; providing Internet document management and control; and providing statistical consultation and support to all OIG components. Provides automated data processing technical support to all elements of the OIG and other Federal Government agencies needing information from VA files.

The Information Technology (IT) and Data Analysis Division provides IT and statistical support services to all components of the OIG. It has responsibility for the continued development and operation of the management information system known as the Master Case Index (MCI), as well as the OIG's Internet resources. The Division interfaces with VA IT units nationwide to establish and support local and wide area networks, guarantee uninterrupted access to electronic mail, service personal computers, detect and defeat computer threats, and provide support in protecting all electronic communications. The Division, which is managed by the OIG's Chief Information Officer, represents the OIG on numerous intra- and inter-agency IT organizations and is responsible for strategic IT planning for all OIG requirements. The Data Analysis section in Austin, TX provides data gathering and analysis support to those employees of the OIG, as well as VA and other Federal agencies, requesting information contained in VA automated systems. Finally, a member of this division serves as the OIG statistician.

Resources

The Division has 19 FTE currently assigned in Washington, DC; Austin, TX; and Atlanta, GA. These FTE are devoted to the following areas:



Overall Performance

Master Case Index (MCI)

During this reporting period, we completed more than 50 enhancements of the MCI, the OIG's enterprise database. Most significantly, we developed a new form and several reports that

allowed our Hotline Division to abandon a standalone database solution to capturing information about the 16,000 telephone calls this Division receives each year. This enhancement reuses data saved on this new form when Hotline personnel open an MCI case on a different form thereby saving tens of thousands of keystrokes each year. We undertook this effort with existing staff when three vendors advised us that the development costs of a form with even less functionality than the one we developed would cost $50,000. We also enhanced the Office of Investigation's forms by providing a more robust case management module. Audit's forms were enhanced with the addition of nearly 14 years of legacy data about report recommendations previously maintained in a standalone database. Finally, we also significantly enhanced the Office of Healthcare Inspections form to allow staff to take full advantage of the time-saving features previously developed on other forms.

Internet and E-FOIA

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG websites and posting OIG reports on the Internet. Data files on the OIG websites were accessed over 631,000 times by more than 107,000 visitors. Our most popular reports were downloaded over 50,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports that must be printed and mailed. Our vacancy announcements accounted for an additional 42,000 downloads.

We posted CAP, healthcare inspection, and audit reports in our electronic reading room in compliance with the Electronic Freedom of Information Act. This included restricted publications that we electronically redact before making them available online. We published 9 reports, 46 Office of Investigations press releases, the OIG's latest strategic plan, and other OIG publications, including this semiannual report to Congress, on our website.

Information Management, Security, and Departmental Coordination

We enhanced the security of sensitive OIG data and systems through OIG employee information security education and awareness, timely computer security incident response, and additional internal network monitoring. During one security incident, we identified and analyzed a macro virus that was not being detected by the Department's antivirus program -- our analysis was used to get updated virus signatures from the Department's antivirus vendor. We provided hands-on encryption training to OIG's healthcare inspectors to further prepare for the pending security and privacy requirements of the Health Insurance Portability and Accountability Act.

We actively participate in the development of departmental policies and programs to improve VA information security, IT accessibility, and Internet resources and utilization. We assessed the Department's proposed public key infrastructure and made recommendations regarding OIG access to encrypted data, protection from unauthorized decryption/key recovery, VA-wide user agreements that include consent to access and recovery of encrypted data, audit trails for all key recovery actions, and improved reporting of key compromise procedures.

We provided comments on the Department's proposed VA-wide intrusion detection statement of work, including recommendations on determining the boundaries of the VA network to be included and reporting requirements if the boundaries are exceeded, stating the depth of the network topology maps to be created, and securing the information generated by the project.

We provided feedback on the Department's proposed Internet/Intranet services policies. In conjunction with the Department of Justice Computer Crimes and Intellectual Property Section, we developed proposed warning notices for all VA Internet and Intranet sites to help ensure

successful prosecutions of future attacks on VA's Internet infrastructure. We also recommended adding Federal Records Act requirements, rewriting the external links policy, and modifying cookie policies to conform with the latest promulgations from the OMB Office of Information and Regulatory Affairs.

Statistical Support

The OIG statistician is part of the technical support team under the direction of the OIG's Chief Information Officer. The OIG statistician is the subject matter expert providing statistical consultation and support to the VA OIG. The statistician provides assistance in planning, designing, and sampling for relevant IG projects. In addition, the statistician provides support in the implementation of appropriate methods to ensure that data collection, preparation, analysis, and reporting are accurate and valid.

For this period, the OIG statistician and a computer specialist provided statistical support for all CAPs. This support involved preparing and processing the random samples of full-time VAMC employees who were part of the CAP's employee satisfaction survey. In addition, the individuals provided support to process the CAP data collected while on-site.

Information Technology Training Initiative

We have contracted with four vendors to provide instructor-led training in a variety of *Microsoft* applications in our newly constructed classroom in our Washington, DC headquarters office and one vendor with training facilities in each city in which the OIG is located to provide training for our field employees. To date, 93 employees have received 196 days of instructor-led training in Washington, DC, while 48 field employees have received 64 days of training locally.

DATA ANALYSIS SECTION

The Data Analysis section analyzes data in VA computer files and systems. They develop proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud and they refer these leads to OIG auditors and investigators for further review.

They conduct reviews that identify invalid or erroneous information in VA computer files that can lead to bad results or erroneous conclusions. They provide automated data processing technical assessments and support to all elements of the OIG and other governmental agencies needing information from VA computer files. They also provide automated data processing technical support to preaward and postaward OIG audit reviews that assist VA contracting officers in price negotiations and to ensure reasonableness of contract prices.

The support work provided by the section staff is reported in many of the OIG audits, inspections, and investigative cases described in other sections of this report.

Collaborations with VA Office of Financial Policy, Financial and Systems Quality Assurance Service

During this reporting period, the section worked closely with auditors from the Service to test newly developed fraud detection computer profiles. They developed four new computer profiles during this reporting period that resulted in three potential fraud cases. Examples include:

- Service auditors reviewed profiled cases at one VARO by pulling folders and reviewing the documentation. The results were three potential fraud referrals to OIG investigators with estimated dollar recoveries for VA of $656,876.

- In May 2000, the section provided the Service auditors with a list of eight potential bogus veterans whose folders were maintained at the VARO. After the auditors on-site visit to the VARO, they reported that a folder for one of the eight could not be located. The section reviewed the computer record further and found the veteran's record had been changed to reflect his death on the first workday following the team's visit to the VARO. The record was referred to OIG investigators. In February 2001, a VARO employee and a non-VA employee associate were indicted by a grand jury with 24 counts of fraud against VA.

Collaborations with VBA

The section worked with the VBA to form a collaborative effort to help identify internal and external fraud within VBA computerized systems. The effort is currently limited to computer profiles developed for the compensation and pension area, but long-range plans include developing additional profiles that include the VA life insurance and loan guaranty programs. An example of this collaboration was the referral to VBA of 21 cases of retroactive one-time payments in excess of $25,000 at VARO Wichita, Kansas. VBA determined that 20 of the cases appeared to be correct. In the remaining case, their review showed that 2 payments of more that $85,000 each had been made erroneously to the same widow. One of the checks was returned. A second check, made 5 months later, was deposited directly into her bank account.

Postaward and Preaward Contract Reviews

The section assisted OIG auditors by providing automated data processing support in obtaining and analyzing the sales data provided by independent vendors seeking or under contract with VA. During the course of providing this assistance, the section coordinated with company personnel and attorneys and OIG auditors to ensure the needs of the audit were met and that VA prices were fair and equitable and in accord with the terms of the contract. Examples include:

- During a postaward contract review, a company provided the top 100 sales made to VA for both federal supply and non-federal supply schedule sales. Many of the item numbers provided by the company had changed from a previous audit and some needed data was omitted from what the company provided. As a result, there was not enough data for the auditor to perform the review. The section worked with company IRM staff and IG auditors to obtain the needed information in the proper format to complete the audit.

- The section assisted auditors during a company's voluntary disclosure concerning pricing reductions they charged VA. The company provided the information voluntarily, but it was on magnetic media more advanced than could be processed at the Austin Automation Center. The section worked with company IRM and the Austin Automation Center staff to successfully convert the data.

Requests from Other Federal Agencies

The section completed 13 requests from other Federal agencies for information contained in VA computer files and systems. Examples include:

- Fourteen requests originated from joint criminal and/or civil investigations between the Department of Health and Human Services and Department of Justice. Allegations generally involved companies or entities alleged to have defrauded Medicare or Medicaid programs and determination that VA may have been defrauded in the same or similar manner.

- The section provided a list of veteran addresses to the FBI that had been involved in a fraudulent medical reimbursement payment scheme. Six VA employees have been indicted.

- The section provided a list containing VA benefit check information on 230 checks requested by a U. S. postal inspector. The checks had been stolen during a large-scale theft.

Requests from VA

During this reporting period, the section completed 27 requests for information from other VA offices. Examples include:

- The section provided eight files to VARO Manila that identified Philippine scouts that served during World War II who are receiving VA pension to which they are not entitled. They also provided lists containing Philippine veterans whose age on VA files was shown as equal to or greater than 99 years. The data was provided so the VARO could identify potential fraud within their records.

- The section also provided OIG investigators with a listing of 17,000 veterans and beneficiaries receiving VA benefits who are living in the Philippines. An analysis of these veterans showed widow's ages ranging from 2 to 194 years old, and a veteran who was recorded as being 6 years old. They also showed nearly 3,000 beneficiaries whose folder resides at VARO Manila, but live in other countries. Based on the information provided by the section, OIG investigators identified about 4,000 folders that warranted closer review.

- At the request of the VHA, the OIG section turned over files, program code, and system documentation they had developed to VHA IRM staff. The programs are used to help VHA perform a national reconciliation of their account receivables. All VHA stations transmit their account receivables to the Austin Automation Center on a quarterly basis. The OIG program code was used to gather, consolidate, and compare station totals to nationally reported totals. VHA expressed an interest in obtaining the programs for their own use. The section worked closely with VHA to ensure everything needed was provided and that VHA could continue to run the system using their own resources. During any given quarter, about 10 million account receivable bills and about 20 million payments are reconciled.

General Workload

During this reporting period, the section completed 238 ad hoc requests submitted from all OIG operational elements and supported 13 OIG Combined Assessment Program reviews. They also worked on 39 proactive projects involving data mining to detect potential fraud in VBA and VHA systems. They also completed 61 requests from auditors in the OIG Contract Review and Evaluation Division.

V. RESOURCES MANAGEMENT DIVISION

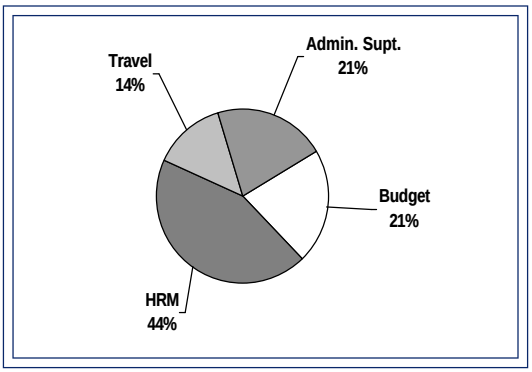
Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely management and administrative support services.

The Division provides support services for the entire OIG. Our services include personnel services and liaison; budget formulation, presentation, and execution; travel processing; procurement; space and facilities management; and general administrative support.

Resources

The Division has 14 FTE currently assigned. The staff allocation for the four functional areas is as follows:



Overall Performance

Budget

The staff assisted in the preparation of the FY 2002 budget submission and materials for associated hearings in the Department and with the Congressional Committees.

The staff executed 45 percent of the OIG's FY 2001 budget authority.

Human Resources Management

During this period, the staff brought 44 new employees on board. In addition, the staff processed 144 personnel actions, 3 outstanding career awards, 53 special contribution awards, 17 time-off awards, 28 on-the-spot awards, and 1 peer award.

Travel

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,600 travel and 56 permanent change of station vouchers in addition to 17 new permanent change of station authorities and 22 amendments to existing authorities.

Administrative Support

The administrative staff works closely with Central Office administrative offices and building management to coordinate various administrative functions, office renovation plans, telephone installations, and the procurement of furniture and equipment.

In addition, this component processed 107 procurement actions and reviewed and approved, each month, the 30 statements received from the OIG's cardholders under the Government's purchase card program.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

Financial Audit Division staff participate in the Federal audit executive committee financial statement audit workgroup. The workgroup facilitates communication of financial statement audit issues throughout the Federal audit community.

OIG Management Presentations

Leadership VA 2000 Program

The Inspector General made a presentation on the work of the OIG to the Leadership VA Class of 2000. This program is VA's premier leadership development program.

Midwestern Intergovernmental Audit Forum

The Inspector General participated in the conference in Chicago. His presentation included real life examples of OIG findings at VAMCs and the efforts by the OIG staff to analyze common problems among these hospitals.

General Accounting Office Intergovernmental Audit Forum

The AIG for Auditing was on a General Accounting Office intergovernmental audit forum panel. The panel addressed audit involvement with Government Performance and Results Act data validation.

Indonesian Audit Agency Meeting

The Director, Operational Support Division; Director, Planning Division; and investigative staff made presentations to the Indonesian audit agency for finance and development supervision. The presentations included an overview of the U.S. Government, VA, VA OIG, Government Performance and Results Act, and the Office of Audit's auditor training program. In addition, they provided summaries of three prior audits.

Office of Acquisition and Materiel Management Seminar

The Financial Audit Division Director provided a presentation on nonexpendable equipment and excess property accounting and controls at an Office of Acquisition and Materiel Management seminar.

VHA Training Sessions on Workers' Compensation Program Cases Management and Fraud Detection

The Central Office Audit Operations Division Director, audit manager, and representatives from the Office of Investigations participated in training sessions for VISN managers who were assigned responsibility for coordinating VHA's national case review. This effort is being completed as part of a one time national case review that we recommended. OIG representatives presented training sessions at VAMCs Bay Pines and Long Beach on *Using Information Technology for Successful Workers' Compensation Program Case Management and Fraud Detection*. Over 50 VHA health and safety staff attended.

National Acquisition Center Federal Supply Schedule Training

The Director and an audit manager from the Contract Review and Evaluation Division assisted the acquisition resources team and Office of General Counsel in conducting training related to price reductions on Federal supply schedule

contracts. The presentation addressed the VA OIG's role in evaluating compliance with price reduction clauses contained in contracts and focused on what actions are needed to improve overall compliance with contract term.

VA Health Care Contracting Training

The Director and an audit manager from the Contract Review and Evaluation Division provided a presentation on contracting for scarce medical specialist services to VHA contracting officers in Little Rock, AR. The presentation covered the history of contracting with affiliates for scarce medical resources, the preaward review process, and common problems the OIG has encountered over the last year performing these reviews.

Association of Military Surgeons of the United States Conference

Three Office of Healthcare Inspections employees (George Wesley, M.D.; Linda DeLong, R.N., MSN; and Jim Marchand, MA, CPHQ, CGFM) made a poster presentation titled: *Hepatitis C: A Study of Clinical and Economic Concerns for HCV Infected Patients Treated by the Department of Veterans Affairs.*

Unsuspected Poisoning in Suspicious Hospital Deaths Conference

Two senior Office of Healthcare Inspections employees (George Wesley, M.D.; and Patricia Christ, RN, MBA, CPHQ) were discussants on the conference's concluding panel. This panel addressed possible protocols in instances of unexpected hospital deaths and what needs to be done when a suspicious death occurs in a hospital.

Awards

Office of the U. S. Attorney for the Eastern District of New York

- The Office of the U. S. Attorney for the Eastern District of New York, Long Island Division, presented VA OIG employees Samantha Lockery, Thomas Valery, Jenny Pate, Shirley Henley, Patricia Christ and Linda DeLong with awards for their involvement in the investigation leading to the indictment and conviction of a former physician. The physician pleaded guilty to the murder of three veteran patients at VAMC Northport and was sentenced to three consecutive life sentences.

- The Office of the U. S. Attorney for the Eastern District of New York, Long Island Division, presented VA OIG special agents Samantha Lockery and Thomas Valery with awards for their involvement in a multi-faceted real estate fraud investigation in which seven defendants have entered guilty pleas and three mortgage banks have been closed. The investigation established the defendants submitted false information enabling non-qualified home buyers to qualify for Government insured loans. Several of the properties purchased have since gone into foreclosure.

American Pharmaceutical Association

Healthcare Inspector, Wilma K. Wong, Pharm.D., was selected as a Fellow of the American Pharmaceutical Association.

International Journal of Military Medicine

Dr. George Wesley, Director, Medical Assessment and Consultation; and Verena Briley-Hudson, Director, Chicago Healthcare Regional Office were recognized in the January 2001 issue of the *International Journal of Military Medicine*, for their work in peer reviews of articles submitted for publication.

OIG Congressional Testimony

In March 2001, the Inspector General testified before the House Committee on Government Reform, Subcommittee on National Security, Veterans Affairs, and International Relations. The testimony addressed the major performance and management challenges facing VA and highlighted the contributions of the OIG in combating crime, waste, fraud, and abuse in the Department.

Obtaining Required Information or Assistance

- Sections 5(a)(5) and 6(b)(2) of the Inspector General Act of 1978 require the Inspector General to report instances where access to records or assistance requested was unreasonably refused, thus hindering the ability to conduct audits or investigations. During this 6-month period, there were no reportable instances under these sections of the Act.

- Under P.L. 95-452, the IG has authority "… to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary . . . ." The use of IG subpoena authority has proven valuable in our efforts, especially in cases dealing with third parties. During this reporting period, the OIG issued 44 subpoenas in conjunction with OIG investigations and audits.

APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
00-02022-17 11/30/00	Combined Assessment Program Review, VA Pittsburgh Healthcare System	$250,794	$250,794	
00-01222-11 12/20/00	Combined Assessment Program Review of VA Montana Healthcare System and Regional Office			
00-02062-22 1/19/01	Combined Assessment Program Review of VA Medical Center Spokane, WA			
00-02974-35 1/31/01	Combined Assessment Program Review, VA Medical Center Miami, FL	$102,639	$102,639	
00-02560-28 2/2/01	Combined Assessment Program Review, VA Regional Office Boston, MA	$66,767	$66,767	
00-02679-41 2/22/01	Combined Assessment Program Review, Hunter Holmes McGuire VA Medical Center Richmond, VA	$333,130	$333,130	
00-02068-24 2/24/01	Combined Assessment Program Review of VA Eastern Kansas Health Care System			
00-02063-52 2/26/01	Combined Assessment Program Review of the VA Palo Alto Health Care System	$1,195,900	$1,195,900	
01-00071-59 3/16/01	Combined Assessment Program Review of the VA Puget Sound Health Care System			
00-02023-36 3/26/01	Combined Assessment Program Review of VA Health Care Network Upstate New York at Syracuse	$188,410		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
INTERNAL AUDITS				
99-00054-1 1/8/00	Audit of Veterans Benefits Administration's Income Verification Match (IVM) Results	$806,300,000	$81,668,735*	
99-00057-4 12/20/00	Audit of Veterans Health Administration Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans	$1,613,617,281	$0**	
00-01702-50 2/28/01	Report of Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2000 and 1999			
00-02165-54 3/26/01	Audit of the Department of Veterans Affairs Health Eligibility Center Atlanta, GA	$15,300,000	$15,300,000	
OTHER OFFICE OF AUDIT REVIEWS				
99-00191-2 10/12/00	Evaluation of Financial and Administrative Controls in the Research Program at the VA Greater Los Angeles Healthcare System	$268,000	$268,000	
99-00177-14 11/16/00	Accuracy of Data Used to Compute the Foreclosure Avoidance Through Servicing Ratio			
00-02285-19 12/6/00	Review of Hotline Complaint: Misuse of Government Purchase Card			
99-01685-10 1/25/01	Review of Selected Construction Contracts, Purchase Card Activities, and Vehicle Administration at Veterans Affairs Medical Center Clarksburg, WV			
CONTRACT REVIEWS * **				
99-00117-3 10/4/00	Postaward Review of VA's Federal Supply Schedule Contract with Sherwood Davis & Geck, Contract Number V797P-3022k			

* VBA did not agree with the OIG average processing time figure used in the extrapolation method.

** VHA deferred on concurrence or non-concurrence with the recommendations pending more focused attention and direction by VHA's National Leadership Board.

*** Management estimates are not applicable to contract reviews. Cost avoidances resulting from these reviews are determined when the OIG receives the contracting officer's decision on the recommendations.

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
00-00242-6 10/6/00	Review of Proposal Submitted by University of Pennsylvania School of Medicine for Radiology Services at the VA Medical Center Philadelphia, PA	$3,198		
00-00240-8 10/13/00	Review of Federal Supply Schedule Proposal Submitted by Mallinckrodt Inc., St. Louis, Missouri, Under Solicitation Number M6-Q5-98	$3,057,692		
01-00060-15 11/16/00	Review of Proposal Submitted by University of Arkansas for Medical Services for Anesthesiology Services at the John L. McClellan Memorial Veterans Hospital Little Rock, AR	$413,704		
01-00343-16 11/16/00	Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5354x, Awarded to Novartis Pharmaceuticals Corporation, East Hanover, NJ			$18,296
00-02769-20 12/12/00	Review of Federal Supply Schedule Proposal Submitted by Medline Industries, Inc., Under Solicitation Number RFP-797-FSS-99-0025	$227,454		
98-00087-21 12/12/00	Review of DuPont Pharmaceuticals Company's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Numbers V797P-5720n and V797P-5337x			$329,128
99-00105-25 12/27/00	Review of a Pharmaceutical Company's Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under 10 Federal Supply Schedule Contracts			$2,367,268
00-00248-26 12/27/00	Review of a Pharmaceutical Company's Voluntary Disclosure of Pricing Violations Under Three Federal Supply Schedule Contract Numbers			$4,915,903
99-00077-27 12/27/00	Review of Billings Submitted by a Prime Vendor Under Five VA Pharmaceutical Prime Vendor Contracts			$4,234,671
00-00239-32 1/18/01	Review of Federal Supply Schedule Proposal Submitted by Olympus America Inc., Under Solicitation Number RFP 797-652A-99-0001	$2,986,205		

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
00-00260-33 1/18/01	Review of Radiation Therapy Systems Proposal Submitted by Nucletron Corporation Under Solicitation Number RFP-797-DD-00-0031			
00-02815-34 1/18/01	Review of Federal Supply Schedule Proposal Submitted by GE Marquette Medical Systems Under Solicitation Number RFP-797-652A-99-0001	$2,109,282		
00-00237-37 1/25/01	Review of a Medical Equipment and Supply Company's Voluntary Disclosure and Refund Offer			$580,000
01-00061-38 1/31/01	Review of Federal Supply Schedule Proposal Submitted by Sewing Source, Inc., Under Solicitation Number RFP 797-652A-99-0001	$715,928		
01-00460-39 1/31/01	Review of Federal Supply Schedule Proposal Submitted by Omnicell, Inc., Under Solicitation Number RFP-797-FSS-99-0025			
98-00068-40 2/1/01	Review of Moore Medical Corporation's Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contracts V797P-5576M and V797P-3137K			$5,822,656
01-00194-44 2/23/01	Review of Federal Supply Schedule Proposal Submitted by Roche Diagnostics Corporation Under Solicitation Number RFP M5-Q52C-00	$1,669,920		
00-02269-45 2/23/01	Review of Proposal Submitted by Department of Surgery, Indiana University School of Medicine Under Solicitation Number RFP 583-46-00 for Cardiovascular Surgery Services at the VA Medical Center Indianapolis, IN	$158,796		
00-00263-46 2/23/01	Review of Federal Supply Schedule Proposal Submitted by Amigo Mobility International, Inc., Under Solicitation Number RFP 797-652F-99-0004	$212,160		
00-00254-48 2/23/01	Review of Proposal Submitted by Varian Medical Systems Under Solicitation Number RFP 797-DD-00-0031 for Radiation Therapy Systems			
00-02396-49 2/23/01	Review of Proposal Submitted by Indiana Pathology Institute, P.C., Under Solicitation Number RFP 583-44-00 for Pathology Services at the VA Medical Center, Indianapolis, IN			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
01-00625-53 2/27/01	Review of Federal Supply Schedule Proposal Submitted by ConvaTec (A Bristol-Myers Squibb Company) Under Solicitation Number RFP 797-FSS-99-0025			
01-00754-60 3/20/01	Review of Proposal Submitted by Advanced Technology Laboratories Under Solicitation No. M6-Q9-00 for Ultrasound Systems			
98-00096-61 3/27/01	Final Report Post-Award Review of a Company's Federal Supply Schedule Contract for X-Ray Equipment and Supplies			$1,821,499
01-00201-62 3/28/01	Review of Federal Supply Schedule Proposal Submitted by Abbott Laboratories, Diagnostic Division, Under Solicitation Number M5-Q52C-00	$576,675		
01-00335-66 3/29/01	Review of Proposal Submitted by University of Minnesota Physicians for Radiologist Services at VA Medical Center Minneapolis, MN	$248,894		
00-00397-64 3/30/01	Review of a Pharmaceutical Company's Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Two Federal Supply Schedule Contracts			$13,185
ADMINISTRATIVE INVESTIGATIONS				
00-02176-9 10/30/00	Administrative Investigation, Attendance, Personnel, and Vehicle Issues, VBA Headquarters, Washington, DC			
00-01137-18 11/30/00	Administrative Investigation, Use of Government Vehicles, Other Property, and Official Time, VA Domiciliary White City, OR			
00-00700-23 12/19/00	Administrative Investigation, Improper Acquisition and Use of Cellular Telephone, VHA Central Office Washington, DC			
98-01138-13 1/2/01	Administrative Investigation, Nepotism Issue, VA Medical Center Philadelphia, PA			
00-01829-63 3/28/01	Administrative Investigation, Resource Misuse Issue, VA Regional Office Phoenix, AZ			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS				
00-02096-5 10/5/00	Letter Report - Department of Transportation Inspection of Department of Veterans Affairs Clinical Laboratories			
99-01260-7 11/15/00	Healthcare Inspection, Multiple Allegations Regarding Psychiatry Service Management and Patient Care Issues, Department of Veterans Affairs Medical Center San Juan, PR			
00-00282-12 11/30/00	Evaluation of Veterans Health Administration Missing Patient Policies and Procedures			
00-02038-29 1/23/01	Ophthalmology Resident Competence, Harry S. Truman Memorial Veterans Hospital Columbia, MO			
00-02019-31 1/23/01	Operation of a Transgender Clinic at the VA Medical Center New Orleans, LA			
99-01321-47 3/23/01	Healthcare Inspection: Patient Research and Other Health Care Issues, John L. McClellan Memorial Veterans Hospital Little Rock, AR			
00-01491-57 3/26/01	Inspection of Allegations Regarding Patient Care and Discharge Planning, Department of Veterans Affairs Central Texas Health Care System Temple, TX			
TOTAL:	**58 Reports**	**$2,450,002,829**	**$99,185,965**	**$20,102,606**

APPENDIX B

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
CONTRACT REVIEWS BY OTHER AGENCIES

Report Title (Report Number, Issue Date)		Funds Recommended for Better Use	Unsupported Costs
Proposal, Solicitation No. 619A4, Renovation, VAMC Tuskegee, Thomas Construction and Masonry Company, Montgomery, AL (2000-00021-PE-0310-N03, 10/4/00)			
Proposal, RFP No. 688-61-00, Replace Fire Alarm System, VAMC Washington, Ferguson and Ramey Electrical Contractors, Capitol Heights, MD (2000-00021-PE-0311-N03, 10/5/00)			
Claim, Contract No. V69DC-142, Install Sprinkler System, VAMC Lakeside, Beckman Construction Company, Fort Worth, TX (2000-00021-PE-0306-N03, 10/23/00)		$926,180	
Proposal, Contract No. V200C-003, Asbestos Removal, Austin Automation Center, O'Neal Construction of Texas, Inc., Austin, TX (1998-02749-PE-0122-N03, 10/30/00)		$89,056	
Proposal, Solicitation No. RFP 521-063-0, Renovation, VAMC Birmingham, LJC Construction Company, Inc., Headland, AL (2000-00021-PE-0315-N03, 11/14/00)			
Proposal, Contract No. V688C1470, Patient Privacy, VAMC Washington, AEC Services, Inc., Gaithersburg, MD (2001-00314-PE-0303-N03, 1/3/01)		$112,558	
Claim, Contact No. V101BC0077, Construction, VAMC Lake City, G. H. Johnson Construction Co., Tampa, FL (2001-00314-PE-0002-N02, 2/5/01)		$541,862	
Claim, Contract No. V626C-597, Ward Upgrade, VAMC Nashville, Jimenez, Inc., Mobile, AL (2001-00314-PE-0306-N03, 3/1/01)		$81,502	
Claim, Project No. 646-400, Construction, VAMC Pittsburgh, Poerio, Inc., Pittsburgh, PA (2000-00021-PE-0006-N02, 3/21/01)		$288,901	
TOTALS:	**9 Reports**	**$2,040,059**	**$0**

The Defense Contract Audit Agency completed all reports issued. This data is also reported in the Department of Defense OIG's Semiannual Report to Congress.

APPENDIX C

CONTRACT REVIEW REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
Contract Reviews by OIG			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Audit of Claims and Requests for Equitable Adjustments Submitted by Bay Construction Company, Contract Number V662C-1439, 8PE-E10-082, 3/25/98		$394,154	Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.
Review of Federal Supply Schedule Proposal (Solicitation Number M3-QF-98), Everest & Jennings, Earth City, MO, 9PE-E02-036, 2/23/99		$680,400	Pending receipt of Contracting officer Price Negotiation Memorandum (PNM); anticipated award date is May 1, 2001.
Final Report Review of Proposal Submitted by University of Pittsburgh Physicians for Anesthesiology Physician Services at the University Drive Division, VA Pittsburgh Healthcare System, Pittsburgh, PA, 00-01584-73, 5/31/00		$297,833	Pending receipt of Contracting officer PNM; no planned resolution date available.
OFFICE OF FACILITIES MANAGEMENT (VHA)			
Review of Structural Design Problems at the New VA Regional Office, Bay Pines, FL, 8PE-E02-053, 3/16/98			Negotiations re-opened. Planned resolution by September 30, 2001.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
Contract Reviews by Other Agencies			
OFFICE OF FACILITIES MANAGEMENT (VHA)			
Proposal, Project No. 672-045, Change Order Outpatient Clinic Addition, VAMC San Juan, J. A. Jones Construction Co., San Juan, PR,7PE-N02-007, 12/9/97	$284,827		Negotiation not finalized; no planned resolution date available.
Claim, Contract No. V101BC131, Ambulatory Care Addition, VAMC San Juan, J. A. Jones Construction Co., Charlotte, NC, 9PE-N02-013, 4/6/99	$3,787,571		Negotiation not finalized; no planned resolution date available.
Proposal, Project No. 614-011, Seismic/Modernization, VAMC Memphis, Caddell Construction, 9PE-N02-007, 9/15/99	$1,912,868		Negotiation not finalized; no planned resolution date available.
Claim, Contracting No. V101CC-0052, Construction, VAMC Detroit, Centex Construction Company, Dallas, TX, 1999-03107-PE-0107-N02, 10/26/99	$24,261,851		Negotiation not finalized; no planned resolution date available.
Claim, Project No. 317-007, Construction, VARO St. Petersburg, J. Kokolakis Contracting, Inc., Tarpon Springs, FL, 1999-03115-PE-0201-N02, 12/22/99	$2,866,738		Negotiations re-opened. Planned resolution by September 30, 2001.
Claim, Project No. 508-018C, Clinical Addition, VAMC Atlanta, Caddell Construction, Co., Montgomery, AL, 1999-03095-PE-0001-N02, 12/29/99	$2,187,794		Negotiation not finalized; no planned resolution date available.
Claim, Contract No. V101AC0141, Construction, VAMC Mt. Home, Summit Construction Company, Inc., Cuyahoea Falls, OH, 2000-00021-PE-0002-N02, 3/21/00	$149,760		Negotiation not finalized; planned resolution by April 30, 2001.
Claim, Project No. 609-019, Construction, VAMC Marion, Huber, Hunt, and Nichols, Inc., 2000-00021-PE-0105-N02, 5/9/00	$95,238		Negotiation not finalized; planned resolution by December 31, 2001.

Report Title, Number, and Issue Date	Recommended Better Use of Funds	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF THE GENERAL COUNSEL			
Adjustment Claim, V101C-1606, Construction Service, VAMC Albany, Bhandari Constructors Inc., Syracuse, NY, 5PE-N02-007, 3/31/95	$271,599		Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.
Claim, Contract V101C-1651, Environment Improvement, VAMC North Chicago, Blount Inc., 4PE-N02-202, 2/7/96	$7,370,861		Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro., VAMC Columbia Fire Security Systems, Inc., Bossier City, LA, 8PE-N03-110, 3/19/98	$503,356		Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.
Claim, Contract No. V621C-505, Correct Lake Drainage, VAMC Mountain Home, TN, Carpenter Construction, Inc., Robbinsville, NC,9PE-N03-107, 5/12/99	$300,626		Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.
Proposal, Project No. 543-015, Sprinkler & Fire Alarm Pro., VAMC Columbia, SC, Fire Security System, Inc., Bossier City, LA, 9PE-N03-108, 7/27/99	$1,109,745		Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.
Claim, Contract No. V640P-5285, Transportation Services, VA HCS Palo Alto, Bay Trans Company, Inc., Santa Clara, CA, 9PE-N03-111, 8/18/99	$1,463,111		Claim in litigation before the VA Board of Contract Appeals; no planned resolution date available.

APPENDIX D

FOLLOW UP/RESOLUTION OF OIG RECOMMENDATIONS

The Inspector General Act Amendments of 1988 require identification of all significant management decisions with which the Inspector General is in disagreement and all significant and other recommendations unresolved for over 6 months (management decisions not made). We had no Inspector General disagreements on significant management decisions and there were no internal audit recommendations unresolved for over 6 months as of the end of this reporting period. Contract report recommendations unresolved for over 6 months are included in Appendix C.

Following are tables which provide a summary of the number of OIG reports with potential monetary benefits that were unresolved at the beginning of the period, the number of reports issued and resolved during the period with potential monetary benefits, and the number of reports that remained unresolved at the end of the period.

As required by the IG Act Amendments, Tables 1 - 3 provide statistical summaries of unresolved and resolved reports for this reporting period. The dollar figures used throughout this report are based on the definitions included in the IG Act Amendments of 1988. The figures may reflect changes from the data in the individual reports due to OIG validation to ensure compliance with the IG Act Amendments definitions.

TABLE 1 - SUMMARY OF UNRESOLVED AUDIT REPORTS

Table 1 provides a summary of all unresolved reports and the length of time they have been unresolved.

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	18
	Contract Review	18	
Less Than 6 Months	Internal Audit	1	19
	Contract Review	18	
TOTAL			**37**

Tables 2 and 3 show a total of 34 reports that were unresolved as of March 31, 2001. This number differs from the 37 reports shown above because tables 2 and 3 include only reports with monetary benefits as required by the IG Act Amendments. Tables 2 and 3 also provide the reports resolved during the period with the OIG estimates of disallowed costs and funds to be put to better use, including those in which management agreed to implement OIG recommendations and those in which management did not agree to implement OIG recommendations. The Assistant Secretary for Management maintains data on the agreed upon reports and Management estimates of disallowed costs and funds to be put to better use in order to comply with the reporting requirements for the Secretary's Management Report to Congress, required by the IG Act Amendments.

TABLE 2 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

Table 2 summarizes reports, the dollar value of questioned costs, and the costs disallowed and allowed.

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 9/30/00	0	$0
Issued during reporting period	9	$20.1
Total Inventory This Period	**9**	**$20.1**
Management decision during reporting period		
Disallowed costs (agreed to by management)	9	$20.1
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**9**	**$20.1**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

VA pursue collection, including Government property, services or benefits provided to ineligible recipients; recommended collections of money inadvertently or erroneously paid out; and recommended collections or offsets for overcharges or ineligible costs claimed.

For contract review reports, it is contractor or grantee costs OIG recommends be disallowed by the contracting officer, grant official, or other management official. Costs normally result from a finding that expenditures were not made in accordance with applicable laws, regulations, contracts, grants, or other agreements; or a finding that the expenditure of funds for the intended purpose was unnecessary or unreasonable.

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

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

TABLE 3 - RESOLUTION STATUS OF REPORTS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

Table 3 summarizes reports with Recommended Funds to be Put to Better Use by management, and the dollar value of recommendations that were agreed to and not agreed to by management.

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 9/30/00	27	$75.6
Issued during reporting period	28	$2,452.0
Total Inventory This Period	**55**	**$2,527.6**
Management decisions during reporting period		
Agreed to by management	18	$830.3
Not agreed to by management	3	$21.9
Total Management Decisions This Period	**21**	**$852.2**
Total Carried Over to Next Period	**34**	**$1,675.4**

Definitions:

- **Recommended Better Use of Funds**

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

For contract review reports, it is the sum of the questioned and unsupported costs identified in preaward contract reviews which the OIG recommends be disallowed in negotiations unless additional evidence supporting the costs is provided. Questioned costs normally result from findings such as a failure to comply with regulations or contract requirements, mathematical errors, duplication of costs, proposal of excessive rates, or differences in accounting methodology. Unsupported costs result from a finding that inadequate documentation exists to enable the auditor to make a determination concerning allowability of costs proposed.

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

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

APPENDIX E

REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

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

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	57
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-66
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-66
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	83
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	69
Section 5 (a) (6)	List of audit reports by subject matter, showing dollar value of questioned costs and recommendations that funds be put to better use	71 to 77 (App. A & B)
Section 5 (a) (7)	Summary of each particularly significant report	i to v
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	84 (Table 2)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	85 (Table 3)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	79 to 81 (App. C)
Section 5 (a) (11)	Significant revised management decisions	None
Section 5 (a) (12)	Significant management decisions with which the Inspector General is in disagreement	None
Section 5 (a) (13)	Information described under section 05(b) of the Federal Financial Management Improvement Act of 1996 (Public Law 104-208)	39

APPENDIX F

OIG OPERATIONS PHONE LIST

Investigations

Central Office Investigations Washington, DC ..... (202) 565-7702
Northeast Field Office (51NY) New York, NY ..... (212) 807-3444
Boston Resident Agency (51BN) Bedford, MA ..... (781) 687-3138
Newark Resident Agency (51NJ) Newark, NJ ..... (973) 645-3590
Pittsburgh Resident Agency (51PB) Pittsburgh, PA..... (412) 784-3818
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Southeast Field Office (51SP) Bay Pines, FL ..... (727) 398-9559
Atlanta Resident Agency (51AT) Atlanta, GA..... (404) 929-5950
Columbia Resident Agency (51CS) Columbia, SC..... (803) 695-6707
Nashville Resident Agency (51NV) Nashville, TN..... (615) 736-7200
New Orleans Resident Agency (51NO) New Orleans, LA ..... (504) 619-4340
West Palm Beach Resident Agency (51WP) West Palm Beach, FL ..... (561) 882-7720
Central Field Office (51CH) Chicago, IL ..... (708) 202-2676
Dallas Resident Agency (51DA) Dallas, TX..... (214) 655-6022
Denver Resident Agency (51DV) Denver, CO..... (303) 331-7673
Houston Resident Agency (51HU) Houston, TX ..... (713) 794-3652
Kansas City Resident Agency (51KC) Kansas City, KS..... (913) 551-1439
Western Field Office (51LA) Los Angeles, CA ..... (310) 268-4268
Phoenix Resident Agency (51PX) Phoenix, AZ..... (602) 640-4684
San Francisco Resident Agency (51SF) Oakland, CA..... (510) 637-1074
Seattle Resident Agency (51SE) Seattle, WA ..... (206) 220-6654, ext 31

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Central Office Operations Washington, DC ..... (202) 565-8305
Healthcare Regional Office Atlanta (54AT) Atlanta, GA..... (404) 929-5961
Healthcare Regional Office Chicago (54CH) Chicago, IL ..... (708) 202-2672
Healthcare Regional Office Los Angeles (54LA) Los Angeles, CA ..... (310) 268-3005

OIG OPERATIONS PHONE LIST (CONT'D)

Audit

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Central Office Operations Division (52CO) Washington, DC ..... (202) 565-4434
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APPENDIX G

GLOSSARY

BDN	Benefits Delivery Network
CAP	Combined Assessment Program
C&P	Compensation & Pension
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
FAA	Federal Aviation Administration
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FOIA	Freedom of Information Act
FTE	Full Time Equivalent
FTI	Federal Tax Information
FY	Fiscal Year
GPRA	Government Performance and Results Act
HEC	Health Eligibility Center
IRS	Internal Revenue Service
IG	Inspector General
IT	Information Technology
IVM	Income Verification Match
MCI	Master Case Index
MT	Means Test
NCA	National Cemetery Administration
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
PI	Principal Investigator
PNM	Price Negotiation Memorandum
QM	Quality Management
SSA	Social Security Administration
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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

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

The report is also available on our Web Site:

http://www.va.gov/oig/53/semiann/reports.htm

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

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Joseph M. Vallowe, Esq.
VA OIG, Washington, DC

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Department of Veterans Affairs
Office of Inspector General
Semiannual Report

October 1, 2000 - March 31, 2001