Office of Inspector General

Semiannual Report to Congress

April 1, 1997 – September 30, 1997

FOREWORD

It is my pleasure to submit the semiannual report on the activities of the Office of Inspector General (OIG) for the period ended September 30, 1997. This semiannual report is being issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

OIG audits, investigations, inspections, and reviews identified over $157 million of actual and potential monetary benefits and resulted in 36 convictions and 127 administrative actions during the semiannual reporting period. OIG coordinated efforts with the Office of Acquisition and Materiel Management, Veterans Health Administration (VHA) and the General Counsel to recover $28 million resulting from contractor overcharges on VA contracts for drugs and medical equipment.

While the OIG continues to provide the best possible coverage of VA programs and activities within available resources, the continuing decline in appropriated dollars has made it increasingly difficult to provide an acceptable level of oversight. Staffing levels for the OIG are currently far below the statutory floor of 417. A VA request to Congress to remove the statutory floor was not acted upon. Since the statutory floor remains, our position is that the mandate should be complied with. My belief is that the statutory floor was established as the minimum level needed to provide an acceptable level of oversight over the second largest Department in the Federal government. Continued funding below the statutory floor creates possible oversight vulnerabilities for Congress and the Department.

WILLIAM T. MERRIMAN
Deputy Inspector General

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EXECUTIVE OVERVIEW

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 September 30, 1997. During this reporting period, 81 audit, review, and inspection reports were issued; 2 settlement agreements were completed; and 115 investigations were closed. These initiatives identified actual and potential recoveries of $30.9 million and made operational recommendations which could result in better use of an estimated $126.5 million. In addition, as a deterrent to fraud, waste, and mismanagement, our investigations and other reviews resulted in 62 indictments, 36 convictions, and 127 administrative actions against third parties, VA employees, and benefit recipients.

Our audits, reviews, inspections, and investigations this period focused on VA's major program areas, as summarized in the following paragraphs.

PROCUREMENT PROGRAMS

Contractor Overcharges

VA recovered over $32 million during FY 1997, with $28 million recovered during the last 6 months, due to our identification of overcharges by Federal Supply Schedule (FSS) companies. In one case, an FSS contractor paid VA $22.1 million, the largest settlement in VA's history under the FSS program.

Reviews of FSS Proposals

We completed 17 preaward reviews of FSS proposals from pharmaceutical companies, with costs questioned totaling $30.2 million. These reviews assist VA contracting officers in negotiating the best possible prices for VA.

Procurement Fraud

As the result of a joint investigation and contract review, a medical corporation that provided health examination equipment to VA acknowledged liability under the False Claims Act for submitting false and fraudulent billings. A $3 million judgment was entered against the corporation and the corporation agreed to permanent exclusion from Government contracting and programs. A joint investigation with two other Federal agencies resulted in an ambulance company owner being sentenced to over 5 years in prison and ordered to pay restitution of over $1 million for submitting inflated billings for ambulance services provided.

MEDICAL CARE PROGRAMS

Resource Utilization

We audited VHA's initiative to implement mobile laboratory carts at selected VAMCs and found that over $10 million earmarked for the initiative was used for other purposes or had been spent on equipment that was never used. Our review of VA's downsized inpatient substance abuse treatment program concluded that VHA had established adequate housing and social support resources for homeless veterans and other frequent users prior to the downsizing, but additional actions are needed to ensure these users have access to inpatient and outpatient care when needed.

Fee Basis Program

Our audit of the fee-basis program concluded that VHA had established controls to ensure payments for fee-basis treatment were appropriate, but additional actions were needed to reduce the rates paid and avoid duplicate or erroneous payments. In addition, $1.8 million could be reduced annually by establishing benchmarks for fees and formal contracts with fee providers.

Quality of Health Care

Our assessment of VHA's compliance with quality standards for mammography services required by law concluded that VHA health care facilities are prepared to provide high quality services either in-house or through contract facilities. The review also concluded that actions were needed to inform female patients of mammography service availability, increase mammography equipment use, and establish quality assurance programs. Our oversight review of VAMCs' implementation of External Peer Review Program (EPRP) requirements concluded that VAMC's used EPRP review results to develop better treatment methods, with action recommended for increased use of EPRP review results to strengthen the program.

Patient Care Inspections

Five of our healthcare inspection reports concluded that the VAMCs involved needed to take actions to improve patient care. In one case, our inspection agreed with a clinical peer review which concluded that providers should have ordered medical tests and more closely monitored a patient that died. In another case, appropriate care was provided for a terminal patient, but an uninformed physician did not comply with the patient's request for heroic measurers and he died. In a third case, a patient's scheduled operation was cancelled twice by a surgeon without sufficient justification. In the other two cases, the alleged patient abuse or patient harm was not substantiated, but programmatic changes were needed at one VAMC to improve the quality of care for their spinal cord injury unit and another VAMC needed to improve its credentialing and privileging process.

BENEFIT PROGRAMS

Delivery of Benefits and Services

We reviewed four VBA areas: (1) compensation of VA beneficiaries who are also active military reservists, (2) compensation and pension (C&P) medical examination services, (3) appointment and supervision of fiduciaries, and (4) Fiduciary Beneficiary System (FBS) data. We estimated that active military reservists improperly received dual compensation payments of $21 million between fiscal years 1993 and 1995, with future dual payments totaling $8 million if corrections are not made. Our followup review on C&P medical examinations found that the rate of incomplete examinations had not changed significantly since FY 1993, and VHA and VBA coordinated efforts were needed to monitor and reduce the rate. Our two reviews of VBA's fiduciary program concluded that appropriate fiduciaries are appointed, but both improved supervision of fiduciaries and establishment of appropriate FBS records are needed to reduce the risk of theft or misuse of beneficiaries' funds.

Program Fraud

Investigations disclosed cases of loan guaranty, fiduciary, and compensation fraud. The owner of several real estate companies pleaded guilty to charges of conspiring to defraud VA and HUD by acquiring and selling property by deceptive means and agreed to property forfeitures valued at over $2.7 million. A county veterans' service officer was sentenced to over 3 years in prison and fined $10,000 for his involvement in schemes to defraud over 17 disabled veterans for whom he acted as fiduciary. An individual and his spouse were sentenced to 10 years and 1 year, respectively, for a telemarketing scheme disclosed by a joint investigation that also disclosed he was improperly collecting VA disability benefits with a 100 percent disability rating.

FINANCIAL MANAGEMENT

Consolidated Financial Statements

We completed nine reviews as part of our audit of VA's Consolidated Financial Statements (CFS), with VA management officials informed of areas where actions are needed to improve accounting operations. Another financial-related review identified duplicate payments totaling over $1 million. None of the conditions identified had a material financial effect on the FY 1996 CFS.

Income Verification

Our review of VHA's procedures to verify self-reported veteran income for means tests found that over 87 percent of the cases reviewed did not have signed means test documents. In addition, VHA lost the opportunity to collect over $3 million because veterans were erroneously identified as exempt from co-payments.

INFORMATION RESOURCES MANAGEMENT

Telephone Access Systems

Our review of VA's use of Personal Identification Number (PIN) telephone access systems found that three VAMCs with PIN systems had reduced their long distance telephone costs by an average 68 percent, with total annual savings nearly $1 million. We concluded that telephone costs could be reduced by over $10 million annually if all VAMCs installed PIN systems.

Security Controls Over Benefits Payments

We evaluated security controls at a Benefits Delivery Center that provides key automation support for payments to veterans and their families, totaling $20 billion. We identified a number of actions needed to make the facility more physically secure and less vulnerable to unauthorized electronic access of data.

EMPLOYEE INTEGRITY

Specialized Investigations

Specialized Investigations Regional Task Force (SIRTF) investigations disclosed instances of sales of controlled substances and workers' compensation fraud. One individual was sentenced to over 2 years in prison for the illegal sale of drugs. Four individuals had their workers' compensation benefits terminated, with one ordered to make restitution of $260,000, and another sentenced to 4 months' imprisonment. In all cases, the investigations disclosed that the individuals involved were working while receiving these payments.

Employee Misconduct

Investigations disclosed drug theft or diversion, workers' compensation fraud, and other employee misconduct. Two licensed practical nurses at different VAMCs received 4 year and 5 year probation sentences, respectively, for drug theft and diversion. A VAMC claims clerk was sentenced to 6 months in prison for workers' compensation fraud after illegally receiving benefits in excess of $159,000. A former VAMC resident, charged with making false statements on his application for a state university residency program, was able to dispense controlled substances while at a VAMC and, after being arrested, fled to Zimbabwe. Zimbabwean officials subsequently charged him with five counts of murder and two counts of attempted murder of patients at a mission hospital. He is currently in the United States in Federal custody pending trial on charges of making false statements and for possession of controlled substances. Other instances of employee misconduct resulted in the resignation and removal of VA employees.

FOLLOWUP ON OIG REPORTS

Unresolved Reports

As of September 30, 1997, the OIG did not have any unresolved internal audit reports. A total of 21 external contract reports had been unresolved for over 6 months, with questioned and unsupported costs totaling $33.5 million. Resolution of external contract reports is pending contracting officers' decisions, with the contracting officer the sole decider in these cases.

SUMMARY OF OIG OPERATIONS

	Current 6 Months 4/1/97 - 9/30/97 (Dollars in Millions)	FY 1997 10/1/96 - 9/30/97
OIG Reviews Completed and Resolution Action		
Reports Issued	81	181
Settlement Agreements	2	4
Value of Reports/Agreements		
Questioned Costs	$28.0	$35.2
Unsupported Costs	1.5	5.8
Recommended Better Use of Funds	120.7	197.7
Total	$150.2	$238.7
Reports Resolved (issued this and prior periods)	34	79
Value of Resolved Reports/Agreements		
Disallowed Costs.	$27.4	$37.5
Funds to Be Put to Better Use	58.1	123.8
Total	$85.5	$161.3
Unresolved Reports		
Over 6 Months as of 9/30/97:		
Internal Audit	0	N/A
External Contract	21	
Less than 6 Months as of 9/30/97:		
Internal Audit	0	
External Contract	33	
Total	54	
Value of Unresolved Reports:		
Questioned Costs	$ 4.5	N/A
Unsupported Costs	1.5	
Recommended Better Use of Funds	101.3	
Total	$107.3	
Investigation Activities		
Investigative Cases		
Opened	88	229
Closed	115	245
Pending	333	N/A
Impact of Investigations		
Indictments	62	107
Convictions	36	110
Probation (in years)	127	313
Prison Sentences (in years)	33	131
Fines, Penalties, Restitutions, and Civil Judgments	$2.2	$3.7
Investigative Recoveries and Savings	$5.0	$13.9
Administrative Sanctions	98	178

	Current 6 Months 4/1/97 - 9/30/97	FY 1997 10/1/96 - 9/30/97
Audit Activities		
Reports Issued		
Internal Audits	13	32
Other Reviews	9	16
Total	22	48
Audit Workload		
Carry-Over Projects Completed	18	34
Planned Projects Initiated	12	25
New Projects Received	11	16
Total	41	75
Contract Review Activities		
Reports Issued/Settlement Agreements		
Contract Reviews by OIG Staff		
FSS Contracts	28	37
PL 102-585 Reviews	1	4
Other	3	5
Contract Reviews by Other Agencies	11	46
Total	43	92
Hotline and Special Inquiry Activities		
Hotline Cases		
Opened	376	733
Closed	313	624
Percent of Founded Allegations	24%	23%
Impact of Hotline Activities		
Administrative Sanctions	29	57
Special Inquiries Completed		
Reports Issued	8	28
Administrative Closures	12	25
Total	20	53
Special Inquiries Workload		
Carry-Over Projects	25	41
New Projects Received	36	56
Total	61	97
Healthcare Inspection Activities		
Projects Completed		
Inspection Reports Issued	10	17
QA/Patient Care Reviews	30	52
Clinical Consultations/Technical Support.	69	130
Total	109	199
Projects Pending		
QA/Patient Care Reviews	51	N/A
MI Case Evaluations	0	
Clinical Consultations/Technical Support	26	
Total	77	

I. SIGNIFICANT OPERATIONAL ACTIVITIES

PROCUREMENT PROGRAMS

1. CONTRACTOR OVERCHARGES

Issue: Contractor Overcharges for Medical Equipment, Medical Supplies, and Drugs

Conclusion: Contract reviews identified contractor overcharges.

Impact: VA recovery of over $32 million from Federal Supply Schedule (FSS) contractors, with $28 million recovered this 6-month period.

Postaward Reviews of FSS Contracts

Contract review efforts during FY 1997 resulted in the recovery of over $32 million from companies selling medical equipment, medical supplies, and drugs to VA and to other Government agencies. This compares favorably to FY 1996 recoveries of approximately $28 million. These recoveries from contractors represent the collective efforts of the Office of Acquisition and Materiel Management, the Office of General Counsel, Veterans Health Administration, and OIG working together, as a team, to produce these results. Some examples of these recoveries follow.

- An FSS contractor for medical imaging equipment paid $22.8 million to the Government (VA received $22,116,000 of the $22.8 million) to settle allegations that they had failed to provide accurate, complete, and current discount and pricing information to the VA contracting officer during contract negotiations for a 5-year, $94 million contract, and had failed to pass on certain price reductions to VA and other FSS users. The company initially had offered a $3.7 million refund associated with their voluntary disclosure involving nondisclosed price reductions and interest. The settlement, the largest in VA's history under the FSS program, was reached through the combined efforts of the OIG, National Acquisition Center personnel and Department of Justice attorneys.

- A pharmaceutical company agreed to pay $2.5 million to VA for FSS contract overcharges resulting from violations of the provisions contained in the price reductions and defective pricing clauses. The company had voluntarily disclosed contract overcharges computed to be $1.1 million and attributed all of the overcharges to price reduction violations. We found errors in the computation of price reductions and also identified defective pricing violations that resulted in the significant increase to the amount due.

- A medical equipment company agreed to pay $656,316 to VA for FSS contract overcharges resulting from violations of the provisions contained in the contract's defective pricing clause. Initially, the company voluntarily disclosed contract overcharges that were attributed to undisclosed price reductions, but did not compute an amount due. After reviewing the contracts, we determined that there was a strong possibility that the pricing violations were related to defective pricing. The

company subsequently used a CPA firm to analyze the data and concluded that the contracts were priced defectively, with a pricing violation of $656,316. We reviewed the workpapers and supporting documentation and concluded the amount of overcharges was represented fairly.

- A medical supply company that provides VA with in vitro diagnostics, reagents, test kits and sets voluntarily disclosed that they owed the Government $425,771 because of price reduction violations in administering their FSS contract. Our review concluded that the company owed the Government a total of $497,089 due to price reduction violations, $71,318 more than the company had disclosed. They agreed with our calculation and remitted $497,089 to VA.

- VA recovered $908,166 from another FSS contractor that supplies VA with in vitro diagnostics, reagents, test kits and sets, based on a voluntary disclosure attributed to undisclosed price reductions and refund made of $854,513. Our review ruled out any pricing violations due to defective pricing, but identified an additional $53,653 associated with price reductions. The contractor agreed with our calculation and remitted the additional amount to VA.

- Two pharmaceutical companies acknowledged errors in calculating Federal Ceiling Prices under Public Law 102-585, and agreed to pay a total of $327,763 to VA for contract overcharges. The companies also agreed to implement policies and procedures that would incorporate the necessary internal controls to correct the errors.

- A joint review, conducted by VA OIG Investigations and Contract Review staff and the FBI, resulted in a consent judgment for $3 million against a former FSS vendor of medical supplies and its employee owners. The review uncovered evidence that the FSS vendor had engaged in a systemic pattern of mischarging VA hospitals and other government agencies for medical supplies by submitting invoices for payment to the government that reflected inflated prices and did give not the government its negotiated discount under the contract. The joint review revealed that the government was overbilled $1,083,041 on two FSS contracts during the period 1989 to July 1994, when the second contract was terminated. The $3 million judgment was made pursuant to the treble damages provisions of the False Claims Act, which entitles the government to recover three times its losses.

- Based on a Defense Contract Audit Agency postaward audit and an OIG supplemental postaward review of an FSS contract, a medical equipment company remitted $459,396 to VA in settlement of contract overcharges due to defective pricing and undisclosed price reductions.

Preaward Reviews of Pharmaceutical Offers

VA's FSS pharmaceutical schedule, with FY 1996 sales of $1.3 billion, represents the largest dollar value, by far, of the 13 Federal Supply Schedules awarded and managed by VA's National Acquisition Center (NAC). During the period, our Contract Review Division auditors, in collaboration with NAC Pharmaceutical Service contracting officers, initiated a major project to conduct 46 preaward reviews of FSS offers from pharmaceutical companies. Due to the significant number of reviews and short time frame allowed for their completion (approximately 3 1/2 months), these auditors were assisted by ten auditors from our Office of Audit. Of the 46 preaward reviews planned, 17 were completed during the period ending September 30, 1997, and are listed in Appendix A. The other 29 are in process, with completion planned during the next period. These preaward reviews assist VA contracting officers in

negotiating best possible prices by determining if an offeror's (i) commercial pricing and sales data disclosed in the offer are accurate, complete, and current, and (ii) proposed FSS prices/discounts are equal to or better than those offered to its most favored customers.

The reviews also identify customer classes (e.g., group purchasing organizations) that Government agencies can use to track price reductions during the life of an FSS contract. Additionally, these reviews identify and comment on pricing concessions, e.g. rebates that pharmaceutical manufacturers offer their commercial customers. When requested, our auditors provide assistance to contracting officers during negotiations with companies.

2. PROCUREMENT FRAUD

Issue: Integrity of VA's Procurement Program

Conclusion: Investigations disclosed third party fraud in VA's procurement program.

Impact: Individuals and companies were either indicted, convicted, or sentenced.

- Following a joint investigation by the VA and Department of Health and Human Services (HHS) OIGs and the Postal Inspection Service, the owner and president of an ambulance company pleaded guilty to four counts of mail fraud, and was subsequently sentenced to 63 months' in prison, over $1 million in restitution, and three years' probation. The guilty plea was the result of a 20-count indictment, which charged that the ambulance service owner contrived a scheme to systemically defraud VA and other Government agencies by submitting false claims for payment utilizing the U.S. mail. He generated false billings by inflating billings for transporting patients by his ambulance company. Loss to the Government exceeded $2 million.

- As described in the prior section on postaward reviews of FSS contracts, a $3 million consent judgment was entered against a medical supply corporation and its three employee owners. The individuals acknowledged liability under the False Claims Act for submission of false and fraudulent billings on Government contracts. The corporation and one of the individuals voluntarily agreed to permanent exclusion from Government contracting and programs, including Medicare and Medicaid. Judgment was entered against a second individual in the amount of $40,000; this individual agreed voluntarily to exclusion from Government contracting and programs for a period of 5 years. The third individual agreed voluntarily to exclusion from Government contracting and programs for a period of 3 years.

- The former owner/operator of a company that provided hand tools, machine tools and hardware to VAMCs was extradited from a prison in Rome on behalf of VA and the Department of Defense (DoD), and placed in the custody of a state Division of Criminal Justice to face outstanding charges. The individual was subsequently placed in the custody of VA and DoD OIG special agents to appear in court on an outstanding 19-count indictment charging the individual with bribery and conspiracy to defraud the United States. An earlier joint VA and DoD OIG investigation revealed that, over a 4-year period, the individual conspired to pay bribes to VA officials to influence the awarding of 190 Government contracts for supplies and services valued at approximately $132,000.

- The owner of a medical equipment business that had a contract with a VAMC pleaded guilty to a one-count criminal information charging him with making false claims to VA. The information stated that the individual billed VA for the purchase and delivery of new medical equipment and beds for disabled and sick veterans when, in fact, the equipment provided was not new nor what the contract specified. Sentencing is pending.

- The owner of a distribution company signed a consent judgment for $5,000 to settle charges that the company violated the Buy American Act and Trade Agreements Act of 1979. An investigation disclosed that although the company certified its products were produced in the United States, the latex examination gloves it provided to VA were produced in Malaysia, a non-designated country which was not an authorized source for this procurement.

MEDICAL CARE PROGRAMS

1. RESOURCE UTILIZATION

Issue: Pathology and Laboratory Medicine Service (PLMS) Mobile Laboratory (Mobile Lab) Initiative

Conclusion: Resources for mobile laboratories were not used as intended.

Impact: Reassignment of $5.2 million in unused equipment to other facilities.

Mobile Lab is a cart with eight testing instruments which can be moved throughout a hospital to perform the 25 most commonly ordered lab tests. It was developed and implemented at selected VAMCs in FY 1994 at a cost of $20.7 million. We conducted an audit of the Mobile Lab initiative to determine whether Mobile Lab implementation was performed in a cost-effective manner that ensured optimal utilization of funding and equipment.

Our review found that the Mobile Lab was not widely used because the instrument configuration on the cart was selected without consideration of the specific needs of individual laboratory operations and VAMCs had difficulty determining the best use for Mobile Lab. As a result, over $5 million was spent on equipment that was never used, and another $5 million provided for the Mobile Lab initiative was spent for other uses. We recommended that VHA reassign the unused equipment to facilities or activities that can utilize it. The Under Secretary concurred with the findings and established a task force to review all viable options to reassign the unused equipment. *(Pathology and Laboratory Medicine Service (PLMS) Mobile Laboratory Initiative)*

Issue: Downsizing VA's Inpatient Substance Abuse Treatment Program (SATP)

Conclusion: VHA managers and SATP officials successfully identified and established adequate resources to ensure that all patients continued to have secure living arrangements as they moved from inpatient status to outpatient status.

Impact: Assurance of continuity of services for fragile patients.

A rapidly evolving health care environment in which it is essential to provide high quality health care to more patients, with fewer resources, led the VA to reduce large numbers of beds (2,409 in FY 1995, and 2,255 during the first two quarters of FY 1996) and to increase its emphasis on the use of ambulatory care to treat many disorders, including substance abuse treatment. All VHA Networks drastically reduced the numbers of inpatient beds devoted to treating SAT patients, and substantially increased the capacity to treat these patients on an ambulatory care basis. This transition required VA clinicians to ensure that SAT patients have available the social and clinical support services they need to be successful in rehabilitation.

We conducted a program evaluation to assess the impact that decreasing the number of inpatient SATPS has had on access for homeless veterans and other frequent users and to determine whether VHA providers had identified and established adequate housing and social support resources before the downsizing began. We found that VHA managers and clinicians worked successfully to identify alternative living situations for SAT patients to ensure that they would have secure shelter during their treatment process, and that clinicians had continued to work with community resources to provide the necessary assistance to these patients. The evaluation also concluded that the following additional VHA actions would strengthen and improve the quality of, and access to, VHA's SATPs: (i) require each VISN to have a core of inpatient beds to accommodate mentally and physically impaired patients and those who experience acute relapses; (ii) require discussion and documentation of transportation needs to ensure that patients who do not have adequate resources have transportation to the treatment site; and (iii) develop accurate methods for reporting the number of patients who access SATP care in order to ensure the commitment of adequate resources to the treatment process at any given time.

The Under Secretary for Health concurred in our recommendations and implemented or planned appropriate actions to strengthen the ambulatory care SAT process. *(The Impact of Downsizing Inpatient Substance Abuse Rehabilitation Programs on Homeless Veterans and Other Frequent Users)*

2. VA'S FEE-BASIS PROGRAM

Issue: VHA Internal Controls Over the Fee-Basis Program

Conclusion: VHA can strengthen the fee-basis program by establishing additional management controls.

Impact: Expenditures could be reduced by at least $1.8 million annually.

Fee-basis treatment is inpatient care, outpatient care, or home health care received from non-VA health care providers at VA expense. During the period April 1, 1994 through March 31, 1995, VHA paid $237 million for fee-basis treatments provided to eligible beneficiaries, including $112 million for outpatient care, $94 million for inpatient care, and $31 million for home health care.

We conducted an audit to determine if VHA had established effective internal controls to ensure that payments for fee-basis treatment were appropriate. Overall, VHA internal controls provided reasonable assurance that payments for fee-basis services were appropriate. However, management controls could be improved by implementing procedures to avoid duplicate payments; notifying veterans when VA pays for fee-basis medical care; and improving procedures to prevent payments for services for decreased veterans. In addition, VHA could reduce fee-basis home health care expenditures by at least $1.8 million annually by establishing formal contracts with fee providers and benchmarks for determining reasonable rates. The Under Secretary for Health concurred with our findings and recommendations and provided acceptable implementations plans. *(Internal Controls over the Fee-Basis Program)*

3. QUALITY OF HEALTH CARE PROGRAM EVALUATIONS

Issue: Mammography Services for Women Veterans

Conclusion: VHA has properly and successfully pursued actions to ensure that eligible woman veterans have consistently high quality mammography services available through its health care facilities.

Impact: Assurance of high quality health care.

In July 1995, the Under Secretary for Health issued a VHA directive requiring VA health care facilities to achieve substantial compliance with the Mammography Quality Standards Act of 1992, which established standards for mammography equipment, personnel, and practices, including quality assurance assessment. The objective of this directive was to ensure that women veterans have access to an equal quality of diagnostic services for detecting breast cancer as that which is available for women in the private sector.

We conducted a program evaluation to assess VHA facilities' compliance with the VHA directive. We concluded that VHA health care facilities are prepared to offer high quality mammography services to women patients, either with in-house facilities, or by means of contracting with private or academic health care facilities. Clinicians, however, do not always ask female patients if they wish to have a mammography, and do not always record in the medical record that they discussed this issue with the patient. Some medical centers that own mammography equipment have not as yet achieved the level of workload necessary to maintain employee expertise in its use (300 mammograms) and managers need to explore ways to increase the workload. Although clinicians recognized the importance of maintaining quality oversight of their mammography products, not all medical centers had developed quality assurance measures to systematically record outcome reviews, including the disposition of positive mammograms and surgical tissue correlation with radiological interpretations.

We made recommendations to address these three areas. The Under Secretary for Health concurred with the recommendations and implemented or planned appropriate actions to strengthen mammography procedures. (*Assessment of the Veterans Health Administration's Status in Providing Mammography Examinations)*

Issue: Private Sector Contracted Review of VA Treatment Quality

Conclusion: VAMCs have substantially implemented External Peer Review Program (EPRP) requirements, but additional actions are needed to strengthen the program.

Impact: Improvements to the EPRP.

In FY 1992, VHA replaced its 6-year-old Medical District Initiated Peer Review Organization with a private sector contract to obtain expert evaluation of the quality of health care provided in its 173 hospitals. VHA managers intended to use EPRP review results to assess the quality of veterans' care,

and to pursue system-wide opportunities for improvement in the quality of care using retrospective medical record review.

We conducted a program evaluation to determine the process used to implement the EPRP and to assess EPRP information utilization at the VAMC level. We found that medical center managers generally communicated EPRP findings to the responsible practitioners and used EPRP findings to develop better treatment methods. We recommended actions to strengthen the program: contractor reporting of the magnitude of cases that do not fully comport with review criteria, contractor trending of EPRP review results by VAMC, and incorporation of EPRP review results into the respective VAMC quality management programs.

The Under Secretary for Health concurred with the recommendations and implemented necessary actions to strengthen the utility of the EPRP for using facilities. [Note: Subsequent to issuance of our report, VHA reported that the EPRP has been restructured, with a shift in focus from case-by-case assessment to a broad systems approach that emphasizes objective assessment of national VHA performance measures.] *(Oversight Review of the Veterans Health Administration's External Peer Review Program)*

Issue: Nationwide Quality Program Assistance (QPA) Reviews

Conclusion: VAMC top managers were individually and collectively involved in several actions that were focused on ensuring that eligible veterans have access to high quality, low cost health care.

Impact: Advisory report to VAMC Management.

We conducted a QPA review at VAMC Manchester, NH as part of our QPA development process. The QPA process is intended to add value to other external review activities that oversee VHA facilities. Review instruments assess the extent to which a VAMC meets VHA's four performance goals: cost-efficient care, high-quality care, improved patient access to care, and improved patient satisfaction.

We concluded that the VAMC's top managers were individually and collectively involved in several actions that were focused on ensuring that eligible veterans have access to high quality, low cost health care. Mid-level managers and operating employees expressed concern over the fast pace with which changes in the health care process and facility reorganization were being made, but they were aware of and supported management's treatment goals. Patients indicated that they were generally pleased with the care they received. *(Quality Program Assistance Review, Department of Veterans Affairs Medical Center Manchester, NH)*

4. INSPECTIONS OF INDIVIDUAL CASES OF PATIENT CARE

Issue: Alleged Inadequate or Inattentive Care of Two Patients

Conclusion: Clinicians had provided appropriate care to one patient, but had not been sufficiently aggressive in recognizing and following up on the other's medical needs.

Impact: Improved procedures to prevent recurrence.

We reviewed allegations that medical center clinicians did not provide attentive care for a Nursing Home Care Unit (NHCU) patient's respiratory distress, causing him to have unnecessary difficulty breathing, and that physicians did not properly respond to a psychiatry patient's lethargic condition, resulting in his ultimate death.

We concluded that clinicians had reacted properly and adequately treated the NHCU patient's respiratory condition. A clinician peer review had been conducted to determine whether the psychiatry patient's care had been appropriate. The review concluded that medical and psychiatric care providers should have ordered neurological and laboratory tests and been more aggressive in monitoring the patient's condition. We agreed with these conclusions and found that medical center managers had initiated appropriate corrective actions to ensure similar instances would not reoccur. They had not, however, discussed the facts of the psychiatry patient's care with their Regional Counsel office to determine the propriety of advising the patient's family of their prerogative to pursue VA benefits or file a tort claim, and we recommended that they do so. The Director agreed to obtain Regional Counsel advice. (*Inspection of Alleged Inadequate Care and Nursing Incompetence on the NHCU, Department of Veterans Affairs Medical Center Bronx, NY*)

Issue: Alleged Poor Care and Disregard for a Patient's Advance Directive

Conclusion: Clinicians provided the patient with appropriate treatment for a terminal condition, but an uninformed clinician did not comply with the patient's wishes for end-of-life care.

Impact: Re-emphasis on compliance with advance directive policy to prevent recurrence.

We reviewed allegations that clinicians did not provide proper care for a patient who had a terminal heart condition and failed to comply with both the patient's and spouse's wishes that all necessary measures be pursued to keep the patient alive.

We found that clinicians had energetically and conscientiously sought to treat the patient's terminal heart condition even though they were fully aware that treatment could not improve the patient's condition or extend his life. Clinicians took great pains to keep both the patient and his spouse informed of his treatment progress and his ultimately poor prognosis, but both individuals wanted clinicians to exert heroic efforts when the patient needed resuscitation. Unfortunately, the patient's condition rapidly deteriorated during a tour of duty when the physician on duty was not familiar with his case or the family's desires for heroic measures. Using his clinical judgment, and based on the patient's

clinical presentation, the physician on duty did not carry through with extensive resuscitative measures and the patient died.

We recommended that the VAMC Director take action to review the resuscitation and advance directives policies with medical center physicians and nursing employees in order to clarify the need to honor patients' requests, and adhere to established policies. We also recommended that local clinicians refer similar cases to the medical center's Ethics Committee for clarification and discussion of the most appropriate way to manage similar end-of-life wishes of future patients.

The Medical Center Director concurred with our recommendations and provided action plans that should improve the treatment process. Medical center managers also offered numerous referrals within the community to assist the patient's spouse in working through her grieving process. *(Inspection of Alleged Poor Quality of Care and Disregard of Patient's Advance Directive for Life-Saving Measures at the Department of Veterans Affairs Puget Sound Health Care System, Seattle, WA)*

Issue: Alleged Inadequate Spinal Cord Injury Unit (SCIU) Clinical and Management Practices

Conclusion: Medical center managers needed to focus on and define the SCIU's mission in order to ensure more consistent patient care for patients with chronic spinal cord injuries.

Impact: Reassessment of SCIU mission and staffing to better focus on patient needs.

In response to a VHA request, we conducted an independent inspection to further evaluate earlier VHA reviews that were conducted to review allegations of alleged patient abuse, instances of improper relationships between SCI patients and SCIU clinicians, and unprofessional activities among some clinical employees. We conducted the inspection in collaboration with VHA's Office of Medical Inspector, and convened a panel of nationally recognized SCI treatment experts in order to fully evaluate all aspects of this highly specialized treatment program. The panel developed independent findings and recommendations which we agreed with and which supported our findings.

We were unable to substantiate any of the allegations, but concluded that actions were needed to improve the quality of care for SCI patients. We found that medical center managers had initiated several measures to improve the SCI treatment process before our inspection began. Managers had reassigned ten employees to other areas of the medical center and began recruiting for qualified replacements, developed an effective cross-training program for all SCIU employees so that each employee was capable of managing more than one function, and established round-the-clock security. Managers and clinicians had also begun to deliberate on ways to bolster the interdiscisciplinary treatment team process, and to streamline the quality improvement team concept.

We made the following recommendations:

- assess the appropriateness of the SCIU's current mission in order to focus staff energies on acute care/rehabilitation,

- in concert with the mission reassessment, re-evaluate staffing needs to reflect the treatment needs of the ultimate patient population,

- strengthen medical record documentation of the treatment process,
- more actively involve employees in the SCIU performance improvement program,
- strengthen the interdisciplinary treatment team approach and patient care planning by requiring more active involvement by all team members, and
- comprehensively assess SCIU employee training needs in order to strengthen all SCIU patient care programs.

The Medical Center Director concurred with the recommendations and provided implementation plans and actions that properly responded to the issues. *(Inspection of Selected Clinical Aspects of the Spinal Cord Injury Unit at the Department of Veterans Affairs Medical Center Hampton, VA)*

Issue: Alleged Improper Clinical Privileges and Resulting Patient Harm

Conclusion: Local clinical managers did not adequately evaluate or validate a surgeon's training and experience and improperly awarded plastic surgery privileges.

Impact: Assurance of properly skilled physician treatment.

We reviewed allegations that medical center clinical managers had improperly awarded plastic surgery privileges and a plastic surgery fellowship position to a surgeon who did not have the requisite training or experience to qualify him to perform the functions of that position. The complainants also asserted that unnamed patients had been harmed in some way because the surgeon did not know what he was doing.

We found that the surgeon had sought a position as a plastic surgery fellow, and had requested surgical privileges to perform a wide range of plastic surgery procedures. He provided medical center clinical managers with a resume of the experience and training that he believed qualified him for the position. He asserted that much of the applied surgical experience had been received in a foreign country and could not be readily validated. Clinical managers accepted his credentials at face value and did not personally validate any of the information as required by VA policy. When nursing employees began to question the surgeon's skills, clinical managers reassessed the surgeon's qualifications and rescinded his privileges. He was subsequently terminated from his fellowship position. Multiple clinical reviews of his patients' medical records failed to elicit any evidence that the surgeon had in any way harmed any patients.

We recommended that the medical center strengthen its credentialing and privileging procedures by ensuring that the Chief of Staff or designee personally verify and validate reported experience and training. The Director concurred with our recommendation and initiated appropriate corrective actions. *(Inspection of Alleged Misrepresentation of Medical Credentials at a Department of Veterans Affairs Medical Center)*

Issue: Alleged Improper Cancellation of Planned Surgery

Conclusion: A surgeon had twice canceled the patient's scheduled operation without sufficient justification.

Impact: Improved scheduling procedures to prevent recurrence.

We conducted an inspection to review allegations that a medical center surgeon scheduled a woman patient for a needed operation on two occasions and acted improperly by cancelling the operation both times.

We found that the patient had followed medical advice prior to admission to the medical center for the scheduled operation, and that the surgeon's supervisors and operating room employees all believed that the surgeon's explanations for canceling and rescheduling the operation may not have been legitimate. We concluded that the patient took proper control of her treatment process and scheduled her treatment at a private health care facility.

Prior to our inspection, the surgeon involved resigned and the VAMC Director convened a Board of Investigation to address the allegations. The Board recommended development of a policy on case cancellations, actions to improve operating room scheduling and equipment availability, and payment of the veteran's medical bills. We concurred with the recommendations which were immediately acted on by the Director, including providing an apology to the woman veteran. (*Inspection of Alleged Refusal to Operate on a Woman Veteran, Department of Veterans Affairs Medical Center Philadelphia, PA*)

5. CONTROL OF DRUGS

Issue: Employee Theft/Diversion of Drugs

Conclusion: Investigations disclosed fraudulent acts by employees to obtain drugs.

Impact: Former employees are held accountable for illegal acts.

During the period, seven former VAMC employees were indicted or sentenced for theft or diversion of drugs. In one case, a licensed practical nurse (LPN) had, diverted Demerol, used to mitigate pain, and replaced it with saline solution. Another LPN had stolen Demerol and a pharmacy technician had stolen numerous types of medication. These individuals received sentences of two to five years' probation and fines ranging from $500 to $2,000. A more detailed summation of the seven cases is included in the section on Employee Integrity and Other Issues.

6. FEE-BASIS FRAUD

Issue: Investigation of Suspected Fraudulent Claims

Conclusion: Individuals submitted false billings and invoices for services not provided.

Impact: Individuals are held accountable for illegal acts.

- An individual, formerly employed as a fee basis nurse for VA, pleaded guilty to one count of mail fraud. An investigation disclosed that, in a 4-year period, the individual billed VA for home nursing visits not made, submitted duplicate billings, and submitted bills for home visits to veterans who were either deceased or hospitalized at the time of the alleged visit. The individual was sentenced to 6 months' home detention, including electronic monitoring, 3 years' probation, and 200 hours' community service.

- A civil complaint was filed in U.S. District Court against an individual who worked as a fee basis nurse for VA. An investigation revealed that, over a 4-year period, the individual submitted false invoices to VA for home nursing care visits.

BENEFIT PROGRAMS

1. DELIVERY OF BENEFITS AND SERVICES

Issue: Procedures to Prevent Dual Compensation of VA Beneficiaries Who are also Active Military Reservists

Conclusion: Procedures to prevent dual compensation need to be improved.

Impact: Recovery of $21 million from current payments and prevention of future dual compensation payments totalling over $8 million annually.

We conducted a review to determine whether VBA procedures ensure that disability compensation benefits paid to active military reservists are offset from training and drill pay as required by law. We determined VBA had not offset VA disability compensation to 90 percent of the sampled active military reservists receiving military reserve pay. We estimated that dual compensation payments of $21 million were made between fiscal years (FYs) 1993 and 1995 and, if the condition is not corrected, annual dual compensation payments estimated at $8 million will continue to be made. Dual payments occurred because procedures established between VA and the Department of Defense (DOD) were not effective or were not fully implemented. We recommended followup on FY 1993-1996 cases to offset either disability compensation or reservists' pay and actions to improve procedures and communication among VBA, DOD, and beneficiaries. The Acting Under Secretary for Benefits concurred with our findings and recommendation and provided acceptable implementation plans. *(Review of Veterans Benefits Administration's Procedures to Prevent Dual Compensation)*

Issue: Medical Examination Services for Veterans with Pending Compensation and Pension (C&P) Disability Claims

Conclusion: VBA and VHA can improve the quality of C&P medical examinations by establishing performance measures and working together.

Impact: Better benefit claims service for veterans.

We conducted a review to followup on the effectiveness of actions taken on our 1994 report on the timeliness of C&P medical examination services and to determine whether additional opportunities exist to further enhance the quality and timeliness of medical examination services. Our prior review found that, in FY 1993, 405,000 examination requests were processed, with 23.5 percent incomplete. In December 1994, VBA and VHA executed a Memorandum of Understanding to jointly improve processing procedures. Our current review found that, in FY 1996, the number of incomplete examinations had not changed significantly, with 21.9 percent of 361,000 requests incomplete. We recommended that VBA and VHA establish performance measures to reduce the rate of incomplete examinations and monitor progress, and that VBA and VHA facility directors be required to work together to reduce the percentage of incomplete examinations. The Under Secretary for Health and the Acting Under Secretary for Benefits concurred in principle with the recommendations and provided acceptable implementation plans. *(Review of Compensation and Pension Medical Examination Services)*

2. OTHER BENEFICIARY ISSUES

Issue: VBA Controls Over Appointment and Supervision of Fiduciaries

Conclusion: VBA appointed appropriate fiduciaries to manage funds of incompetent beneficiaries, but more effective supervision of certain fiduciaries was needed.

Impact: Reduced risk of theft and improved service to the veteran.

As a follow-up to a 1989 OIG report, we audited VBA controls over appointment and supervision of fiduciaries appointed to protect the incomes and estates of incompetent beneficiaries. As of September 30, 1996, VBA supervised fiduciaries of more than 110,000 incompetent beneficiaries with assets valued at over $1.4 billion.

Audit results showed that VBA appointed appropriate fiduciaries to manage the funds of incompetent beneficiaries, but more effective supervision of certain fiduciaries was needed to reduce the risk of theft or misuse of beneficiaries' funds. VBA needed to strengthen monitoring of fiduciaries who were required to submit periodic reports of income, expenses, and assets by following up on questionable or inconsistent data, independently verifying beneficiaries' assets, and requiring documentation supporting selected expenses reported by fiduciaries. We also concluded that the resources to perform supervisions of higher risk fiduciaries could be obtained by providing less supervision of estates of certain beneficiaries whose situations are stable and who are considered less vulnerable to fiduciary fraud. The Acting Under Secretary for Benefits agreed with or provided acceptable alternatives to our recommendations, and provided acceptable implementation plans. *(Audit of Appointment and Supervision of Fiduciaries)*

Issue: Completeness of Data in VBA's Fiduciary Beneficiary System (FBS)

Conclusion: Records needed to be established for additional beneficiaries.

Impact: Reduce the risk of theft or misuse of incompetent beneficiaries' funds.

The primary mission of VA's fiduciary program is to ensure that incompetent beneficiaries are well cared for, and their estates protected from fraud, waste, and abuse. We audited VBA's Fiduciary Beneficiary System (FBS) to determine if system data was complete. We concluded that some beneficiaries did not have records because VBA personnel overlooked, or were unaware of, applicable policies and procedures, and because of clerical errors. Establishing appropriate FBS records would help fiduciary program personnel monitor the financial affairs of incompetent beneficiaries, and reduce the risk of theft or misuse of the beneficiaries' funds.

We recommended that VBA establish the appropriate FBS records and periodically compare C&P data to the FBS to identify incompetent beneficiaries with no FBS records and establish FBS records when appropriate. The Acting Under Secretary for Benefits agreed with our recommendations and provided acceptable implementation plans. *(Completeness of Data in the Veteran's Benefits Administration's Fiduciary Beneficiary System)*

3. LOAN GUARANTY PROGRAM FRAUD

Issue: Fraud in Loan Guaranty Program

Conclusion: The Loan Guaranty Program remains vulnerable to fraud involving loan origination and equity skimming.

Impact: Individuals are held accountable for illegal acts.

Loan Origination Fraud

- The owner of several real estate and investment companies pleaded guilty to charges of wire fraud and conspiracy. A joint investigation by VA OIG and the Department of Housing & Urban Development (HUD) revealed that the individual conspired to defraud VA, HUD, and two mortgage companies through the acquisition, financing, and sale of real property by deceptive means. The individual purchased 34 distressed residential properties of low value which were then cycled through various companies he owned in order to artificially inflate the market value of the properties. These properties were then sold to individuals, many of whom were active duty military members, who were recruited and fraudulently qualified for the loans needed to consummate the sales. As part of the plea, the individual agreed to property forfeitures totaling $2,746,564. Sentencing is pending.

- The owner of a real estate brokerage firm was sentenced to 30 months' imprisonment, 36 months' supervised probation, fined $6,000, and ordered to make restitution of $45,171 to the Government. He previously pleaded guilty to conspiracy to defraud VA, making false statements to VA, and fraudulent use of Social Security numbers. A VA OIG investigation disclosed that the broker and co-conspirators submitted false information to make applicants for VA guaranteed mortgage loans appear creditworthy when, in fact, they were not qualified for these loans. In addition to the broker, six real estate agents affiliated with his firm also have been charged with defrauding VA. Five have pleaded guilty and one was convicted following a 4-day trial in U.S. District Court.

- An individual was arrested following an indictment by a Federal grand jury, which charged him with three counts of making false statements and one count of using a false Social Security number. The individual made false statements to VA regarding his employment, income, and Social Security number in order to qualify for the purchase of a VA portfolio home. A trial date is pending.

Equity Skimming

- Five subjects were arrested after a joint VA OIG, FBI, and IRS/CID investigation revealed that the individuals were engaged in equity skimming schemes and related criminal activities. The investigation revealed that the five individuals identified mortgage borrowers who were in default on their loans, including VA guaranteed loans. The individuals then contacted the property owners and led them to believe that, by deeding the property to one of the individuals and agreeing to pay rent while continuing to reside at the premises, the rent payment would go toward payment of debt and the mortgage would be saved. The investigation disclosed that none of the rent money was paid on

the mortgages but was retained by the individuals accused. In all, there were 15 mortgages and properties involved in this scheme. One of the individuals also was indicted on 31 counts of defrauding financial institutions, businesses, and Government agencies.

4. BENEFICIARY FRAUD

Issue: Integrity of Beneficiary Programs

Conclusion: Fraud continues in dependency and indemnity compensation, pension, fiduciary, insurance, education, compensation, and other programs.

Impact: Individuals are held accountable for illegal acts.

Dependency and Indemnity Compensation Benefits

- An individual was sentenced to 60 months' supervised probation after pleading guilty to theft of Government funds. An investigation disclosed that the individual negotiated Dependency and Indemnity Compensation (DIC) checks issued to his mother following her death. Loss to VA was in excess of $46,000.

- An individual pleaded guilty to one count of theft of Government funds. An investigation revealed that the individual had been collecting and negotiating monthly benefit checks that were issued to a relative who died over 25 years ago. The individual claimed to be using the funds as compensation for having cared for the relative. Loss to VA was over $175,000. Sentencing is pending.

- An individual pleaded guilty to one count of theft of Government property. A VA OIG investigation revealed that, over a 5-year period, the individual endorsed U.S. Treasury checks representing DIC benefits payable to his deceased mother. The individual's actions resulted in a loss to the Government in excess of $50,000. Sentencing is pending.

- Two individuals pleaded guilty to one count each of conspiracy to defraud the United States. A joint investigation conducted by VA OIG, the Air Force Office of Special Investigations, and the U.S. Secret Service revealed that the individuals conspired to misappropriate VA DIC benefits and U.S. Air Force pension payments. The loss to the Government was $207,287. The individuals each face up to 5 years' incarceration and up to $250,000 in fines.

Pension Fraud

- An individual pleaded guilty to theft of Government funds, false statements, and fraudulent acceptance of payments. An investigation revealed that the individual fraudulently received VA benefits while failing to report income received for work. Loss to VA was over $26,000.

Fiduciary Fraud

- An individual employed as a county veterans service officer was sentenced to 46 months' imprisonment, 3 years' probation, and fined $10,000. The sentence also included an additional 12 months in prison for obstruction of justice during the sentencing process, for providing false testimony and evidence to the court. The individual previously was convicted of making false statements to VA, involvement in schemes to defraud over 17 disabled veterans for whom he acted as fiduciary, and for filing false personal income tax returns. The individual's co-conspirator, a former counselor at a VAMC, pleaded guilty to a conspiracy charge involving a kickback scheme and testified against the individual at trial.

- An individual was sentenced to 21 months' imprisonment, 2 years' probation and ordered to pay over $4,000 in restitution to a disabled veteran for whom the individual was appointed as fiduciary. An investigation revealed that the individual, acting as court-appointed fiduciary for two disabled veterans, misappropriated money from the veterans' accounts and made false statements to both VA and a state agency to conceal the missing funds.

- An individual acting as fiduciary for the widow of a deceased veteran pleaded guilty to a charge of theft of Government funds. A VA OIG investigation revealed that the fiduciary failed to report the widow's death in July 1994, subsequently converting for her own use 21 VA benefit checks totaling $20,836 in a 2-year period. Sentencing is pending.

Insurance Benefits Fraud

- Three individuals, one a former VA insurance claims examiner, were sentenced after pleading guilty in U.S. District Court, for their roles in the theft of VA insurance benefits. The former insurance claims examiner was sentenced to 4 months in a community halfway center, 5 years' probation, a $2,000 fine, and was ordered to pay $19,904 in restitution to VA. The second individual, not a VA employee, was sentenced to 3 years' probation, 50 hours' community service and fined $1,000. The third individual was sentenced to 6 months' home detention, 5 years' supervised probation, a $2,000 fine and ordered to make restitution in the amount of $19,905 after pleading guilty to 4 counts of theft of public monies. A joint VA OIG/U.S. Secret Service investigation revealed that the conspirators diverted approximately $40,000 in proceeds from unclaimed VA insurance policies that had matured or were payable due to the death of insured veterans but for which the beneficiaries could not be located. In addition, two checks totaling approximately $18,000 were seized when the defendants attempted to cash them and were arrested by local police.

Education Benefits Fraud

- Three college instructors and two student instructional aides were indicted for their roles in the fraudulent payment of VA educational assistance benefits to veterans enrolled at a community college. A 3-year joint investigation by VA OIG and the Postal Inspection Service disclosed a "special program" that existed from 1988 to 1995 through which over 300 student veterans obtained over $3.8 million, without attending regular classes, by paying kickbacks up to $200 per student each semester. As a result of the investigation, VBA announced administrative sanctions against the college and a program of frequent, on-site compliance inspections. In a collateral action, the U.S. Attorney's Office has recovered $370,000 in restitution and additional efforts are continuing.

Compensation Fraud

- An individual was convicted on 40 counts of mail and wire fraud, and for making false statements. A joint VA OIG/FBI investigation revealed that the individual, by posing for more than 20 years as a wheelchair bound veteran who had lost use of his right arm and leg, collected disability benefits from VA amounting to more than $500,000. Testimony from business people, contractors, and medical workers established that the individual was not disabled, and co-owned and operated a successful commercial painting business.

- An individual was sentenced to 120 months' imprisonment and his spouse to 12 months' imprisonment in connection with a telemarketing scheme that defrauded consumers of over $31 million. A joint VA OIG, FBI, and IRS investigation revealed that, while operating a business that defrauded consumers in the sales of vending and game machines, he was collecting disability benefits from VA based on, at first, a 30 percent disability rating, and later, a 100 percent disability rating. In addition, the couple evaded paying income taxes by disguising payments received from the vending machine sales. Over an 11-year period, the individual collected benefit payments from VA in excess of $200,000.

- An individual who had pleaded guilty to charges of false claims and theft of Government property was sentenced to 5 years' probation, 90 days to be served in a community center, and 80 hours of community service. A VA OIG investigation revealed that the individual falsely completed annual employment questionnaires certifying that he was unemployed in order to receive service-connected disability at the 100 percent rate when, in fact, he was employed as a teacher. Additionally, the individual admitted that family members wrongfully received VA educational benefits based on the false unemployment claims. The loss to VA was over $150,000; restitution is being made by reducing the individual's future VA entitlements until the debt has been satisfied.

Other

- A civil complaint was filed charging a husband and wife with one count each of false claims and conspiracy to defraud the United States. The complaint charges that both individuals presented claims for $1,000,000 and $200,000, respectively, to VA under the Federal Tort Claims Act, claiming VA had been negligent in providing medical treatment to the husband, resulting in the subsequent loss of consortium. On both claim forms, the individuals stated their status as married when, in fact, they were not married at the time the alleged negligent treatment occurred.

FINANCIAL MANAGEMENT

1. VA'S FINANCIAL STATEMENTS

Issue: VA's Accounting Operations

Conclusion: Additional management actions are needed to further improve accounting operations.

Impact: Improved accuracy of financial information.

For FY 1996, VA reported assets totaling $43.4 billion and expenses totaling $43.9 billion. As part of our ongoing work on the Audit of VA's Consolidated Financial Statements (CFS), we issued nine reports – eight management letter reports resulting from OIG reviews of financial information and one report resulting from a contractor review of two Financial Management System (FMS) subsystems. The reports are intended to provide Department managers observations and advice for improving accounting operations and controls in day-to day operations. A summation of these reports follows.

The first management letter concluded that financial information processed at the Austin Finance Center was generally reliable for operations and transactions tested. However, operations could be enhanced by ensuring that (i) compensating controls were in place where prescribed separation of duty controls were impractical, (ii) user identifications in VA's FMS reflected each employees' current employment status, (iii) manual payroll accruals were reversed, (iv) reconciliation of the Minor Construction Appropriation with U.S. Treasury records was completed timely, and (v) staff emphasize accuracy when coding FMS disbursement transactions that could affect the reliability of management reports. *(Management Letter - FY 1996 Selected Accounting Operations and Systems at Austin Finance Center)*

The second management letter concluded that staff established required internal controls for monitoring financial information, and generally complied with VA policies and procedures based on audit tests made and had made improvements during the past year. However, there remained three areas in which further improvements would be beneficial. These concerned (i) improving data used to calculate the future liability for Compensation and Pension (C&P) benefits, (ii) improving the financial statement preparation process, and (iii) strengthening policies and procedures for contract counseling accounting. *(Management Letter - Tests of Selected Veterans Benefits Programs Accounting Functions Performed at VA Central Office)*

Three management letters concluded that much progress had been made in improving Property, Plant, and Equipment (PP&E) reporting, but that continuing efforts were needed to further refine the accuracy of PP&E accounting information. The first management letter provided information and observations from our overall analysis of PP&E data in the general ledger and fixed asset subsystem, and encouraged VHA and the Chief Financial Officer (CFO) to improve internal controls by continuing efforts to oversee PP&E accounting activities, provide additional guidance and training, and to analyze PP&E accounts and provide operating facilities the results when adjustments are needed. The other two management letters described actions needed at the facility level to help ensure the accuracy of PP&E information in the general ledger. Actions needed included efforts to ensure: (i) reconciliations of

property accounts are completed and appropriate adjustments are made, (ii) physical inventories are completed as required, and (iii) costs in the construction work-in-process are capitalized when the resulting building or improvement is put into service. *(Three Management Letters - Management Oversight of Property, Plant, and Equipment Financial Information; Accuracy of Non-Expendable Equipment Financial Information; and Accuracy of Real Property Financial Information)*

A sixth management letter concluded that staff established required internal controls for monitoring life insurance financial information, and generally complied with VA policies and procedures based on audit tests made. Of the eight conditions discussed in our prior year audit report, one had been overtaken by events, management had corrected two, and actions were in process to correct the other five. No new conditions were identified in this year's audit. *(Management Letter - FY 1996 Financial Statement VA Life Insurance Programs)*

A seventh management letter provided additional explanation and detail regarding a reportable condition in our previous report on VA's FY 1996 Consolidated Financial Statements to aid in establishing an effective corrective plan. We concluded stronger financial reporting controls were necessary to provide reasonable assurance that transactions continue to be properly reported, and that material misstatements would be prevented or detected in three areas: (i) the automation and integration of financial accounting and reporting systems, (ii) financial and credit reform accounting training of staff responsible for HCA financial data, and (iii) review of financial data and reports. *(Management Letter - Tests of Selected VA Housing Credit Assistance Accounting Functions Performed at VA Central Office)*

We conducted the eighth review at management's request. We evaluated accounting procedures used to resolve errors caused by data limitations in some total dollar fields resulting in truncation during the February 1997 transfer of active policy master records from the computer data base administered by the St. Paul, MN Department of Veterans Affairs Regional Office and Insurance Center (VAROIC) to the VAROIC Philadelphia, PA data base. In our advisory, we concluded that management performed adequate adjustments to general ledger insurance accounts to resolve errors in certain fields which occurred during the first in a series of data transfers. In addition, management's procedures should adequately preserve the integrity of financial data transferred during the consolidation. *(Adequacy of Procedures Used to Transfer Life Insurance Policy Data from VAROIC St. Paul, MN to VAROIC Philadelphia, PA)*

The ninth report contained the results of a requested contractor review. The contractor concluded that application controls incorporated into the Accounts Receivable Subsystem and the Fixed Asset Subsystem of VA's FMS were adequate. However, the general controls over the information systems did not adequately ensure that computer programs and data files were protected from unauthorized access and modification. The review identified 9 reportable conditions and 15 significant but less important management letter comments. VA management agreed with all but two items. We will follow-up and evaluate the effectiveness of the actions and related compensating controls for all items in our Audit of VA's FY 1997 Consolidated Financial Statements (CFS). *(Electronic Data Processing Controls in the Financial Management System Accounts Receivable and Fixed Asset Subsystems)*

None of the conditions noted above for the nine reports had a material financial effect on the FY 1996 CFS, but correction of the conditions is considered necessary for effective operations. Where needed, appropriate adjustments were made to the financial statements.

2. OTHER FINANCIAL CONTROL ISSUES

Issue: Duplicate Payments

Conclusion: Collection actions should be pursued on duplicate payments

Impact: Repayment of over $1 million.

As part of our ongoing audit of VA's financial operations and reporting, we identified two duplicate payments made to a commercial vendor totaling over $1 million that had not been previously detected. VA Central Office financial staff promptly confirmed the overpayment and sent a collection letter, and the vendor paid the amount due. VA management officials agreed that collection efforts should be handled in a timely manner, and agreed to aggressively pursue collection of duplicate payments. *(Duplicate Payments)*

Issue: VHA's Income Verification Procedures for Veterans Reporting No Income

Conclusion: VHA facilities should obtain means test information from veterans, and conduct periodic reviews of zero income means tests.

Impact: Improved compliance with means test and Privacy Act requirements.

Each year, VHA's Health Eligibility Center (HEC) matches VA's records with the records of the Internal Revenue Service and Social Security Administration based on income information provided by VHA facilities. During FY 1996, HEC matched 726,758 veteran records and identified 106,029 veterans whose incomes exceeded statutory thresholds, and who were potentially responsible for making medical care co-payments.

We reviewed VHA procedures for verification of veterans reporting no income on means tests, and assessed VHA compliance with means test and Privacy Act requirements. We found that over 87 percent of the cases reviewed had no signed means test documents to attest to the accuracy of income information reported or to certify receipt of the Privacy Act statement. We also found that VHA lost the opportunity to collect over $3 million because some veterans had been erroneously identified as exempt from co-payments. We recommended that VHA take action to improve compliance with means test and Privacy Act requirements, including ensuring that VHA facilities obtain means test and Privacy Act information, and requiring VISN Directors to conduct periodic reviews of zero income means tests. The Under Secretary concurred with the findings and recommendations and provided an acceptable implementation plan. *(Means Testing and Income Verification Procedures)*

INFORMATION RESOURCES MANAGEMENT

1. TELEPHONE ACCESS SYSTEMS

Issue: Personal Identification Number (PIN) Telephone Access Systems

Conclusion: VA could reduce overall telephone costs by installing the PIN system nationwide.

Impact: Telephone costs could be reduced by over $10 million annually.

In Fiscal Year 1996, VA medical centers spent about $22.4 million on long distance services (62 percent of VA's $36.1 million long distance costs). We evaluated the effectiveness of PIN telephone access systems used by three VAMCs. The three VAMCs had installed PIN access systems as a means of reducing telephone costs and improving accountability over telephone usage. They reported that system installation costs were minimal, accountability for telephone usage had improved, and long distance expenses had been reduced by an average of 68.9 percent, with total annual savings estimated at $934,000.

We contacted all 158 other VAMCs and found that 148 VAMCs did not have PIN systems or plans to install them. Based on the experience of the three VAMCs reviewed, we concluded telephone costs could be reduced by an estimated $10.1 million annually if all VAMCs installed PIN systems. In addition, VBA, NCS, and VA Central Office activities could benefit from installing PIN systems. We recommended that management officials inform facilities and activities about the benefits of PIN access and encourage installation in existing telephone systems, and/or integration of PIN access with new telephone systems or upgrades.

The Under Secretary for Health concurred with the recommendations and stated that VHA had initiated actions to install PIN systems at all VAMCs, as appropriate, with first-year start up costs expected to be about $10.8 million. The Acting Under Secretary for Benefits; Director, National Cemetery System; and Assistant Secretary for Management all expressed an interest and commitment to improving telephone system management and reducing long distance costs. *(VA Use of Personal Identification Number Telephone Access Systems)*

2. SECURITY CONTROLS OVER AUTOMATED BENEFITS PAYMENTS

Issue: Adequacy and Appropriateness of Security Controls at Hines Benefits Delivery Center (BDC)

Conclusion: The BDC needed to establish a proactive security program, and correct weaknesses identified by the audit.

Impact: Improved security

We evaluated the adequacy and appropriateness of security controls at the Hines Benefits Delivery Center (BDC), focusing on areas where management could strengthen physical and electronic access controls. In FY 1996, the BDC provided key automation support for processing over 40 million benefit payments totaling $20 billion to veterans and their families. The audit identified a number of key security enhancement opportunities needed to make the BDC facility more physically secure and less vulnerable to unauthorized electronic access of systems and data. The BDC Director concurred with our recommendations and agreed to: establish a proactive security program, complete a risk assessment, and implement necessary physical and electronic security controls to correct weaknesses identified by the audit. *(Security Controls at the Hines Benefits Delivery Center)*

3. INTEGRATION OF COMMERCIAL SOFTWARE IN VHA SYSTEMS

Issue: Integration of Commercial Off-the-Shelf Software into VHA Systems

Conclusion: VHA has made progress integrating commercial software.

Impact: Improved compatibility between VHA computer software systems, resulting in better service to veterans.

As part of our audit of the Veterans Health Information System and Technology Architecture (VISTA), we evaluated the effectiveness of VHA efforts to integrate commercial off-the-shelf software applications into VISTA. We found that VHA has been reviewing methods for integrating commercial software into VISTA, and has made progress assisting VAMC programmers in integration efforts. Three of the seven commercial software applications were successfully integrated with VISTA, and satisfactory progress had been made toward integrating the remaining four applications. A Message Routing and Translation System (MRTS) had been installed at one medical center, which allows commercial software to be recognized by VHA internal computer systems and has the potential to lessen the burden of adapting commercial software to VISTA.

We also found that nationwide use of MRTS technology has been delayed because VA management officials have differing opinions on deployment and funding strategies for MRTS. We recommended that VHA and the Office of Management determine whether to continue to use MRTS or develop another alternative approach to the system integration.

The Under Secretary for Health and the Assistant Secretary for Management concurred in principle and the Under Secretary agreed to establish a working group to review alternatives, including the MRTS. *(Efforts to Integrate Commercially-Developed Software to Hospital Information Systems)*

EMPLOYEE INTEGRITY AND OTHER ISSUES

1. SPECIALIZED INVESTIGATIONS

Issue: Specialized Investigations Regional Task Force (SIRTF) Investigations

Conclusion: SIRTF investigations continue to disclose sales of controlled substances, workers' compensation fraud, and corruption.

Impact: Individuals are held accountable for illegal acts.

The SIRTF is an enforcement unit comprised of special agents from the VA OIG and VHA. Under the direct control of the VA OIG, SIRTF became operational in the spring of 1994, and has successfully investigated allegations of drug diversion, sales of controlled substances, sales and possession of firearms, and other criminal violations occurring at VAMCs in the New York metropolitan area.

SIRTF was created in response to concerns voiced by the directors of three New York area VAMCs over various criminal activities taking place at their facilities. The VA OIG's assistance was sought because federal agencies such as the DEA and the FBI have workloads and priorities which often preclude addressing criminal activity at VAMCs. In addition, VA Security Police lack the personnel and expertise to conduct these investigations, and local authorities were unable or unwilling to devote limited resources to what they perceived as a Federal problem.

In the three years that SIRTF has been operational, the unit has achieved a remarkable record of success. Initially targeted at the criminal activities mentioned above, the unit's role was expanded to include the investigation of workers' compensation fraud, a problem that was costing VA millions of dollars each year, funds that could be spent on our nation's veterans. This effort also enjoyed great success as indicated by the cases cited below.

Controlled Substances

- An individual pleaded guilty to charges of distribution and possession with intent to distribute cocaine after selling cocaine to an undercover special agent assigned to SIRTF on the grounds of a VAMC. The individual was sentenced to 30 months' imprisonment followed by 6 years' probation.

- An individual was sentenced to 5 years' probation after pleading guilty to the illegal sale of controlled substances. An investigation conducted by SIRTF determined that the controlled substance, Percocet, which he sold to an undercover agent, was diverted from a VA pharmacy.

- A former Environmental Management Services employee at a VAMC pleaded guilty to charges of distribution of, and possession with intent to distribute, controlled substances. A joint investigation by special agents from VA OIG and SIRTF revealed that the individual purchased drugs in large quantities from local neighborhood drug establishments, and resold the drugs for profit inside and outside the VAMC to employees and patients. Sentencing is pending.

Workers' Compensation Fraud

- The former Director of a Regional Educational Medical Center at a VAMC signed a settlement agreement with the U.S. Attorney's Office to make restitution in the amount of $260,000 for overpayment of workers' compensation benefits. An investigation conducted by SIRTF revealed that for almost 8 years, the individual was employed in various pursuits, including ownership of a real estate management company, operating a private medical practice, and teaching in Europe and the Far East, while collecting workers' compensation benefits.

- A former motor vehicle operator at a VAMC was sentenced to 5 years' probation, 6 months' home detention and ordered to pay the Government $85,800 in restitution. The individual pleaded guilty to one count of making false statements in order to receive workers' compensation benefits as a result of a SIRTF investigation. The individual admitted that, over a 6-year period, he submitted false statements to the Government indicating he was unable to work due to an on-the-job injury received at the medical center. During that period, he received over $85,000 in workers' compensation benefits while owning and operating a restaurant, where he was observed engaging in strenuous physical activity. The estimated Office of Workers' Compensation Program (OWCP) costs that will not be paid out as a result of his removal from the program are $200,000.

- A former Chief of Labor Relations at a VAMC was sentenced to 4 months' imprisonment, 5 months' home confinement, and 19 months' supervised release after pleading guilty to conspiracy to commit workers' compensation fraud. An investigation by SIRTF revealed that the individual assisted her husband, who previously pleaded guilty in this case, in submitting false claims to the Department of Labor in order to receive workers' compensation benefits.

- A former food service worker at a VAMC was sentenced to 60 months' probation and ordered to pay $14,042 in restitution to the Government. The employee claimed to have injured his lower back during 1992 while working at the medical center. He subsequently received $29,049 in workers' compensation payments. An investigation conducted by SIRTF revealed that the food service worker was employed as a home health care attendant while receiving benefits and failed to report the income as required by the Department of Labor. The estimated OWCP costs that will not be paid out as a result of the conviction and termination from the program are approximately $374,000.

Corruption

- A former VAMC police sergeant was sentenced to 15 months' imprisonment and 3 years' probation after pleading guilty to bribery of a public official. An investigation by SIRTF revealed that the former employee accepted money and things of value from an undercover agent in exchange for allowing the sale of narcotic drugs inside the VAMC cafeteria. During the undercover operation, 20 individuals were arrested for possession or distribution of narcotics at the VAMC.

2. EMPLOYEE AND THIRD-PARTY INTEGRITY

Issue: Investigations of Misconduct and/or Illegal Acts by Employees and Third Parties

Conclusion: Instances of thief, embezzlement, bribery, fraud, and other acts of misconduct were disclosed.

Impact: Individuals are held accountable for illegal acts.

Employee Theft/Diversion of Pharmaceuticals

- A licensed practical nurse in the Nursing Home Care Unit at a VAMC was sentenced to 5 years' probation, 360 hours' community service, and ordered to pay a fine of $2,000. The nurse had pleaded guilty to one felony count of obtaining the administration of a narcotic drug and one misdemeanor count of reckless endangerment. A joint investigation by VA OIG, DEA, and local authorities revealed that the nurse had diverted Demerol, used to mitigate patient pain, and replaced it with saline solution. If undetected, the saline solution, when administered to a patient needing medication for pain control, would have no effect and would constitute patient abuse. The individual was placed on administrative leave by VAMC officials and has since resigned.

- A former licensed practical nurse at a VAMC was sentenced to 4 years' imprisonment (suspended), 4 years' probation, and fined $850 following a guilty plea to 31 counts of theft by deception of a controlled substance. A VA OIG investigation revealed that the nurse diverted Demerol from the hospital ward while on duty by signing out doses to patients who had already been discharged.

- A former pharmacy technician at a VAMC was sentenced to 2 years' supervised probation, 200 hours of community service, and fined $500. He previously pleaded guilty to the theft of Government property. An investigation revealed that he had stolen numerous types of medication and other items from the medical center pharmacy for his own use.

- Two former VA employees, a food service worker and a housekeeping aide at a VAMC, were arraigned before a Federal Magistrate Judge following their arrest on charges of possession with intent to distribute marijuana and cocaine. A VA OIG investigation revealed that the individuals were selling controlled substances to substance abuse patients at the VAMC. Both individuals have prior criminal records. A trial date is pending.

- A former employee at a VAMC was arraigned in state court in response to a superseding indictment charging the individual with three counts of selling controlled substances on VAMC property. A VA OIG investigation revealed that the individual sold heroin to undercover agents inside of, and on property adjacent to, the VAMC. A trial date is pending.

- A former pharmacist at a VAMC was indicted by a Federal grand jury on 11 counts of distribution of a controlled substance. The former employee was charged with forging prescriptions to divert Percocet, morphine sulfate, and Darvon. In a sworn statement taken by VA OIG special agents, the employee admitted forging the prescriptions and subsequently resigned from VA employment.

Theft and Embezzlement

- The former president of a labor union at a VAMC pleaded guilty to charges of conspiracy, mail fraud, making false statements, and concealing material facts from the Department of Labor, all in connection with the embezzlement of union funds; and to filing false Federal income tax returns and possession of a firearm in a Federal facility. The union officer had been employed at the VAMC as a morgue technician. A joint VA OIG, IRS, and Department of Labor investigation determined that approximately $190,000 of union funds had been misappropriated. The individual and co-conspirators caused false Labor Organization Annual Reports to be mailed to the Department of Labor.

- Three individuals pleaded guilty to charges of conspiracy and theft of Government funds and were sentenced to serve various terms of home confinement, probation, community service and restitution. An investigation revealed that the individuals fraudulently caused five U.S. Treasury checks to be generated and mailed to a non-existent vendor. The checks were then cashed and the money funneled through two bank accounts opened under a false identity. The money was distributed among the three conspirators. The loss to VA was over $88,800.

- A husband and wife both resigned their positions as medical clerks at a VAMC after receiving notices of proposed removal actions. These actions were based on information developed as a result of a joint investigation by the VA OIG and the Postal Inspection Service. While working at the hospital, the husband allegedly stole pre-approved credit card applications and other mailings intended for patients and, using personal information from the VA computer system, obtained credit cards in the names of patients. The couple allegedly used the credit cards to purchase various items and services, and to obtain cash for their personal use.

- Two former VA employees were voluntarily separated from Government service following charges of unauthorized use of Government property. A joint investigation by the VA OIG and local police revealed that the first individual, the former chief of Community Resource Services at a VAMC, used a Government-issued credit card for personal purchases of musical equipment and permitted the inappropriate use of the credit card by unauthorized parties, including VAMC volunteers, in over 20 instances. The second individual, a former VA program specialist in Community Resource Services, was charged with use of the Government-issued credit card for personal items.

Acceptance of Gratuity

- A former VA benefits counselor was sentenced to 4 months' home detention and 5 years' probation after pleading guilty to a two-count Information charging him with the acceptance of a gratuity by a public official. The Information charged that, while he was a VA employee, he accepted cash payments to expedite processing of various VA loan application documents.

Workers' Compensation Fraud

- A former claims clerk at a VAMC was sentenced to 6 months in prison; 3 years' supervised release, with the first 6 months' in home confinement; and ordered to pay restitution in the amount of $46,245. The sentence followed her conviction on a three-count indictment charging her with making false statements to obtain workers' compensation benefits. A VA OIG investigation revealed that the individual worked as a licensed vocational nurse while claiming workers' compensation benefits. She failed to report employment income on documentation submitted to the Department of Labor in order to receive benefits in excess of $159,000.

- An individual was sentenced to 20 months' imprisonment, 36 months' probation, and was ordered to pay $14,500 in restitution to VA. The individual pleaded guilty to multiple counts of fraud against the Government following a joint investigation by the VA OIG, Department of Labor OIG, FBI, and Army Criminal Investigations Division. The investigation determined that the individual submitted fraudulent claims of unemployability over a 3-year period causing the Government to pay approximately $80,000 in workers' compensation and VA pension benefits to which he was not entitled.

- A former registered nurse at a VAMC was indicted on one count of making false statements on Department of Labor workers' compensation forms. An investigation disclosed that the nurse was employed by at least two home health care services while reporting that she had no outside income. She was paid approximately $181,000 in workers' compensation payments.

Other Employee Misconduct

- A Federal grand jury returned a superseding indictment charging a physician, formerly assigned to a residency program at a VAMC, with one count of false statements, and five counts of possession of controlled substances by misrepresentation, deception and subterfuge. The individual was originally indicted in July 1997 for the false statement charge only. It is charged that, in connection with his application to enter a residency program at a state university, he failed to disclose to officials that he had been convicted and incarcerated for assault arising from the non-lethal poisoning of his co-workers while employed as a paramedic. Upon his assignment to the VAMC, he was able to dispense controlled substances including Demerol and morphine. In 1993, an arrest warrant was issued based on the false statement charge. The individual left the United States at that time and accepted an appointment as a resident at a mission hospital in Zimbabwe. An arrest warrant was issued in Zimbabwe charging him with five counts of murder and two counts of attempted murder of patients at that hospital. He was arrested upon his return to the United States in July 1997. He is being held in Federal custody pending trial on the false statement and controlled substance charges. If convicted, he could receive a maximum sentence of 25 years' imprisonment and $150,000 fine.

- Two individuals, one a VAMC Environmental Management Service Chief, were indicted by a Federal grand jury on 36 counts, including conspiracy, money laundering, theft of Government funds, and making false claims to VA. The two individuals were arrested shortly thereafter.

- A joint VA OIG/FBI investigation disclosed that the Chief of Environmental Management Service used her management position to authorize the procurement of, and approve the payment for, over $55,000 for decorating services rendered to the medical center when, in fact, no services were provided. Payments for invoices submitted for the alleged services were made using Government checks while the official Government credit card was used in other instances.

- Two former physicians at a VAMC resigned their positions and a third physician submitted retirement papers as a result of a joint VA OIG and FBI investigation. The investigation revealed that the individuals conspired in a scheme to defraud VA by placing resident physicians from the VAMC on a rotating schedule where they spent up to 30 percent of their time staffing a privately run clinic owned by one of the physicians.

- A certified registered nurse anesthetist at a VAMC has been indicted on one count each of felony theft and practicing medicine without a license. A joint investigation, conducted by VA OIG and local police, determined that the individual, while on sick leave from the VAMC, was posing as a licensed physician and treating patients in her own private office.

- A former staff psychiatrist at a VAMC resigned after a VA OIG investigation revealed that the individual was never qualified, either by accreditation or education, as a board-certified psychiatrist, as had been claimed. The individual was, however, licensed as a general practitioner. The individual had been placed on a special pay scale commensurate with the position of staff psychiatrist, resulting in an overpayment of $119,000. Restitution will be made to the VAMC.

- The chief of a VA outpatient clinic was removed from that position and punitively transferred to a staff physician position on charges of unethical conduct and conflict of interest. An investigation revealed that the individual used clinic personnel and equipment in the treatment of family members; used the services of clinic employees to perform personal services during duty hours; and accepted free, non-emergency transportation from an ambulance company that provides patient transportation services for the clinic.

- A physician at a VAMC was issued a letter of reprimand for violations of VA Standards of Ethical Conduct and Common Standards of Work Behavior. An investigation revealed that the individual was writing prescriptions for a VA employee, even though the physician was not the employee's personal physician; did not perform a medical examination on the employee to determine the necessity for the prescribed medication; and had no reason to prescribe large quantities of drugs for the employee.

- A former VA rating specialist at a VA Medical & Regional Office Center (VAMROC) was indicted on one count of mail fraud. A VA OIG investigation disclosed that the individual made false statements in order to obtain over $24,000 in VA benefits for post traumatic stress disorder that the individual was not entitled to receive, which caused numerous VA benefits checks to be delivered by the U.S. Postal Service. The individual has resigned from Government service.

Issue: Special Inquiries of Alleged Employee Misconduct or Mismanagement

Conclusion: Various conditions were substantiated, but willful misconduct or mismanagement as a cause was rarely disclosed.

Impact: Collection of salary overpayments totalling over $76,000, cancellation of planned employee demotion, transfer of unused equipment, and administrative action.

During the period, we issued eight special inquiry reports. Following are summations of five of the more significant reports issued:

- A special inquiry found that three employees were inappropriately appointed to the step 10 grade level. This occurred because of an apparent contradiction in Federal pay setting requirements in effect at the time of the actions. Medical Center management adjusted the salaries of two of the employees still employed at the time of our report. Collection actions were also initiated to recover $76,382 in overpayments made to the two current employees and one former employee.

- Another special inquiry found that management had inappropriately issued a decision to "reassign" a white collar employee to a blue collar position. When we examined the action, we found that the "reassignment" actually constituted a demotion under Federal personnel rules. Since the Medical Center had not followed required procedures for an involuntary demotion, the action was improper. The Medical Center canceled the pending reassignment and assigned the employee to a position at the appropriate grade level.

- A third special inquiry concluded that a supervisor treated one staff member differently by allowing that employee to work beyond his normal duty hours, while other staff were directed not to do so. The inquiry further concluded that the same employee engaged in improper practices relating to a commercial business in which he had a financial interest. Both matters were satisfactorily resolved. We also brought additional concerns to management's attention, including indications of a disruptive working environment and an additional instance of disparate employee treatment.

- In another special inquiry, we found that a VAMC acquired an infectious waste sterilizer, spent nearly $170,000 in site preparation and repair, but was never able to operate the machine. At our suggestion, the Director planned to provide the machine to another facility that could use it.

- In a fifth special inquiry, we found that two service chiefs coerced subordinates to join a personal business venture. The allegations had been investigated by the VAMC Director and appropriate administrative actions were taken.

II. OTHER SIGNIFICANT OIG ACTIVITIES

In addition to its operational audit, investigative, contract review, and healthcare inspection roles, the OIG is responsible for a wide range of other significant activities that contribute to fulfilling the OIG's overall mission objective. A description of these activities follows.

HOTLINE

The Hotline staff operates a toll-free telephone service 24 hours a day, 7 days a week or individuals can send their concerns in writing (address on back cover). In addition, the OIG Hotline has a Homepage (http://www.va.gov/oig/hotline/hotline.htm) on the Internet and E-mail access. Calls, letters, and E-mail are received from employees, veterans, the general public, the Congress, GAO, and other Federal agencies reporting issues of fraud, waste, and abuse. Due consideration is given to all complaints and allegations received, with each addressed by OIG or other Departmental staff and a response provided to the reporting individual.

1. HOTLINE CASES PROCESSED

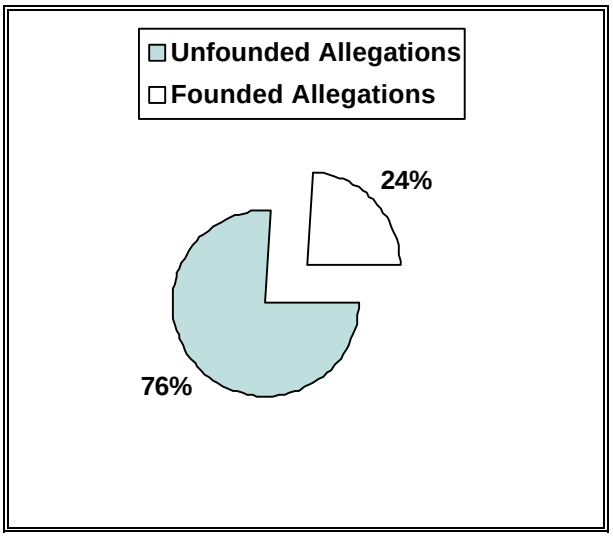
During the period, the Hotline Section received 10,959 contacts, with 376 cases opened and referred, and 313 cases closed, as follows:

HOTLINE WORKLOAD	
Total Contacts	**10,959**
Cases opened and referred*	**376**
OIG Audit	1
OIG Investigations	10
OIG Hotline and Special Inquiries	23
OIG Healthcare Inspections	26
Other OIG	2
VA Program Managers	324
Cases closed	**313**

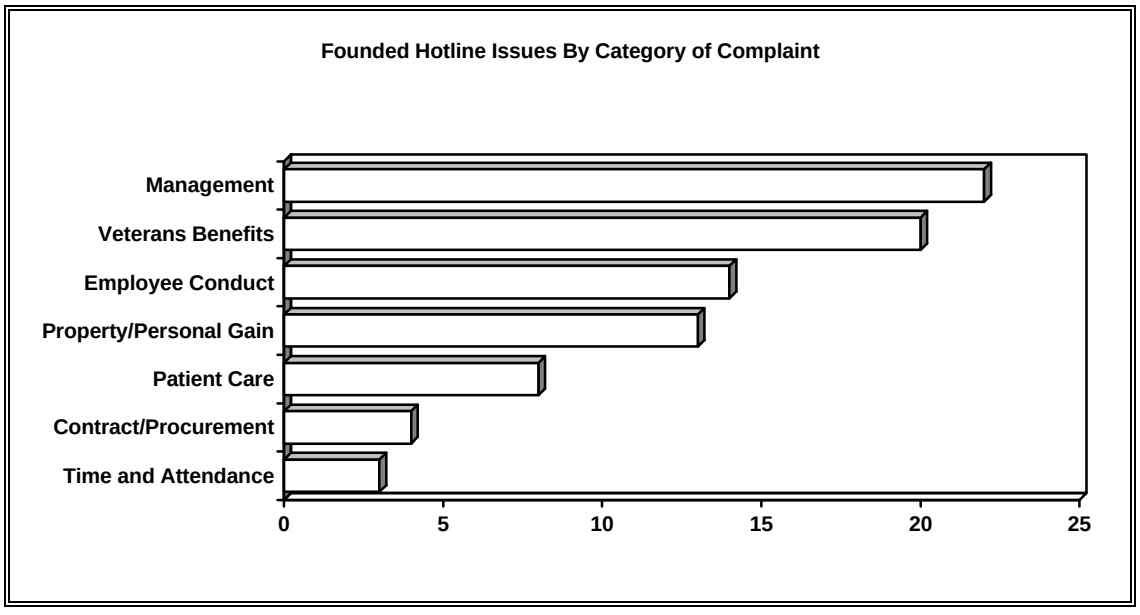
* Some cases referred to more than one office.

2. FOUNDED ALLEGATIONS

Of the 313 cases closed during this period, 75 cases (24 percent) contained founded allegations. The following graph illustrates the percentage of cases warranting corrective actions.



The majority of the issues associated with the founded allegations concerned management, veterans benefits, employee conduct, property and personal gain, patient care, contract/procurement irregularities, and time and attendance. The following table illustrates the number of complaints by category for the founded allegations.



As a result of these reviews, VHA managers imposed 29 administrative sanctions (e.g. counselings, admonishments, reassignments, and terminations) against employees during this reporting period. A total of $161,928 in potential recoveries was also identified. Following are examples of allegations that were founded for each of the categories listed on the preceding table.

Management

- A review found that a VAMC employee used the wrong social security number when admitting a patient, who later died at the VAMC. Because of the error, a living veteran's compensation checks were erroneously stopped and his insurance company was billed for the deceased veteran's care. As a result of the review, the living veteran's compensation was reinstated, his insurance company was reimbursed and he was sent an apology. All records were corrected, and the employee was counseled.

Veterans Benefits

- A review determined that a veteran failed to report an income change to the VA, resulting in his VA award continuing inappropriately. The VA wrote to the veteran giving him an opportunity to rebut the resulting overpayment of $57,930 before proceeding with corrective action.

- Another review found that a claimant failed to report information relevant to his claim due to lack of awareness of requirements, resulting in an $11,249 overpayment. The amount was subsequently paid back.

Employee Conduct

- A review found multiple instances of misconduct within a VAMC Police and Security Service. A police officer was given a 5-day suspension for using his master key to access medical center property with a female employee, and the female was issued a reprimand. Two police officers received 5-day suspensions for sleeping on duty. Another officer was counseled for allowing unauthorized personnel in the Police and Security office, and one officer was given a 5-day suspension for using E-mail to send personal messages.

- As a result of another review, a Service chief was reprimanded for sponsoring subordinates as AMWAY distributors. Another employee was verbally counseled for using the E-mail system to solicit interest in a non-VA trip.

Property and Personal Gain

- A review found that an employee used Government fax and telephone equipment for non-VA business on VA time. The employee was counseled.

- Another review found that an employee made personal telephone calls over a period of several months. The employee was reprimanded and required to pay $218, which included a $50 administrative charge.

Patient Care

- A review by our Office of Healthcare Inspections (OHI) found that VAMC staff did not attempt to resuscitate a veteran after his spouse found him unresponsive, although the patient was on "full code" status. OHI concluded that attempts at resuscitation would have been medically futile, but recommended that the Chief of Staff review the code status policy with staff to ensure patients' requests are appropriately acted on.

- As a result of another review, a VAMC employee was admonished for failing to follow policy, which required he wear gloves while drawing a patient's blood.

Contract/Procurement

- A review found that a contract was executed without going through the proper contractual procedure. The contract was cancelled on completion of the prepaid term.

Time and Attendance

A review found that a supervisor allowed employees to work extra hours and reimbursed them the following week. The supervisor pulled hours from future weeks to allow the employees to work the extra hours. Guidance was issued to address the inappropriate use of unscheduled hours.

FORENSIC DOCUMENT LABORATORY

The OIG operates a nationwide forensic laboratory service for fraud detection, which can be utilized by all elements of VA. The types of requests routinely submitted to the laboratory include handwriting analysis, typewriting, inks, paper, photocopied documents, and suspected alteration of official documents. During this reporting period, the forensic laboratory received 473 documents from various non-OIG sources that required 1,816 laboratory examinations. The laboratory received 358 additional pieces of evidence in 6 OIG criminal investigations, which required 956 laboratory examinations. There were a total of 39 laboratory reports issued during the period covered by this report.

LABORATORY CASES FOR THE PERIOD	
REQUESTER	**CASES COMPLETED**
OIG Office of Investigations	6
Regional Offices	27
VA Security and Law Enforcement	1
VA Top Management	5
TOTAL	**39**

The following are examples of the fraudulent activities that were involved and the laboratory work that was completed:

- The Board of Veterans Appeals (BVA) requested forensic document laboratory examinations related to a veteran's military records to determine if they had been altered. In addition, the veteran may have committed perjury at a VA hearing about his military records. The laboratory examinations determined that a different type font design had been used to alter information contained in the military records.

- BVA also requested laboratory examinations of another veteran's medical records. The examinations determined that parts of the medical records had been altered with additional typed entries, with the same typewriter used to produce several fraudulent medical records.

- Four requests were received from the VARO Manila, Philippines, for handwriting, fingerprint, paper, ink, photocopy, and typewriter laboratory examinations for four different cases to determine the eligibility of veterans or their widows. The documents consisted of military service and medical records, and fingerprint cards. Laboratory examinations of documents in two cases determined that the questioned documents were fraudulent. Fingerprint examinations determined that an individual attempted to fraudulently obtain the benefits of a widow who received VA benefits.

- Our Office of Investigations received information that an individual had assumed the identity of a veteran, and that the individual was receiving the veteran's benefits. Fingerprint examinations determined that the individual receiving VA benefits was the true veteran.

REVIEW AND IMPACT OF LEGISLATION AND REGULATIONS

The OIG reviews existing and proposed legislation and regulations relating to Department programs and operations. The OIG makes appropriate comments and 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, 68 legislative and 53 regulatory proposals were reviewed and commented on, as appropriate.

Acquisition Reform and Its Impact on Our FSS Reviews

Approved legislation can and does affect OIG operations. Two Public Laws on federal procurement reform could have denied us postaward access to contractors' records - the Federal Acquisition Streamlining Act of 1994 (FASA), P.L. 103-355, and the Federal Acquisition Reform Act of 1996, now known as the Clinger-Cohen Act of 1996. In response to FASA and the Clinger-Cohen Act, the General Services Administration (GSA) issued an interim rule in February 1996 on the acquisition of commercial items, and a final rule on August 21, 1997.

The final rule addresses the commercial item acquisition provisions of FASA and the Clinger-Cohen Act through reform of GSA's Multiple Award Schedule (MAS) program. The final rule retains the most favored customer MFC pricing objective and gives VA the flexibility to continue doing postaward

audits of FSS contracts. The provisions in the final rule that resulted in the continuation of the MFC pricing objective and provided the flexibility to modify the Examination of Records clause to allow for postaward audit access to a contractor's records represented a major victory for VA's FSS contracting program. The Department of Justice, VA officials, and the GSA Inspector General successfully argued for the retention of the MFC pricing objective and postaward audit rights to protect the Government and ultimately the taxpayer from paying inflated prices due to inaccurate or fraudulent pricing disclosures on its contracts. Since October 1993, monetary recoveries associated with postaward reviews of FSS contracts have amounted to about $85 million.

HAMMER AWARD RECIPIENT

On July 31, 1997, the VA Procurement Working Group received a Hammer Award from the Vice President. The VA Procurement Working Group, which is led by the Office of Inspector General, was developed and implemented to provide the Department with a new and fully coordinated approach to requesting and reviewing contracts and contracting practices, and recovering contractor overcharges. In addition to the Office of Inspector General, the Procurement Working Group consists of representatives from the Office of Acquisition and Materiel Management and the Office of General Counsel.

As a result of this creative and unified approach, there has been enhanced customer satisfaction, improved quality and timeliness of audit results, a dramatic increase in companies voluntarily disclosing to VA that they have overcharged the Government and offering a refund, and a dramatic increase of dollar recoveries to VA. In the 3 years since the establishment of the Procurement Working Group, dollar recoveries for the Department exceeded $74 million.

The Procurement Working Group demonstrates that when employees from different parts of the VA organization work together, as one-VA and toward a common goal, both veterans and taxpayers benefit. In addition, the Government receives fair and reasonable prices for goods and services, which means additional dollars to treat more veterans.

OIG MANAGEMENT PRESENTATIONS

Presentation at "Transparency in Government" Conference in Argentina

Our Assistant Inspector General for Healthcare Inspections, sponsored by the Department of State, gave a presentation and provided consultations to officials in Argentina concerned with establishing effective administrative procedures to combat corruption. In his presentation 'Vigilance of Public Health Care Systems,' in Buenos Aires, he discussed VA's health care system and the various methods of providing the necessary external scrutiny, including the essential role of the IG, to more evidently assure that public funds are used in an economical, efficient and effective manner. He also met with many individuals and groups, as convened by the American Embassy and the World Bank, on investigative, audit and inspection mechanisms designed to identify and eliminate fraud and abuse in public health care systems.

Presentation at Midwestern Intergovernmental Audit Forum

VA OIG staff participated in a Midwestern Intergovernmental Audit Forum held in Milwaukee, Wisconsin in May 1997. The Assistant Inspector General for Auditing was a featured speaker, and provided a presentation on performance auditing in the Federal environment.

Presentation at Association of Government Accountants (AGA) Conferences

The Deputy Assistant Inspector General for Auditing and the Director, Financial Statement Audit Division gave a presentation on "Innovative Auditing on VA's Financial Statement Audits" at the June 1997 AGA Professional Development Conference. The presentation discussed a number of computerized audit techniques that VA OIG developed and uses in conducting its program and financial statement audits. These include extensive use of Computer Assisted Audit Techniques (CAATS) and remote computer access that enable the OIG to (i) better serve audit clients in today's environment of increasingly complex, computerized operations, (ii) conduct audits more efficiently in today's environment of austere budgets and continuing downsizing, and (iii) identify significant internal control weaknesses and erroneous transactions.

The Director of our Kansas City Operations Division conducted a seminar on "Cooperation and Conflict with the Audit Client," at the AGA Midwestern Region Financial Management workshop in April 1997. A similar seminar was provided at the AGA Professional Development Conference held in Topeka, Kansas in May 1997.

Presentation at Information Security Conference

VA OIG staff participated in the Information Security Officers' Conference held in Nashville, TN in August 1997, with a presentation by one of our Office of Audit project managers on the VA OIG's overview and perspective concerning information security.

Participation in Financial Statement Audit Task Force

During this reporting period, OIG Financial Statement Audit (FSA) staff continued its participation in the "Governmentwide Financial Statement Audit Task Force" subgroup on credit reform accounting and auditing issues. The subgroup consists of GAO, OMB, CFO and OIG participants, with the focus on key accounting and auditing issues facing the audit of the FY 1997 Government-wide financial statements. FSA staff also continued their participation in the Federal Audit Executive Council financial statement audits subgroup and in the President's Council on Integrity and Efficiency financial statement audit manual task force. Both working groups are important in sharing information on areas of common interest, with the objective of improving the Federal financial statement audit process.

Presentation at FSS Industry Conference

OIG Contract Review staff participated in the VA National Acquisition Center's (NAC) Industry Conference in April 1997 by giving a presentation related to preaward reviews. The conference was attended by representatives of the NAC, DOD, pharmaceutical manufacturers, and medical/surgical suppliers.

Participation in FSS Pharmaceutical Pre-proposal Conference

OIG Contract Review staff participated in the May 1997 Pre-proposal Conference attended by pharmaceutical industry representatives. The OIG staff were part of a VA panel that responded to questions from industry during the conference.

Presentation of FSS Preaward Review Training

OIG Contract Review staff developed and conducted a 3-day training session in May 1997 on FSS preaward reviews, which was attended by NAC contracting officers and OIG auditors.

Federal Audit Executive Council

During the year, our Assistant Inspector General for Auditing was elected Vice-Chairperson of the Federal Audit Executive Council (FAEC). The purpose of the FAEC is to discuss and coordinate on issues affecting the Federal audit community in general, and, in particular, matters affecting audit policy and operations of common interest to FAEC members.

OIG CONGRESSIONAL TESTIMONY

In April 1997, the Deputy Inspector General testified before the House Veterans' Affairs Oversight and Investigations Subcommittee at a hearing on sexual harassment allegations against senior VA managers. The testimony addressed hotline inquiries received by the OIG over the past five years. In July 1997, the Deputy Inspector General again testified before the Subcommittee at a follow-up hearing on sexual harassment in VA. The testimony addressed OIG involvement in corrective initiatives addressing the issue of sexual harassment in the VA workplace.

In May 1997, the Deputy Inspector General testified before the Senate Committee on Veterans' Affairs at a hearing on VA's policies and practices protecting VA employees from sexual harassment and the implementation of those policies. The testimony addressed the history and results of OIG investigations into cases of suspected sexual harassment by VA employees.

FREEDOM OF INFORMATION/PRIVACY ACT/OTHER DISCLOSURE ACTIVITIES

During this reporting period, we processed 121 requests under the Freedom of Information and Privacy Acts and released 250 audit, investigative and other OIG reports. In four instances we had no records. We totally denied one request under the appropriate exemptions of the Acts. Information was partially withheld in 88 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.

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, 20 subpoenas were issued in conjunction with various OIG investigations and audits.

III. FOLLOWUP ON OIG REPORTS

OIG ROLE AND RESPONSIBILITY

The OIG is responsible for maintaining the Department's centralized, computerized followup 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 management are resolved as promptly as possible and that corrective actions are implemented as agreed upon by management officials. Disagreements unable to be resolved between OIG and management are decided by the Deputy Secretary, VA's audit followup official.

Management officials are required to provide the OIG with documentation showing the completion of corrective actions, including reporting of collection actions until the amounts due VA are either collected or written off. OIG staff evaluate information submitted by management officials to assess both the adequacy and timeliness of actions and to request periodic updates on an ongoing basis. As of September 30, 1997, the Department had no unresolved internal OIG recommendation and 342 unimplemented internal OIG recommendations.

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 as of September 30, 1997. External contract report recommendations unresolved for over 6 months are included in Appendix C.

Following on the next pages 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.

SUMMARY OF UNRESOLVED AND RESOLVED OIG AUDITS

As required by the IG Act Amendments, Tables 1 through 5 below provide statistical summaries of unresolved and resolved audit reports for the period April 1, 1997 - September 30, 1997. The dollar figures used throughout this report are based on the definitions included in the IG Act Amendments of 1988. The figures are current as of September 30, 1997, and 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 audit reports and the length of time they have been unresolved.

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	21
	Contract Audit	21	
Less Than 6 Months	Internal Audit	0	33
	Contract Audit	33	
TOTAL			**54**

Tables 2 through 5 show a total of 45 reports that were unresolved as of September 30, 1997 - no internal audit reports and 45 contract (postaward and preaward) audit reports. This number differs from the 54 reports shown above because the tables include only reports with monetary benefits as required by the IG Act Amendments.

Tables 2 through 5 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 POSTAWARD CONTRACT AUDIT REPORTS

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

RESOLUTION STATUS OF POSTAWARD CONTRACT AUDIT REPORTS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 3/31/97	4	$ 6.0
Issued during reporting period	6	$ 26.8
Total Inventory This Period	**10**	**$ 32.8**
Management decision during reporting period		
Disallowed costs	6	$ 26.2
Allowed costs	1	$ 2.1
Total Management Decisions This Period	**7[1]**	**$ 28.3**
Total Carried Over to Next Period	**3[2]**	**$ 4.5**

[1] Of the 7 reports resolved, the contracting officers agreed with the recommended disallowed costs for 6 reports.

[2] Of the 3 reports carried over, 1 was unresolved for over 6 months as of 9/30/97, with a dollar value of $1.3 million.

Definitions:

Questioned Costs are 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. 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 INTERNAL AUDIT REPORTS WITH QUESTIONED COSTS

Table 3 summarizes internal audit reports, the dollar value of questioned costs, and the costs disallowed and allowed.

RESOLUTION STATUS OF INTERNAL AUDIT REPORTS	**NUMBER OF REPORTS**	**QUESTIONED COSTS (In Millions)**
No management decision by 3/31/97	0	$ 0
Issued during reporting period	3	$ 1.2
Total Inventory This Period	**3**	**$ 1.2**
Management decisions during reporting period		
Disallowed costs	3	$ 1.2
Allowed costs	0	$ 0
Total Management Decisions This Period	**3**	**$ 1.2**
Total Carried Over to Next Period	**0**	**0**

Definitions:

• **Questioned Costs for Internal Audit Reports** are amounts paid by VA and unbilled amounts for which the OIG recommends VA pursue collection, including Government property, services or benefits provided to ineligible recipients; recommended collections of money inadvertently or erroneously paid out; and recommended collections or offsets for overcharges or ineligible costs claimed.

• **Disallowed Costs** are costs that management officials have determined should not be charged to the Government 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 management officials have determined that VA will not pursue recovery of funds.

TABLE 4 - RESOLUTION STATUS OF INTERNAL AUDIT REPORTS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

Table 4 summarizes internal audit reports with Recommended Funds to be Put to Better Use.

RESOLUTION STATUS OF INTERNAL AUDIT REPORTS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 3/31/97	0	$ 0
Issued during reporting period	5	$ 49.4
Total Inventory This Period	**5**	**$ 49.4**
Management decisions during reporting period		
Agreed to by management	5	$ 49.4
Not agreed to by management	0	$ 0
Total Management Decisions This Period	**5**	**$ 49.4**
Total Carried Over to Next Period	0	$ 0

Definitions:

- **Recommended Better Use of Funds Associated with Internal Audit Reports** represents a quantification of funds that could be used more efficiently if management took actions to complete OIG recommendations pertaining to deobligation of funds, costs not incurred by implementing recommended improvements, and other savings specifically identified in audit reports.

- **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.

- **Dollar Value of Recommendations Not Agreed to by Management** is the amount associated with recommendations that management decided will not be implemented.

TABLE 5 - RESOLUTION STATUS OF PREAWARD CONTRACT AUDIT REPORTS WITH RECOMMENDED FUNDS TO BE PUT TO BETTER USE BY MANAGEMENT

Table 5 summarizes preaward contract audit 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 OF PREAWARD CONTRACT AUDIT REPORTS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 3/31/97	37[1]	$ 52.3
Issued during reporting period	25	$ 72.8
Total Inventory This Period	**62**	**$125.1**
Management decisions during reporting period		
Agreed to by management	13	$ 8.7
Not agreed to by management	7	$13.6
Total Management Decisions This Period	**20[2]**	**$22.3**
Total Carried Over to Next Period	**42[3]**	**$102.8**

[1] The opening inventory does not match the closing inventory as of 3/31/97. One report was cancelled, resulting in a decrease to the number of reports and the associated dollars.

[2] Of the 20 reports with recommended funds to be put to better use, management fully agreed with the recommended cost reductions for 7 reports, partially agreed with reductions for 6 reports, and did not agree with the cost reductions on 7 reports.

[3] Of the 42 reports carried over, a management decision had not been made for over 6 months on 19 reports with a dollar value of $31.2 million.

Definitions:

- **Recommended Better Use of Funds Associated with Preaward Reviews** of contracts is the sum of the questioned and unsupported costs identified in preaward contract audit reports 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** is 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 of questioned and/or unsupported costs that contracting officers decided to allow.

IV VA AND OIG MISSION, ORGANIZATION AND RESOURCES

VA Establishment

VA was established as an independent agency by Executive Order 5398 on July 21, 1930, in accordance with Public Law 71-536, Activities for War Veterans, Consolidation and Coordination (Act of July 30, 1930). This Act authorized the President to consolidate and coordinate Federal agencies especially created for or concerned with the administration of laws providing benefits to veterans. Under this Act, the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers were consolidated in VA. Effective March 15, 1989, Public Law 100-527 elevated VA to Cabinet-level status as the Department of Veterans Affairs.

VA Resources

The Department's budget authority for FY 1997 was $40.8 billion. Full-time equivalent (FTE) employment for the year was 211,507. VA operates medical facilities or regional offices in every State, the District of Columbia, Puerto Rico, Guam, and the Philippines.

VA Mission and Organization

VA's mission is to serve America's veterans and their families as their principal advocate in ensuring that they receive the care, support, and recognition they have earned in service to the Nation. The Department includes 3 administrations that provide for the delivery of services and benefits; 5 assistant secretaries and 13 deputy assistant secretaries who advise and support the Secretary and the administrations; and 6 Department staff offices that provide specific assistance to the Secretary. Highlights of the services and benefits provided by the 3 administrations follow.

VETERANS BENEFITS ADMINISTRATION (VBA)

To provide benefits, VBA maintains 58 regional offices and 2 insurance centers.

Compensation for service-connected disabilities and death

2.6 million veterans and survivors receive continuing benefits valued at about $16.3 billion.

Pensions for income maintenance of veterans and survivors

.7 million veterans and survivors receive continuing benefits valued at about $3.2 billion.

Education and training assistance

Approximately 485,000 trainees receive education and training assistance payments valued at about $1.4 billion.

Housing and other credit assistance

In FY 1997, VA granted an estimated 260,000 home loans valued at an estimated $26.1 billion.

Veterans' and servicemens' life insurance

The 5 million policies in force in VA life insurance programs have a total face value of about $560.4 billion.

VETERANS HEALTH ADMINISTRATION (VHA)

To provide medical care, VHA maintains 173 hospitals, 473 outpatient clinics (includes independent, satellite, community-based, and rural outreach clinics), 40 domiciliaries, and 131 nursing home units.

Hospitals, medical, dental, and outpatient care

The preliminary FY 1997 data on average daily census for inpatient VA and non-VA-provided care was 66,357. The locations of the patients are shown in the table.

LOCATIONS	PATIENTS
VA Hospitals	23,571
VA Nursing Home Care Units and Domiciliaries	18,750
Non-VA Facilities	24,036
TOTAL	**66,357**

An estimated 31 million outpatient visits were provided in FY 1997.

Medical and prosthetic research

The research appropriation for FY 1997 was $262 million.

NATIONAL CEMETERY SYSTEM (NCS)

To provide interment services, the NCS operates 115 cemeteries and 34 other miscellaneous sites.

There were an estimated 73,200 interments in national cemeteries in FY 1997 and an estimated 326,000 headstones or markers were provided.

VA OIG Establishment

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 of 1978 (P.L. 95-452) was enacted and established a statutory Inspector General (IG) in VA.

Role and Authority

The Inspector General Act of 1978 states that the IG is responsible for: (1) conducting and supervising audits and investigations, (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect fraud and abuse in, the programs and operations of the Department, and (3) keeping the Secretary and the Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action.

The Inspector General Act Amendments of 1988 were enacted in October 1988. The major effect of these amendments was to provide the OIG with a separate appropriation account and a revised and expanded procedure for reporting semiannual workload to Congress.

The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. The inquiries may be in the form of audits, investigations, contract reviews, inspections, or other appropriate actions. The responsibility for program integrity rests with VA administration heads and staff offices.

Funding

Fiscal Year 1997 funding for OIG operations was $32.5 million, with $30.9 million from appropriations and $1.6 million through reimbursable agreements. Approximately 82 percent of the total funding was for personnel salaries and benefits, 5 percent for travel, and 13 percent for all other operating expenses such as contractual services, rents, supplies, and equipment.

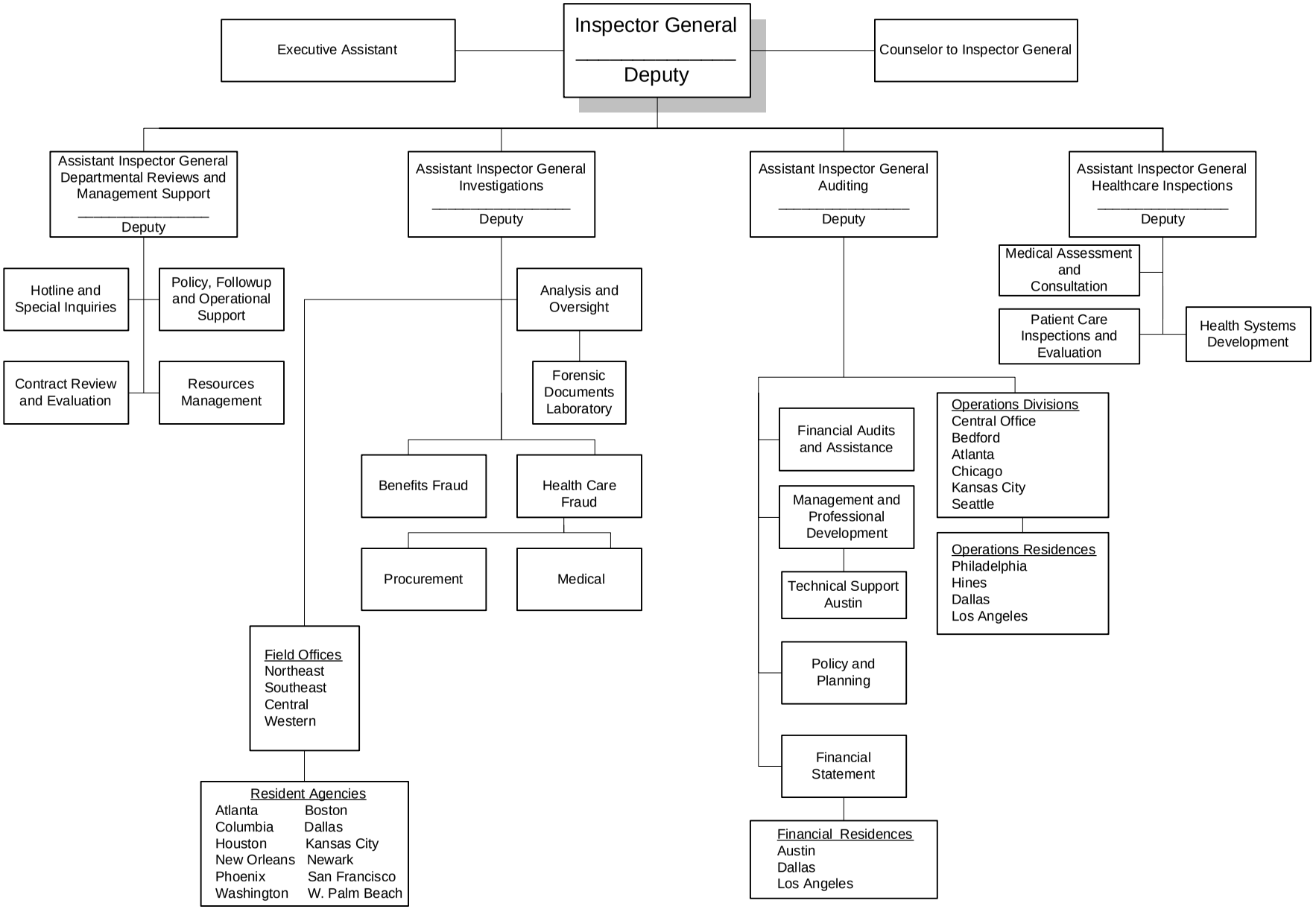
Staffing

The OIG average employment level for FY 1997 was 339. Employees on board as of September 30, 1997, were distributed as follows:

OFFICE	**PERSONS EMPLOYED**
Inspector General's Office	2
Office of Counselor to IG	4
Office of Investigations	70
Office of Audit	177
Office of Departmental Reviews and Management Support	57
Office of Healthcare Inspections	19
TOTAL	**329**

The OIG organization chart is presented on the next page.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL



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
INTERNAL AUDITS				
7AFG10073 4/4/97	Management Letter – Fiscal Year 1996 Selected Accounting Operations and Systems at Austin Finance Center			
7R1G10072 4/11/97	Management Letter – Fiscal Year 1996 Financial Statements – VA Life Insurance Programs			
7R5B13074 5/1/97	Audit of Appointment and Supervision of Fiduciaries			
7AFG10080 5/9/97	Management Letter – Tests of Selected Veterans Benefits Programs Accounting Functions Performed at VA Central Office			
7AFG10084 5/12/97	Review of Electronic Data Processing Controls in the Financial Management System Accounts Receivable and Fixed Asset Subsystems			
7AFG10085 5/12/97	Management Letter – Management Oversight of Property, Plant, and Equipment Financial Information			
7AFG10086 5/12/97	Management Letter – Accuracy of Non-Expendable Equipment Financial			
7AFG10087 5/12/97	Management Letter – Accuracy of Real Property Financial Information			
7D2G07062 5/13/97	Audit of Security Controls at the Hines Benefits Delivery Center			
7R3A05099 6/20/97	Audit of Internal Controls Over the Fee-Basis Program	$1,800,000	*	

* Management estimate will be provided after completion of planned actions, anticipated by October 1998.

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
7AFG10102 6/20/97	Management Letter - Tests of Selected VA Housing Credit Assistance Accounting Functions Performed at VA Central Office			
7R5B13129 9/15/97	Completeness of Data in the Veterans Benefits Administration's Fiduciary Beneficiary System			
7R3A01140 9/30/97	Audit of the Pathology and Laboratory Medicine Service (PLMS) Mobile Laboratory Initiative	$5,202,562	$5,202,562	
SPECIAL INQUIRY				
7PRB08076 5/7/97	Possible Violation of Criminal Statutes, Federal Acquisition Regulations, and Ethical Conduct Standards			
7PRF03095 6/19/97	Alleged Mismanagement in the Health Services Research and Development Field Program and the Compensation and Pension Unit at the VA Puget Sound Health Care System Seattle, WA			$3,669
7PRA99100 6/24/97	Alleged Improper Personnel Action, VA Medical Center Washington, DC			
7PRB18103 7/2/97	Alleged Misconduct and Personnel Irregularities, VA Regional Office Baltimore, MD			
7PRA19104 7/2/97	Alleged Mismanagement of Resources, Improper Personnel Practices, and Misconduct, VA Medical Center Tuscaloosa, AL			
7PRA11106 7/3/97	Alleged Personnel Irregularities, VA Medical Center Cleveland, OH			76,382
7PRA19125 9/4/97	Alleged Mismanagement, Misconduct, and Personnel Irregularities, VA Medical Center Bronx, NY			
7PRG03137 9/23/97	Alleged Preferential Treatment by a Veterans Integrated Service Network Official, Kansas City, MO			

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
HEALTHCARE INSPECTIONS				
7HIA28077 4/22/97	Assessment of the Veterans Health Administration's Status in Providing Mammography Examinations			
7HIA28082 5/6/97	Inspection of Alleged Substandard Medical Care, Department of Veterans Affairs Northern California Health Care System, Oakland and Martinez Outpatient Clinics			
7HIA28091 5/19/97	Inspection of Alleged Refusal to Operate on a Woman Veteran Department of Veterans Affairs Medical Center Philadelphia, PA			
7HIA28101 6/19/97	Inspection of Alleged Poor Quality of Care and Disregard of Patient's Advance Directive for Life-Saving Measures at the Department of Veterans Affairs Puget Sound Health Care System Seattle, WA			
7HIA28108 7/8/97	The Impact of Downsizing Inpatient Substance Abuse Rehabilitation Programs on Homeless Veterans and Other Frequent Users			
7HIF03111 8/11/97	Quality Performance Assistance Review, Department of Veterans Affairs Medical Center Manchester, NH			
7HIA28115 8/14/97	Oversight Review of the Veterans Health Administration's External Peer Review Program			
7HIA28122 8/28/97	Inspection of Alleged Misrepresentation of Medical Credentials at a Department of Veterans Affairs Medical Center			
7HIA07139 9/17/97	Inspection of Alleged Inadequate Care, and Nursing Incompetence on the Nursing Home Care Unit, VAMC Bronx, NY			
7HIA28144 9/25/97	Inspection of Selected Clinical Aspects of the Spinal Cord Injury Unit at the Department of Veterans Affairs Medical Center Hampton, VA			

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS				
7PEE02075 4/23/97	Review of Glaxo Wellcome Inc.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797p-5783m		*	$132,109
7PEE09078 4/30/97	Audit of Equitable Adjustment Claim Submitted by Joint Venture/Gardner Machinery Corporation & R. W. Martin & Sons, Inc, Contract No. V797p-6500a, Order No. 93-MC-64189	$56,158		
7PEE12081 5/6/97	Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Healthcare Systems, Inc., Codman Division, Piscataway, NJ	1,755,575		
7PEE02083 5/8/97	Postaward Review of Federal Supply Schedule Contract V797p-3142k Awarded to 3M Health Care (Medical/Surgical Products) St. Paul, MN			
7PEE12088 5/20/97	Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Health Care Systems, Inc. Ethicon Inc., Piscataway, NJ	4,570,800		
7PEE02090 5/27/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q53-97) Bristol-Myers Squibb Company, ConvaTec, Princeton, NJ			
7PEE02092 6/6/97	Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Healthcare Systems, Inc., Ethicon Endo Surgery, Inc., Piscataway, NJ			
7PEE13097 6/12/97	Federal Supply Schedule (FSS) Contract V797p-5266n, Awarded to Idexx Laboratories, Inc., Westbrook, ME			497,089
7PEE02093 6/13/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q53-97) Ecolab Inc., St. Paul, MN	964,241		
7PEE02094 7/11/97	Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Health Care Systems Inc., Johnson and Johnson Medical Inc., Piscataway, NJ	10,806,808		

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

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
7PEE12107 7/24/97	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92) Johnson and Johnson Healthcare Systems Inc., Cordis Corporation and J&J Interventional Systems, Piscataway, NJ	$5,918,605		
7PEE02126 8/7/97	Settlement Agreement – Postaward Review of Olympus America, Inc., FSS Contract No. V797p-3278j			$22,800,000
7PEE02109 8/19/97	Review of Pharmacia & Upjohn's Voluntary Disclosure of Pricing Violations Under Federal Supply Schedule Contract Numbers V797p-5640m, V797p-5566m, V797p-5562m, and V797p-3702j			2,500,000
7PEE02116 8/21/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Pfizer Incorporated, U.S. Pharmaceuticals Group, New York, NY			
7PEE02123 9/3/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Pharmacia & Upjohn, Kalamazoo, MI	1,919,827		
7PEE02119 9/4/97	Review of Sunrise Medical HHG Inc.'s (Formerly Known as Guardian Products, Inc.) Voluntary Disclosure of Pricing Violations Under Federal Supply Schedule Contract Numbers V797p-3485j, V797p-3567j, and V797p-3122k			656,316
7PEE02127 9/4/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Wyeth – Ayerst Laboratories, Philadelphia, PA	5,484,450		
7PEE02120 9/5/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Sanofi Pharmaceuticals, Incorporated, New York, NY			
7PEE02121 9/8/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Astra Merck Inc., Wayne, PA			
7PEE02124 9/8/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Amgen, Inc., Thousand Oaks, CA	91,550		

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
7PEE02132 9/16/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Dupont Merck Pharmaceutical Co., Wilmington, DE	$733,529		
7PEE02134 9/17/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Schein Pharmaceutical Inc., Florham Park, NJ	3,800,590		
7PEE02136 9/17/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Rhone-Poulenc Rorer, Inc., Collegeville, PA	2,791,444		
7PEE02128 9/22/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Merck and Co., Inc., West Point, PA			
7PEE02130 9/23/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Bayer Corporation Pharmaceutical Division, West Haven, CT	3,580,134		
7PEE02143 9/23/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Bayer Corporation Biological Products, West Haven, CT	15,170		
7PEE02138 9/24/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Janssen Pharmaceutical Inc., Piscataway, NJ	522,415		
7PEE02141 9/24/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Roche Laboratories, Inc., Nutley, NJ	69,091		
7PEE02142 9/24/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Parke-Davis Division of Warner-Lambert Co., Morris Plains, NJ	8,624,775		
7PEE02147 9/30/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) G. D. Searle and Co., Managed Care Contracts, Chicago, IL	2,525,457		
7PEE02148 9/30/97	Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Tap Pharmaceuticals, Deerfield, IL			
7PEE02149 9/30/97	Settlement Agreement – Review of Amgen Inc. Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797p-5077n			$195,654

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
OTHER REVIEWS				
7AFG01035 4/24/97	Duplicate Payments			$1,082,070
7R1B01089 5/15/97	Review of Veterans Benefits Administration's Procedures to Prevent Dual Compensation	$29,062,950	$29,062,950	
7R8G07067 5/16/97	Review of VA Use of Personal Identification Number Telephone Access Systems	10,100,000	*	
7R1G10079 5/16/97	Advisory – Adequacy of Procedures Used to Transfer Life Insurance Policy Data from VAROIC St. Paul, MN to VAROIC Philadelphia, PA			
7R1G01096 6/10/97	Review of Means Testing and Income Verification Procedures	3,276,498	3,276,498	
7R8A16098 7/15/97	Use of General Post Funds to Purchase Day Room Furniture, VA Medical Center West Los Angeles, CA			
7R1A02114 8/6/97	Review of Compensation and Pension Medical Examination Services			
7R5G07112 8/11/97	Evaluation of Efforts to Integrate Commercially-Developed Software to Hospital Information Systems			
7ANA14113 8/13/97	Review of Selected Aspects of the Compensated Work Therapy Program, VA Medical Center West Los Angeles, CA			
TOTAL:	**72 Reports**	****$103,672,629**	**$37,542,010**	**$27,943,289**

* Management did not provide an alternative estimate.

** The difference between the OIG and Management estimates is $66,130,619. The difference is explained as follows: Pending receipt of contracting officer's decision - $54,230,619; Management did not provide an alternative estimate - $10,100,000; Management estimate will be provided after completion of planned actions - $1,800,000.

APPENDIX B

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

Report Number/ Issue Date	Report Title	Questioned Costs	Unsupported Costs
7PEN03113 4/23/97	Proposal, Project 532-112, New Ramps to Bldgs. 5 & 7, VAMC Canandaigua, Strock Paving and Construction, Inc., Depew, NY	$15,323	
7PEN02001 4/25/97	Claim, Contract V101AC-0105, 180 Bed Psychiatric Bldg., VAMC Lyons, Terminal Construction Corp., Wood-Ridge, NJ		
6PEN03125 4/29/97	Proposal, RFP No. 574-66-96 Replace Tel. System, VAMC Grand Island, Innovative Systems Incorporated, Kansas City, KS		
7PEN03003 5/2/97	Proposal, RFP 614-51-96 Radiologists, VAMC Memphis, University of Tennessee, Memphis, TN	6,167	$541,483
7PEN03007 5/2/97	Proposal, RFP 648-60-95 Liver Transplant Serv., VAMC Portland, Oregon Health Sciences University, Portland, OR	24,798	10,705
7PEN03111 5/2/97	Proposal, Solicitation 640-87-96 Fire Sprinkler System, VAMC Palo, Alto A & D Fire Protection, Inc., Santee, CA		
7PEN03002 5/5/97	Proposal, RFP 614-41-96 Anesthesiologists, VAMC Memphis, University of Tennessee, Memphis, TN		906,586
6PEN02001 5/19/97	Claim, Project No. 690-035 Construction Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla, NY	724,755	
7PEN02303 5/20/97	Proposal, Project No. 549-085 Clinical Addition, VAMC Dallas, Centex Construction Company, Inc., Dallas, TX	14,804,392	
7PEC99057 6/2/97	A-128, Fiscal Year Ended 9/30/93, Cemetery Grant Government Of Guam, Agana, GU		
7PEN03114 9/30/97	Claim, Contract V101DC-0048 Expand/Renovate Bldg-1, VAMC Salt Lake, Interwest Construction, Salt Lake City, UT	1,469,934	
TOTALS:	**11 Reports**	**$17,045,369**	**$1,458,774**

The Defense Contract Audit Agency (DCAA) completed 7 of the 11 reports issued, with Questioned Costs totaling $17 million. This data is also reported in the DoD OIG's Semiannual Report to Congress.

APPENDIX C

EXTERNAL CONTRACT AUDIT REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS AS OF SEPTEMBER 30, 1997

Report Title, Number, and Issue Date	Questioned Costs	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Postaward FSS Contract No. V797P-3113J, Medical Equipment, Audit 9/30/90-11/30/92, Invacare Corporation, Elyria, OH; 2PE-E10-072; 10/1/93		$ 1,333,917	Pending OIG action; resolution planned for next reporting period.
Proposal, RFP 561-17-96; Radiology Service, VAMC East Orange, NJ, University of Medicine & Dentistry, Newark, NJ; 7PE-N03-001; 2/11/97	174,822		Negotiation not finalized; resolution planned for next reporting period.
OFFICE OF FACILITIES MANAGEMENT			
Change Order, Contract No. V101BC-0026, 120-Bed Nursing Home Care Unit, VAMC New Orleans, Broadmoor/Boh, A Joint Venture, New Orleans, LA; 2PE-N02-104; 10/28/92	856,257	32,664	Negotiation not finalized; resolution planned for next reporting period.
Change OR/FR 10 Contract No. V101BC0053 VAMC Atlanta, GA Caddell Construction, Masterclean, Incorporated, Decatur, GA 3PE-N02-111; 11/16/93	126,130		Negotiation not finalized; resolution planned for next reporting period.
Claim, Contract No. V200C-003, Renovate Space, VAAC Austin, O'Neal Construction, Inc., Austin, TX; 4PE-D99-035; 2/17/94	95,235		Pending receipt of CORR documenting disposition of questioned costs.
Claim, Contract No. V101BC0026, 120 Bed Nursing HCU/Parking, VAMC New Orleans Broadmoor/BOH, Metairie, LA; 4PE-N02-102; 8/9/94	727,576		Negotiations not finalized; resolution planned for next reporting period.
Claim, Contract No. V101BC0006, Clinical Addition/Fire & Safety, VAMC Durham, Blount, Inc., Montgomery, AL; 4PE-N02-104; 10/05/94	1,142,352		Negotiations not finalized; resolution planned for next reporting period.
Adjustment Claim, V101C-1606, Construction Services, VAMC Albany, Bhandari Constructors, Inc., Syracuse, NY; 5PE-N02-007; 3/31/95	$ 271,599		Negotiations not finalized; contractor is to submit additional support documentation; no planned resolution date available.

Report Title, Number, and Issue Date	Questioned Costs	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF FACILITIES MANAGEMENT			
Claim, Contract No. V101C-1651, Environment Improvements, VAMC North Chicago, Blount Inc., 4PE-N02-202; 2/7/96	7,370,861		In discussion on monetary resolution; planned resolution date not available.
Claim, Contract V101C-1532, Asbestos Removal, VAMC W. Roxbury, Saturn Construction Co. Inc., Valhalla, NY; 5PE-N02-006; 2/23/96	875,708	$ 1,898	Negotiation not finalized; resolution planned for next reporting period.
Claim, Project No. 632-062, 120 Bed Nursing Home Care Unit, VAMC Northport, J.F. O'Healy Construction Corporation, Bayport, NY 3PE-N02-001; 3/26/96	$ 1,623,126		Negotiation not finalized; resolution planned for next reporting period.
Claim, Project No. 642-034C, Clinical Addition/Parking Structure, VAMC Philadelphia Charles Shaid Company of Pennsylvania, Inc., Clarksboro, NJ; 5PE-N02-002; 8/26/96	512,961		Pending receipt of CORR documenting disposition of questioned costs.
Claim, Project No. 553-808, Replacement Hospital VAMC Detroit, MI; Bateson/Dailey, Dallas TX; 6PE-N02-204; 12/11/96	11,952,726		Claim under review; no planned resolution date available.
Claim, Contract No. V101C-1603, Install Sprinklers, VAMC Boston, L. Addison & Associates, Inc., Wakefield, MA 6PE-N02-108; 12/19/96	1,120,170		Negotiation not finalized; resolution planned for next reporting period.
Claim, Contract V101BC0036; Defect. Drawings, VAMC Palm Beach County, FL, Clark Construction Group, Inc., Hollywood, FL 6PE-N02-106; 11/06/96	3,363,356		Negotiation not finalized; resolution planned for next reporting period.
OFFICE OF THE GENERAL COUNSEL			
Claim, Contract No. V539C-591, Install Incinerator, VAMC Cincinnati, R.E. Schweitzer Construction, Cincinnati, OH 4PE-N03-113; 6/21/94	131,932		Contract in litigation; resolution planned for next reporting period.
Claim, Equit A/J Contract No. V657C-1110, Install Energy Management System, VAMC St. Louis, Landis & GYR Powers, Inc., Maryland Heights, MD; 4PE-N03-117; 9/30/94	57,947		Contract in litigation; resolution planned for next reporting period.

Report Title, Number, and Issue Date	Questioned Costs	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF THE GENERAL COUNSEL			
Equitable Adjustment Claim Submitted by Valley Forge Flag Company, Inc., Contract No. 797DA309553, Womelsdorf, PA 6PE-E09-061; 7/24/96	$ 556,333		Claim in litigation; resolution expected during next reporting period.
Claim, Contract No. V657C-1103; Replace HVAC, VAMC St. Louis, Gross Mechanical Contractors, Inc., St. Louis, MO; 6PE-N03-119; 10/24/96	90,437		Claim in litigation; resolution planned for next reporting period.
VETERANS HEALTH ADMINISTRATION			
A-128, Fiscal Year Ended 6/30/95, State Home Construction Grant(s), Domiciliary & Nursing Home Care, Formula Grants, State Approving Agency Contract, State of Wisconsin, Madison, WI; 6PE-G06-059; 7/24/96	72,052		Negotiations not finalized; planned completion date could not be provided.

APPENDIX D

REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

The table below cross-references the reporting requirements 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), to the specific pages where they are addressed.

IG Act References	Reporting Requirement	Page
Section 4 (a) (2)	Review of legislation and regulations	2-5
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-1 to 1-31
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-1 to 1-31
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	3-1
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	v
Section 5 (a) (5)	Summary of instances where information was refused	2-8
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	A-1 to B-1
Section 5 (a) (7)	Summary of each particularly significant report	i to iv
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	3-3 and 3-4
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	3-5 and 3-6
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	C-1 to C-3
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

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