Office of Inspector General

Semiannual Report to Congress

October 1, 1997 – March 31, 1998

FOREWORD

It is my pleasure to submit the semiannual report on the activities of the Office of Inspector General (OIG) for the period ended March 31, 1998. 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 $334.4 million of actual and potential monetary benefits and resulted in 57 convictions and 135 administrative actions during the reporting period. OIG oversight of VA's major program areas resulted in systemic improvements and increased efficiencies in the areas of procurement, medical care, benefits, facilities management, and financial management. A particularly noteworthy accomplishment was the completion of 31 preaward reviews of Federal Supply Schedule contract proposals from vendors of health care items. These reviews, designed to assist VA contracting officers in negotiating the best possible prices, made recommendations that may save VA $216 million.

The OIG continues to strive to provide the best possible coverage of VA programs and activities within available resources. However, the decline in appropriated dollars over the past several years 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, which I believe was established as the minimum staffing level needed to provide an acceptable level of oversight over the second largest Department in the Federal government. Continued funding below the statutory floor, combined with the ever growing requirement to perform mandated work, creates oversight vulnerabilities for the Congress and VA.

For the VA to be considered a world class organization, it must have the independent, synergistic support of a properly staffed OIG. While I recognize that the competition for available dollars is strong, I see an increase in OIG resources as an investment in VA and the veterans we serve. For example, during the past five years the OIG provided a ten-to-one return on investment ratio. Over the past three years the OIG recovered its budget in actual dollar returns.

I look forward to working with the Secretary and the Congress in improving service to our nation's veterans.

(Original signed by)

RICHARD J. GRIFFIN
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 March 31, 1998. During this reporting period, 111 audit, review, and inspection reports were issued and 125 investigations were closed. These initiatives identified actual and potential recoveries of $16.4 million and made operational recommendations which could result in better use of an estimated $318 million. In addition, as a deterrent to fraud, waste, and mismanagement, our investigations and other reviews resulted in 35 indictments, 57 convictions, and 135 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

Reviews of FSS Proposals

We completed 31 preaward reviews of Federal Supply Schedule (FSS) proposals from vendors of healthcare items. We made recommendations to VA contracting officers totaling $216 million. These reviews assist contracting officers in negotiating the best possible prices for FSS users.

Contractor Overcharges

VA will recover over $5.6 million due to our identification of overcharges by FSS companies.

Contract Management

We audited VA's procurement initiatives for computer hardware and software, and the procurement of automated information resources solutions. We found VA addressed the most significant lessons learned from past contracts, however better management will reduce costs by $58 million, in part by enhancing contracting initiatives to meet expectations of the Clinger-Cohen Act. Also, our audit of the pharmaceutical prime vendor program found internal controls were adequate; however, responsibilities needed clarification.

MEDICAL CARE PROGRAMS

CHAMPVA

This requested audit concluded that the Civilian Health and Medical Program of VA was generally well-managed and controls over this $98 million program were effective. However, reviewing certain claims paid in prior years and pursuing 3rd party liability could increase recoveries by $4.5 million.

Data Validity

We found the Pathology and Laboratory Medicine Service's Workload Reporting System was accurate, but incomplete. A total of 105 million laboratory tests were reported accurately, but 7 million tests were not reported because some VA facilities did not report or reported sporadically. We made recommendations to improve workload reporting.

Program Reviews

We conducted three health care program reviews: (i) Our assessment of Veterans Health Administration's (VHA's) quality management (QM) process concluded VHA managers have dramatically revised and in many ways strengthened the process, but need to strengthen, coordinate, and consolidate QM programs; (ii) Our review of VHA's expansion of Advance Practice Nurse functions supported VHA's initiative, but we cautioned managers to strengthen credentialing and privileging procedures and quality oversight; and, (iii) Our evaluation of the National Customer Feedback Center concluded patient survey questionnaires accurately capture impressions of their treatment process, but feedback is slow.

Quality Program Assistance

Our Quality Program Assistance reviews at five VA medical centers (VAMCs) found that managers are working to ensure that veterans have access to high quality, low cost health care. Employees generally support the changes, but the rapid pace is negatively affecting employee morale.

Patient Care Inspections

The following reviews concluded, even though no patients were harmed, that managers could improve patient care by correcting certain employees' practices and behaviors: (i) A nurse committed a medication error by administering a drug without a written order and a physician prescribed a medication without apparent justification; (ii) Nursing employees did not consistently record medical information, raising the potential for treatment errors to occur; (iii) Clinical employees improperly discharged a nursing home patient without the spouse-guardian's permission and without providing the family with due process; (iv) Interpersonal conflicts led to employees infringing on patients' privacy in the examining room; and, (v) Managers did not consider an employees' physical capabilities before making assignments that he could not accommodate.

BENEFIT PROGRAMS

Delivery of Benefits and Services

Reviews included: (i) Our summary report on VA claims processing consolidated recommendations to improve the claims processing system made by the VA OIG, Congressional commissions, and several task forces established by VA; (ii) Our evaluation on whether Veterans Benefits Administration (VBA) compensation and pension (C&P) system messages ensured the accuracy of payments found that 44 percent of the messages generated did not serve as an effective control (by better managing the messages, VA could prevent annual payment errors of $33 million); (iii) A follow-up audit to our 1995 report of service-connected disability determinations found that prior audit recommendations were satisfactorily implemented; (iv) Our audit of Social Security Administration/VA death match procedures found that VBA needs to develop and implement a more effective method to identify deceased beneficiaries and timely terminate their C&P benefits, thus reducing expenditures by $4 million; (v) An audit of collection of premium payment and reporting procedures for the Servicemembers' Group Life Insurance program found that reserve component reporting and validation procedures need improvement to ensure the accuracy of $163 million in life insurance premium payments; and, (vi) Our evaluation of safeguards to detect or prevent irregular disbursements of Matured Endowment awards totaling $136 million from life insurance policies, found that increased oversight of high risk disbursements will reduce the potential for fraud.

Program Fraud

The following examples of investigations disclosed instances of fraud relating to loan origination, compensation, education assistance, and dependency payments: (i) An individual was sentenced to 60 months' confinement, restitution of $517,384, and to forfeit holdings of over $2 million. The individual purchased low-cost distressed properties, cycled them through front companies to inflate their assessed value, and then sold them to fraudulently qualified applicants. (ii) An individual was sentenced to 46 months' imprisonment and was ordered to pay restitution of $447,182. The individual posed as a wheelchair-bound veteran who had lost the use of his right arm and right leg, and collected over $500,000 in VA benefits while, in fact, he ran a successful painting business. (iii) The U.S. Attorney's Office is continuing to obtain civil settlements from student veterans who received VA education benefits but did not attend scheduled college classes. Bribes were paid to faculty staff, including a department chairman, to ensure high grades would be given with no class attendance required. To date, 77 students have agreed to pay $1,261,400 in restitution. Negotiations are continuing with additional students. (iv) An individual pleaded guilty to theft of public funds. Our investigation found that, over a 15-year period, the individual cashed his deceased mother's Dependency and Indemnity Compensation checks. Loss to VA totaled more than $100,000.

FACILITIES MANAGEMENT

Lease Management

We reviewed VA leased space with annual costs of $171 million to evaluate the effectiveness of lease administration. We found leases were generally properly administered, but in five cases VA is paying General Services Administration $1.6 million more than the current market value.

Capital Asset Acquisition

An evaluation of VA's capital asset acquisition practices and capital programming process, which involved $1.3 billion in FY 1997, found VA is making good progress towards a capital program. We recommended VA develop a network-level investment policy and that alternative capital funding strategies be explored.

Prior Year Funds

We reviewed VHA management controls over $11.5 million in average annual prior year funds, used to pay for work on nonrecurring maintenance construction projects. We concluded that $3.8 million was used inappropriately and VAMCs needed additional guidance.

Structural Design Problems

The OIG reviewed structural framing problems which became apparent during construction of the new VA regional office (VARO) building at Bay Pines, FL. The review determined the major cause of the structural design problems was due to a private Architect/Engineering (A&E) firm and its engineering subcontractor providing VA with structural plans for the project which contained structural framing design errors. A VA OIG consultant determined the structural framing design, as modified, would safely support VA's standard requirements for a VARO building. The engineering subcontractor to the A&E firm has reimbursed VA $706,000 to date, the cost to correct some of the design errors.

FINANCIAL MANAGEMENT

Debt Collection

In FY 1996, we began a multi-phase evaluation of VA's $4.2 billion debt management program focusing on the identification, prevention, and recovery of overpayments of C&P benefits, and the billing and collection of medical care costs owed by veterans and third party insurers. Overall audit results to date identified monetary benefits totaling over $249 million.

Medical Care Collection Fund

Our review of Medical Care Collection Fund (MCCF) collection and billing practices at one VAMC concluded that collections could be further increased by using collection tools developed by the MCCF program office and obtaining insurance data from veterans.

EMPLOYEE INTEGRITY

Employee Misconduct

The following examples of investigations disclosed drug and other property theft, workers' compensation fraud, and other employee misconduct: (i) Based on our undercover investigation, two registered pharmacists pleaded guilty to numerous offenses. Both individuals admitted reselling more than $200,000 worth of stolen VA pharmaceuticals. (ii) A VAMC pharmacy supervisor was terminated from his employment based on an investigation that revealed he ordered drugs to be sent by mail in the names of inactive VA patients, but had them sent to his home address. (iii) One former and two current VA employees pleaded guilty to the theft of Government property based on a 1-year VA OIG undercover operation. The three employees sold stolen computers, printers, and furniture to VA OIG undercover agents. (iv) A VAMC chief of environmental services and her accomplice each pleaded guilty to one felony count of filing false claims. The service chief approved VA payments in excess of $73,760 for services that were not rendered. (v) An individual who served as an uncompensated VAMC employee pleaded guilty to numerous counts of theft and false statements. The offenses were committed in connection with drug research. As part of the plea agreement, the individual will serve 5 years in prison, pay approximately $175,000 in fines and expenses, and $1.1 million in restitution and forfeitures. (vi) A former VAMC psychologist was indicted concerning a scheme to defraud the Government in connection with the receipt of workers' compensation benefits. We determined that, for more than 13 years, the individual received workers' compensation benefits in excess of $300,000 for a back injury alleged to have occurred while working at the VAMC. During this time, however, he was employed. (vii) A former VAMC nurse was found guilty of one count of making a telephone bomb threat. As a result of several bomb threats, patients were evacuated from the building which housed the intensive care unit. (viii) An individual pleaded guilty to a charge of false statements stemming from the misrepresentation he made concerning the nature of a prior conviction when he applied for a position as a VAMC medical doctor. As a result of a plea agreement, he was sentenced to 42 months' imprisonment and waived his right to appeal.

FOLLOWUP ON OIG REPORTS

Unresolved Reports

As of March 31, 1998, the OIG did not have any unresolved internal audit reports. A total of 39 external contract reports had been unresolved for over 6 months, with funds costs totaling $104 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 10/1/97 - 3/31/98 (Dollars in Millions)
OIG Reviews Completed and Resolution Action	
Reports Issued	111
Settlement Agreements	0
Value of Reports/Agreements	
Questioned Costs	$8.7
Unsupported Costs	$1.1
Recommended Better Use of Funds	$314.2
Total	$324.0
Reports Resolved (issued this and prior periods)	30
Value of Resolved Reports/Agreements	
Disallowed Costs	$10.1
Funds to Be Put to Better Use	$97.3
Total	$107.4
Unresolved Reports	
Over 6 Months as of 3/31/98:	
Internal Audit	0
External Contract	39
Less than 6 Months as of 3/31/98:	
Internal Audit	0
External Contract	42
Total	81
Value of Unresolved Reports:	
Questioned Costs	$5.5
Unsupported Costs	$2.6
Recommended Better Use of Funds	$317.2
Total	$325.3
Investigation Activities	
Investigative Cases	
Opened	113
Closed	125
Pending	332
Impact of Investigations	
Indictments	35
Convictions	57
Probation (in years)	183
Prison Sentences (in years)	61
Fines, Penalties, Restitutions, and Civil Judgments	$7.6
Investigative Recoveries and Savings	$2.8
Administrative Sanctions	103

	Current 6 Months 10/1/97 - 3/31/98
Audit Activities	
Reports Issued	
Internal Audits	11
Other Reviews	7
Total	18
Audit Workload	
Carry-Over Projects Completed	17
Planned Projects Initiated	5
New Projects Received	9
Total	31
Contract Review Activities	
Reports Issued/Settlement Agreements	
Contract Reviews by OIG Staff	
FSS Contracts	35
PL 102-585 Reviews	2
Other	4
Contract Reviews by Other Agencies	24
Total	65
Hotline and Special Inquiry Activities	
Hotline Cases	
Opened	401
Closed	284
Percent of Founded Allegations	21%
Impact of Hotline Activities	
Administrative Sanctions	32
Special Inquiries Completed	
Reports Issued	12
Administrative Closures	13
Total	25
Special Inquiries Workload	
Carry-Over Projects	25
New Projects Received	6
Total	31
Healthcare Inspection Activities	
Projects Completed	
Inspection Reports Issued	16
QA/Patient Care Reviews	10
Clinical Consultations/Technical Support.	82
Total	108
Projects Pending	
QA/Patient Care Reviews	49
MI Case Evaluations	3
Clinical Consultations/Technical Support	18
Total	70

I. SIGNIFICANT OPERATIONAL ACTIVITIES

PROCUREMENT PROGRAMS

1. CONTRACTOR OVERCHARGES

Issue: Completed 31 preaward reviews of Federal Supply Schedule (FSS) proposals with an estimated contract sales value of $3.3 billion

Conclusion: Recommendations to reduce contract costs by $216 million.

Impact: Reviews will assist VA contracting officers in negotiating the best possible prices for FSS users.

We completed 31 preaward reviews of FSS proposals from pharmaceutical, dental and X-ray supplies, and equipment' manufacturers. We made recommendations to VA contracting officers amounting to $216 million in better use of funds compared to the contracts' estimated sales value of $3.3 billion. Better use of funds represent the difference between FSS offered prices compared to prices offered to most favored customers with terms, conditions, and volume similar to the FSS. To assess the reasonableness and validity of our recommended better use of funds, we review the contracting officer's price negotiation memorandum to identify how much cost avoidance the contracting officer achieved by negotiating the best possible contract prices. The success of the preaward review efforts is the result of VA working as a team with auditors and contracting officers training together and sharing goals and objectives, and with auditors, Office of Acquisition and Materiel Management (OA&MM) acquisition resources team, and Office of General Counsel attorneys working together to assist contracting officers in negotiating the best possible prices for FSS users.

Issue: Contractor Overcharges for Pharmaceuticals and Medical Supplies

Conclusion: Reviews of voluntary disclosures and other contract reviews disclosed overcharges.

Impact: VA will recover over $5.6 million from FSS contractors.

As a result of VA team efforts during the period, VA will recover over $5.6 million in contract overcharges on several FSS contracts.

- A pharmaceutical company acknowledged errors in calculating Federal Ceiling Prices (FCPs) under Public Law 102-585. The company made a voluntary disclosure to VA and offered a refund of $2,030,825. We reviewed the refund offer and determined that the overcharges amounted to $2,533,924, which the company agreed to remit to VA in settlement of the contract overcharges. As a result of the voluntary disclosure and our follow-up review, the company has developed and implemented policies and procedures that would incorporate the necessary internal controls to correct the errors they had discovered. The company had detected the errors in their FCPs as a

result of a "Dear Manufacturer" letter sent by VA's Office of General Counsel to all manufacturers of covered drugs. The "Dear Manufacturer" letter was based on several common errors we noted in the FCP calculations at companies being reviewed by us. The significance of the trend we observed led to our collaboration with the Office of General Counsel and the issuance of the "Dear Manufacturer" letter. This letter has resulted in several other voluntary disclosures and remittances.

- As a result of our postaward review, a pharmaceutical company agreed to pay $1,700,000 to VA for FSS contract overcharges resulting from not disclosing accurate, complete, and current pricing information at the time of negotiations and from violations of the provisions contained in the price reductions clause.

- An FSS contractor that provides VA with medical supplies voluntarily disclosed they owed the Government $944,500 because of price reduction violations in administering their FSS contract. Our review concluded the company actually owed the Government a total of $993,270 which they subsequently remitted to VA.

- A pharmaceutical company remitted $223,478 to VA for contract overcharges resulting from not disclosing accurate, complete, and current pricing and discount information to the contracting officer during negotiations. Our review found that while the company generally maintained a no-discount policy, the lower prices resulted from granting price protection for an extended period of time to certain commercial customers.

- Three pharmaceutical companies concurred with our conclusion that they had been underreporting sales subject to the Industrial Funding Fee (IFF). Their internal reviews revealed they owed VA an additional $133,220 in IFF because they had understated sales. The companies have remitted the adjustment to VA. We identified the underreported sales by matching sales totals obtained from VA's Pharmaceutical Prime Vendors and VA internal records of direct sales against sales totals that contractors reported to VA. We are continuing our review of other major pharmaceutical manufacturers whose reported sales differ significantly from sales reported to VA.

- A pharmaceutical company acknowledged errors totaling $6,195 in calculating FCPs under Public Law 102-585. Our review also disclosed other billing errors totaling $34,649. The contractor agreed to pay the $40,844 due and to implement policies and procedures incorporating necessary internal controls to correct the errors.

Issue: Procurement of Computer Hardware and Software (PCHS) and the Procurement of Automated Information Resources Solutions (PAIRS)

Conclusion: VA addressed the most significant lessons learned from past contracts, however the acquisition strategy should be reevaluated to assure VA meets the intent of the Clinger-Cohen Act.

Impact: Better use of $58 million.

We conducted a review of VA acquisition initiatives for the PCHS and the PAIRS contracts. The PCHS contract is valued at $1.5 billion over 5 years and PAIRS is valued at $875 million. We found that acquisition risks associated with the PCHS initiative were effectively addressed by VA's procurement planning actions. During the award of the PCHS contract, officials addressed most lessons learned from past VA information technology (IT) contracts and took actions that compared favorably with the best practices in the industry. We identified opportunities for VA to enhance its IT contracting initiatives and to help address and meet IT performance expectations included in the Clinger-Cohen Act.

Key issue areas requiring VA's attention include: (i) reassessing the need and benefits of using national IT contracts, given the availability of other procurement mechanisms, (ii) requiring VHA's decentralized Clinical Workstation Replacement initiative be subject to the new capital IT investment review process, (iii) addressing performance expectations included in Section 5132 of the Clinger-Cohen Act which would reduce IT costs by $22 million yearly and $101 million over 5 years, (iv) ensuring replacement computer terminals do not upgrade original project requirements to unnecessary higher performance systems costing an additional $36 million, (v) establishing a realistic estimate of cost, schedule, and performance goals for the PAIRS initiative that excludes the VHA Infrastructure Upgrade project requirements that have already been completed, and (vi) assuring that the Contracting Officer Technical Representative (COTR) be provided with formal training in COTR duties and COTR designations are in writing. The Acting Assistant Secretary for Management and the Under Secretary for Health concurred with the report recommendations and provided appropriate implementation actions. The PAIRS contract was terminated on January 29, 1998. *(Audit of VA PCHS/PAIRS and Selected Information Technology Investments)*

Issue: Pharmaceutical Prime Vendor (PPV) Program

Conclusion: Internal controls were generally adequate, however price-monitoring efforts could be more efficient and responsibilities needed clarification.

Impact: Improved contract management.

We conducted an audit of the PPV Program as part of our continuing coverage of OA&MM and National Acquisition Center (NAC) procurement activities. The purpose of the audit was to determine if internal controls were adequate to ensure that VAMC buying activities paid correct prices, as contracted by NAC staff, for drug items purchased through prime vendors.

Audit test results showed that internal controls governing the solicitation and award of prime vendor contracts were effective and controls to ensure correct PPV pricing were generally effective. Tests of the largest prime vendor (accounting for 74 percent of PPV sales in FY 1995) identified few exceptions. However, price-monitoring efforts could be more efficient and price monitoring responsibilities needed clarification in VA policy.

We recommended that NAC and OA&MM officials develop an electronic PPV price monitoring system and that policy be established defining the respective responsibilities of NAC, VHA's Pharmacy Benefits Management Strategic Healthcare Group, and VAMC purchasing staff for monitoring prime vendor contract performance. The Under Secretary for Health and the Deputy Assistant Secretary for Acquisition and Materiel Management concurred in the report's recommendations and provided acceptable implementation plans. (*Audit of VA's Pharmaceutical Prime Vendor Program)*

3. PROCUREMENT FRAUD AND PRODUCT SUBSTITUTION

Issue: Integrity of the Procurement Program

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

Impact: Companies and individuals are held accountable for illegal acts.

Contract Fraud

- A Federal search warrant was executed by VA OIG special agents at the offices of a plumbing subcontractor who was awarded a Government contract to renovate part of a VA Extended Care Center. The total value of this contract is $7.8 million. A joint investigation with the Department of Labor (DOL) OIG, revealed the subcontractor was billing VA for union wages, but paying its workers at well below the union wage. Potential loss to the Government may exceed $50,000.

- An investigation into fraudulent activities in a VA vocational rehabilitation program was launched in response to evidence that vendors fraudulently billed VA for goods and services that were not provided. In response to information that time and attendance files were being altered in anticipation of a subpoena being served, a search was conducted jointly by VA OIG, Federal Bureau of Investigation (FBI), and state police, during which altered documents were seized. State police joined the investigation on behalf of a state Bureau of Vocational Rehabilitation after the initial phase of the inquiry disclosed that the Bureau was being subjected to some of the same fraudulent practices.

Procurement Fraud

- A hearing was held in U.S. District Court addressing two motions: one brought by the Government to enforce a VA OIG subpoena issued to a company doing business with VA and one brought by the company to suppress evidence from a search warrant executed at the company's offices. With regard to the Government's motion, the company was ordered to comply with the demands of the subpoena within 60 days. With regard to the company's motion, the court denied it. The company is the subject of a joint VA OIG, Food and Drug Administration, and U.S. Customs Service

investigation into allegations that it sold non-conforming and unauthorized surgical instruments to VA and to other agencies.

Product Substitution

- A computer hardware distributor pleaded guilty in U.S. District Court to one count of mail fraud. A joint investigation by VA OIG and the Postal Inspection Service revealed the individual altered approximately 300 central processing unit (CPU) chips so they appeared to be a higher speed chip and sold them to VA at inflated prices. The distributor altered 50 MHz chips by "pushing" the speed on the altered chips and marking them as 66 MHz chips when installed. The scheme resulted in higher profits for the distributor, but would result in ultimate failure of the computers. Loss to VA exceeds $34,000.

- The owner of a medical equipment supply company pleaded guilty and was sentenced in U.S. District Court to 6 months' home detention, 5 years' probation, and 100 hours of community service, fined $1,000 and ordered to make restitution of $11,701 to VA. The individual had contracted with a VAMC to provide new medical equipment to homebound veterans, but a VA OIG investigation revealed the individual instead delivered used equipment and billed VA for new.

MEDICAL CARE PROGRAMS

1. RESOURCE UTILIZATION

Issue: Medical Care Usage Patterns and Availability of Resources

Conclusion: VHA is addressing historical funding inequities that existed among VHA facilities.

Impact: Improved allocation of resources.

In FY 1997, VA spent about $17 billion to deliver health care to America's veterans. The scope of the audit included reviewing historical VHA workload and expenditures from FY 1992 through FY 1995 and projected workload for FY 1998, 2000, and 2005. The audit confirmed that inequities in resource distribution existed among the 22 Veterans Integrated Service Networks (VISNs) that provide medical care to eligible veterans. Some VISNs received resources in greater proportion to their workload than others. These inequities resulted because VHA resource distribution systems did not adequately respond to changing veteran demographics.

During the course of the audit, VHA established VISNs, and implemented the Veterans Equitable Resource Allocation System (VERA) in response to Public Law 104-204. Legislation was also passed that delineated new veteran eligibility requirements. VHA is appropriately responding to resource allocation inequities by decentralizing resource distribution authority to Network Directors, initiating use of a new resource allocation system, and developing automated management information systems which should help control costs. Our analysis of VHA's data supports the actions taken by VHA. *(Audit Of VHA Medical Care Usage Patterns and Availability of Resources)*

2. ELIGIBILITY AND ENTITLEMENTS ISSUES

Issue: Management of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

Conclusion: While CHAMPVA was generally well-managed, reviewing certain claims paid in prior years and aggressively pursuing third party liability claims could increase cost recoveries.

Impact: Recovery of $4.2 million in inappropriate payments and $293,000 from potentially liable third parties.

This audit was requested by the House Veterans Affairs Committee to evaluate the management effectiveness of the program. CHAMPVA provides healthcare benefits for the dependents of: (i) veterans rated as permanently and totally disabled, (ii) veterans who died as a result of service-connected conditions, or (iii) veterans who died on duty with less than 30 days of active service. The Health Administration Center (HAC) in Denver is responsible for processing claims for reimbursement and otherwise administering the program. As of September 30, 1997, there were 81,000 beneficiaries enrolled in CHAMPVA. During FY 1997, the HAC processed 913,000 claims pertaining to medical services for 49,000 of the enrolled beneficiaries. FY 1997 program costs totaled $98 million of which

$91 million were direct costs for medical care claims and $7 million were indirect costs for program administration.

Our audit found that CHAMPVA was generally well-managed and program controls were effective. The HAC had corrected prior internal control problems. The HAC had also established procedures to ensure claim payments were accurate, rates paid were reasonable, and high cost medical claims were monitored to ensure that care was necessary and appropriate.

The audit identified two opportunities to further improve program operations by increasing the recovery of medical care costs. First, the HAC could use commercial medical procedure and diagnostic code auditing software to review prior year outpatient claims for inappropriate payments. Based on the HAC's success in using this software for reviewing current claims, we estimated a review of certain prior year claims could identify about $4.2 million in inappropriate payments that may be recoverable. Second, the HAC identified, but did not always aggressively pursue, potentially liable third parties. We reviewed 37 cases that the HAC had not fully developed and found 3 cases where a third party could possibly be held liable for the cost of care. CHAMPVA paid $293,000 in claims for care of these 3 beneficiaries. The HAC Director concurred with our recommendations and provided responsive planned actions. *(Audit of CHAMPVA)*

3. VALIDITY OF DATA IN VA SYSTEMS

Issue: Pathology and Laboratory Medicine Service's Workload Reporting System

Conclusion: National laboratory workload data was accurate, but not complete.

Impact: Better workload reporting would improve the utility of workload information.

This audit is the third in a series of Pathology and Laboratory Medicine Service audits intended to provide an overall assessment of program performance. This audit was conducted to determine whether the data in the workload reporting system, the Laboratory Management Index Program (LMIP), was accurate and complete. LMIP was implemented on October 1, 1995 to accumulate national laboratory workload data from all VAMCs. During a recent 12-month period, LMIP reports showed that 105 million tests were performed nationwide.

Workload data reported to LMIP was generally accurate, but was not complete because some VAMCs reported sporadically, or did not report at all. We estimate that Pathology and Laboratory Medicine Service may be underreporting workload by almost 7 million tests annually representing program costs of over $5 million per year. We also found that one of the system controls used to test the accuracy of data, the National List of Tests, was allowing inappropriate items to be reported as tests. We recommended steps the Under Secretary for Health could take to further improve data management and ensure LMIP is complete and accurate. The Under Secretary for Health provided an acceptable action plan in response to our findings and recommendations. *(Audit of Pathology and Laboratory Medicine Service's LMIP)*

4. QUALITY OF HEALTH CARE PROGRAM EVALUATIONS

Issue: Status of VHA's Quality Management Activities

Conclusion: VHA managers need to strengthen and consolidate program leadership.

Impact: Assurance of high quality health care to veterans.

Quality Management Programs are essential to VHA's ability to ensure high quality, safe patient care. Since late 1995, VHA top managers have dramatically revised and in many ways strengthened the quality management process. At the request of the Senate Committee on Veterans Affairs, we conducted a program evaluation of VHA's quality management activities at VACO, VISN, and VAMC levels in order to determine the extent of changes that have occurred since the advent of new quality management leadership in late 1995. We concluded that quality management programs have not been materially reduced in scope or activity during this 2-year period. VHA managers abolished the QUality Improvement Checklist (QUIC), but the clinical indicators that QUIC measured are still available in a nationally distributed, automated database. Thus, there was no net loss of Quality Management information during this transition. Similarly, we found that the manpower commitment to quality management has not materially changed insofar as numbers of employees who evaluate health care are concerned, but the configuration or distribution of these employees has changed. Particularly, VISNs did not have consistent oversight of their subordinate VAMCs' quality management activities. The Under Secretary for Health strengthened Quality Management Programs by developing the 12 Dimensions of VHA's Healthcare Quality Framework, and by articulating Core Values of trust, respect, commitment, compassion, and excellence as VHA policy.

The overall leadership of the Quality Management activities needed to be strengthened, and quality management activities needed to be consolidated at the Headquarters level in order to further strengthen the program. We made nine recommendations to strengthen, coordinate, and consolidate quality management programs. The Under Secretary for Health concurred with the recommendations and implemented or planned appropriate actions that will lead to a stronger quality management process. (*Quality Management in the Department of Veterans Affairs VHA)*

Issue: Use of Advanced Practice Nurses (APN) to Extend Patient Care Capability

Conclusion: VHA managers need to consider strengthening quality management initiatives to oversee their practice.

Impact: Treating more patients at less cost.

The VHA operates the most extensive health care delivery system in the country, and is the largest single employer of APNs in the nation, with about 1,850 APNs on its rolls. In his "Vision for Change," the Under Secretary for Health launched some dramatic changes in traditional health care delivery, including an objective of increasing by 200 percent, the use of non-physician providers to supplant and supplement physicians' services in primary care settings.

We conducted an oversight inspection of VHA's efforts to identify the APN population and the functions that they perform, particularly in reducing physicians' direct care responsibilities in VAMCs throughout the nation. We found there are several opportunities for VHA to strengthen its use of APNs, but that at least three remedial barriers prevented this from occurring: lack of, or limited prescriptive authority; lack of nurses' and physicians' understanding of the APN roll; and lack of administrative support. VHA's survey showed that, disregarding the barriers, agency APNs are highly satisfied with their jobs, but only about 23 percent of them planned to remain in the VHA for their entire careers. VHA promulgated policies in 1995 and 1997, that facilitate APNs' ability to function more independently in patient care settings. We cautioned VHA managers about the need to recognize an increasing opposition to expanding the use and clinical prerogatives of APNs, and of the inherent risks in awarding expanded privileges to non-physician practitioners. We advised VHA to encourage local facilities to carefully manage the APN credentialing and privileging process, and to ensure strong quality assurance oversight of the treatment provided. We did not make any formal recommendations since we did not identify any apparent deficiencies. *(Oversight Review of the VHA's Use of APNs in Primary Care)*

Issue: Systematic solicitation of patient assessments of health care services

Conclusion: Feedback is too slow to make meaningful changes in a fast-moving environment.

Impact: Meaningful information enhances responsiveness to patient needs.

VHA managers have been obtaining feedback from patients as to their perceptions of the quality of services that they have received in VAMCs for nearly 20 years, but questionnaires have not been designed to elicit information that pertained to the actual treatment process itself. In 1994, VHA managers began to revise the patient feedback questionnaire instrument in order to obtain pertinent, meaningful information that is associated with, and would help in measuring medical centers' standing in complying with the Secretary's Customer Service Standards.

We conducted a program evaluation of VHA's National Customer Feedback Center (NCFC) in order to evaluate the revised patient survey process, and how resulting information analyses are used to affect patient care. We found the newly revised survey process is founded on time-tested methodologies and the surveys elicit valid information that can be used to measure a facility's standing in complying with the Secretary's 10 Customer Service Standards. The NCFC uses two survey instruments to obtain patients' impressions of their acute inpatient and outpatient experiences. Current analytic methods are slow and inhibit center employees' ability to transmit analyzed results to VAMCs in a sufficiently timely fashion for it to be useful in making meaningful operational changes quickly enough in a rapidly changing health care environment. VAMC managers are conducting their own patient satisfaction surveys to compensate for the late arriving NCFC results, but the information gathered from these two types of surveys is not correlated, and we could not find any indication that anyone determines if the independently done survey questions are properly designed to capture valid information. We made two consultative recommendations intended to strengthen NCFC operations. The Under Secretary for Health provided responsive comments. (*Review of VHA's NCFC*)

Issue: Nationwide Quality Program Assistance (QPA) Reviews

Conclusion: Pace of change was reflected increasingly in employee morale.

Impact: Advisory reports to VAMC and VISN managers.

We conducted QPA reviews at five VAMCs. 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 of cost-efficient care, high quality care, improved patient access to care, and improved patient satisfaction.

We found that VAMCs' 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 reorganizations have been made, but they were aware of, and generally supported management's treatment goals. Patients at all of the VAMCs that we visited, indicated they were generally pleased with the care they received. OHI did not identify any incidents that relate to poor employee morale at any of the facilities that we visited. Nevertheless, the consistently identified concerns about the potential for adverse morale among employees, associated with the rapid changes in VA health care, comprise an issue that VHA managers need to consider and address in order to ensure continuing high quality patient care, and patient satisfaction. (*QPA Reviews, VAMCs Iowa City, IA; Dublin, GA; Loma Linda, CA; Tucson, AZ; and Lexington, KY*)

5. INSPECTIONS OF INDIVIDUAL CASES OF PATIENT CARE

Issue: Alleged Improper Community Nursing Home Placement of an Elderly Patient

Conclusion: Clinicians did not respond to requests for alternative placement; did not provide due process opportunity; and could not agree on the severity of the patient's impairment.

Impact: Clarified policies should prevent recurrence of similar incidents.

We inspected allegations that VAMC clinicians did not properly include a patient's spouse in plans to outplace the patient to a remotely located nursing home. Clinicians placed the patient in a nursing home that was located more than 300 miles from the family home, and the patient died a few days after his arrival. We found VAMC clinicians did not properly manage arrangements to discharge the patient and transfer him to a private nursing home. The patient's spouse was his legal guardian and did not consent to the transfer; clinicians did not provide the patient's spouse, or any other family member with information about the right to due process to contest the placement; and two senior clinicians could not agree on the patient's mental status that would be influential in the placement decision. We made three recommendations to reduce the possibility that similar incidents will occur in the future. The Medical Center Director concurred with the recommendations and provided acceptable implementation plans. (*Inspection of Alleged Mismanagement of a Nursing Home Patient's Discharge, VAMC Biloxi, MI*)

Issue: Infringement of Patients' Right to Privacy

Conclusion: Interpersonal hostility among employees resulted in behaviors that led to invasions of patients' privacy, and that had the potential to adversely affect patient care.

Impact: Reducing interpersonal tensions improves patient/provider relationships.

We inspected allegations that a female physician had improperly touched several male patients at a satellite outpatient clinic. We concluded the physician had not improperly touched, fondled, or otherwise assaulted any patients. Instead, several male patients complained that as they were seated, essentially disrobed, in examining rooms, various clinic employees would enter the room, unannounced, and without any apparent purpose. The experience was embarrassing and demeaning to some of the patients, and they blamed the physician since they considered that she was responsible for their well-being while they were under her care.

We found that selected Outpatient Clinic employees were engaged in hostile interpersonal relationships, or openly disagreed with selected clinic operations, and apparently acted out their disputes by embarrassing patients in the described manner. We interviewed a random sample of 42 patients who had been treated by the clinic physician during the previous year. All of the patients whom we interviewed praised the physician's professional demeanor and caring attitude, and all of them rated the care that she provided to them as very good or excellent. Several of these patients attested to their knowledge of the interpersonal tensions among clinic employees, and cited examples of incidents that they had witnessed or heard of that confirmed our findings. The Director of the parent medical center had become aware of these unwarranted behaviors and had initiated a team-building effort in order to reduce the tensions and direct employees' energies into providing high quality patient care.

Since the Director had already initiated corrective actions to improve clinic conditions, we did not make any recommendations. Nevertheless, we cautioned the Director to maintain surveillance over clinic employees' actions to avoid recurrence of such behavior, and he agreed to do so. (*Inspection of Alleged Patient Sexual Molestation by a Physician at a VA Medical Clinic*)

Issue: Improper Nursing Practices on an Acute Medical Ward

Conclusion: A patient received appropriate care, but nursing practices need to be strengthened to ensure consistent patient care, and the availability of important medical information.

Impact: Improved documentation of clinical information.

We inspected allegations that a patient died several days after surgeons amputated his leg because nurses did not provide basic nursing care. We inspected the issues in the case and determined that the nurses provided the patient with adequate nursing care, and that other aspects of his treatment were within accepted standards of practice. Family members had expressed concerns about the patient's care early on in the treatment process, and the head nurse, as well as ward nursing employees took great care to maintain a high level of communication with them. During our inspection, several senior-level clinicians approached an inspector and expressed concerns that nurses were not properly recording important medical information, such as fluid intake and output values, and patients' vital signs, in the medical records. Medical records reviews confirmed these charting deficiencies. We recommended

actions to correct the deficiency, and the VAMC Director provided responsive implementation plans. (*Inspection of Alleged Patient Neglect and Inadequate Care, VAMC Syracuse, NY*)

Issue: Alleged Misdiagnosis of a Patient's Chronic Heart and Lung Disease

Conclusion: The patient had clear evidence of congestive heart failure, but did not have a history or symptoms of chronic obstructive lung disease.

Impact: Improved medical record documentation and quality improvement procedures.

We reviewed allegations that a patient may have been subjected to improper treatment because physicians had diagnosed him as having congestive heart failure, and chronic obstructive lung disease, and the patient's spouse insisted that he had never suffered from these maladies. We concluded that the patient received adequate and timely treatment for his illness throughout his hospitalization. The patient had clear signs of congestive heart failure, and his physician provided appropriate treatment for this condition. The medical record contained conflicting information as to whether the patient had chronic lung disease, even though he had smoked more than one pack of cigarettes a day for more than 40 years. The lung condition was not mentioned in at least seven previous chest x-rays, but he had pneumonia at the time of admission. Our review found the patient's physician had prescribed thyroid medication before he had obtained objective evidence of the need for this medication. The medication was probably unnecessary, but did not harm the patient. Nursing employees also committed a medication error in that a nurse gave the patient a medication based on a reported telephone order, but the physician never wrote such an order. The patient's record shows he had signs and symptoms that would suggest the need for the medication, and we speculated that the nurse probably obtained the order by telephone, but the physician neglected to write the order after the fact. Physicians had previously prescribed the medication for similar symptoms. We made recommendations to address the discrepancies, and the VAMC Director took appropriate corrective actions. (*Inspection of Alleged Inappropriate Patient Care and Misdiagnosis of a Patient's Illness, VAMC Northampton, MA*)

Issue: Alleged Improper Leg Ulcer Treatment

Conclusion: Nurses wrapped wounds in impervious material to enable them to move freely in the medical center.

Impact: Maintenance of a restraint-free patient environment.

We reviewed allegations that VAMC nursing employees routinely wrapped patients' lower leg and foot wounds in red plastic biohazard bags, and that this procedure led to increased rates of wound gangrene and limb amputations. We visited the VAMC without providing prior notice, and twice visually inspected several wards, including all three Nursing Home Care Units (NHCUs), without prior notice. We concluded nursing employees had, at one time, wrapped patients' lower leg and foot wounds in red plastic biohazard bags, but nursing managers had directed this practice cease between 18 and 24 months before we initiated our inspection. Nursing employees used these wraps if the patients had open, weeping wounds or stasis ulcers that had the potential to become infected. Similarly, nurses would apply such wraps if patients had colonized communicable infections in these areas which could be transmitted to other patients, employees, or visitors, if left unprotected. The use of the red plastic bags was a matter of convenience in that these bags are available on any isolation cart, several of which were strategically stationed outside of isolated patients' rooms on the NHCU. The purpose of using

impervious wrappings for these patients' wounds was to facilitate their ability to leave their rooms and be as free to ambulate to other areas of the medical center as possible. Nursing employees continue to use clear plastic bags to wrap patients lower limbs when they shower, but they wrap the wounds in alternate impervious material when the patients have to leave the ward for any purpose. Nursing employees readily articulated the rationale and methodology for wrapping the patient's lower legs and feet, and asserted they always removed the impervious dressing immediately upon the patients' return to the ward.

We did not make any recommendations because nursing managers had already discontinued the use of the bags for wound wrapping. Nursing managers were revising local infection control policies to clarify the meaning of impervious wrap, and to clarify the methodology to be used in protecting patients from infection and protecting other individuals from incurring a patient's unprotected communicable infection. (*Inspection of Alleged Improper Leg Ulcer Treatment, Jerry L. Pettis Memorial Veterans Hospital Loma Linda, CA*)

Issue: Alleged Inappropriate Proposal to Discharge a NHCU Patient

Conclusion: Employees acted properly in attempting to gain the patient's cooperation, and did not threaten him with expulsion. A physician prescribed a drug without recording his rationale.

Impact: Improved treatment of Nursing Home patients who have behavioral problems.

We reviewed allegations that NHCU employees had told a patient that he was being discharged because he was too ill to be cared for in the NHCU. We concluded that NHCU employees had told the patient that he was being considered for alternative outplacement because he no longer met the criteria to occupy a NHCU bed. The patient and his son vehemently resisted this outplacement attempt, and VAMC employees did not follow-up on the issue.

The head nurse and a social worker both approached the patient and asked him to comply with NHCU rules that require him to bathe and change underclothing periodically, and to not confront other patients or employees in a hostile manner. However, they denied that they threatened to expel him from the unit if he did not behave as expected. The VAMC adopted a policy that patients would only be accommodated in the nursing home for relatively short periods of time, with a view that they would be relocated to appropriate facilities to continue rehabilitation or recuperation. Clinicians thoroughly explained this policy to the patient and his son, but they continued to resist alternative placement, and the patient continued to resist complying with established policies. The patient's physician, a certified geriatrician, concluded the patient may be depressed, and his resistance to complying with the rules may be secondary to this condition. He prescribed a mood-altering drug to alleviate the depression, but did not record his rationale for initiating this therapy in the medical record.

We made a recommendation to correct the lack of medical record documentation insofar as the patient's mood-altering medication is concerned. The VAMC Director concurred with the recommendation and initiated corrective action. (*Inspection of Alleged Inappropriate Proposed Extended Care Discharge, VAMC Cheyenne, WY*)

Issue: Alleged Improper Assignment of a Physically Impaired Physician

Conclusion: Managers were aware a physical impairment could interfere with adequately performing Medical Officer of the Day duties, but continued to assign the responsibility.

Impact: Assurance of safe patient care.

We reviewed allegations, from three physicians, that VAMC managers had treated them improperly or unfairly, in separate incidents. We did not substantiate two of the physicians' allegations. We concluded that managers had treated two of the physicians fairly in administering disciplinary action to one of them, and in reassigning the other to accommodate shifting patient loads and to meet the medical center's reorganization imperatives. The third physician had a severe physical impairment that interfered with his ability to provide aggressive patient care such as may be needed in the event of cardiopulmonary resuscitation. The physician and his personal physician had notified VAMC managers that he was physically unable to perform all aspects of Medical Office of the Day duties, but managers had continued to assign him to these duties. We did not find any instance that the physician's physical impairment resulted in patient harm. We recommended actions to prevent such events from occurring in the future, and the VAMC Director provided responsive implementation plans. (*Inspection of Selected Clinical and Administrative Issues, VAMC Lake City, FL)*

Issue: Verification of Implementation of Previous Recommendations

Conclusion: All but two previously agreed upon recommendations had been implemented.

Impact: Strengthened Anesthesiology Service leadership.

We reviewed previously agreed upon recommendations from an inspection into alleged clinical and administrative irregularities on a VAMC's Anesthesiology Service. We concluded VAMC managers had addressed and initiated appropriate actions to correct most of the deficiencies that we had identified in an earlier inspection. However, we concluded that, even though managers had made some progress, they had not fully implemented two of the previous recommendations.

Two of the major deficiencies, cited in the earlier report, pertained to the need for stronger Anesthesiology Service management, and a need to provide stronger supervision of anesthesiology residents. We found VAMC managers had initiated a program to provide leadership mentoring and development for the service chief, but documentation of this oversight suggested a lack of management resolve to improve the chief's skills. Managers had not apparently provided the service chief with a performance evaluation, and after our inspection visit, gave him a post-dated evaluation. The previous inspection also identified a need for stronger supervision of anesthesiology residents. We found even though managers had initiated steps to strengthen supervision, the VAMC's records show that senior anesthesiologists who are required to supervise residents continued to inadequately record the quality or quantity of their supervision in the medical records. We recommended the VAMC Director emphasize completion of actions taken to implement these two remaining recommendations. (*Follow-up Inspection of Selected Clinical and Administrative Issues on Anesthesiology Service, Hunter Holmes McGuire VAMC Richmond, VA*)

6. PATIENT CARE ISSUES

Issue: Investigation of Patient Death

Conclusion: The patient was murdered.

Impact: Unusual incident with no VA-wide implications.

A Federal grand jury returned a one count indictment in U. S. District Court against a VAMC physician charging him with first degree murder. The indictment alleges that in 1994, the physician, while working at the VAMC, unlawfully killed a patient by injecting the patient with potassium chloride in violation of Title 18, United States Code (U.S.C.), Sections 7 (3) and 1111.

Issue: Charge Nurse Inattentive to Duties

Conclusion: Patient care top priority at VA facilities.

Impact: Health care professionals held accountable for sacred trust.

An individual employed as a VAMC registered nurse was arrested and charged with making a false statement, a violation of Title 18, U.S.C. 1001. In an earlier interview by special agents of the VA OIG and in a signed sworn statement, she stated that she never slept during her duty hours. Investigation, however, uncovered a pattern of the individual sleeping during her regular tour of duty, midnight to 8:00 AM, and that she was not attentive to patient needs.

7. CONTROL OF DRUGS

Issue: Employee Theft/Diversion of Drugs

Conclusion: Investigations disclosed fraudulent acts by an employee to obtain drugs.

Impact: Former employee is held accountable for illegal acts.

A former VAMC registered nurse was sentenced to 6 months' home confinement and 3 years' probation. She previously had pleaded guilty to acquiring morphine by fraudulent means. An investigation revealed that, on approximately 60 occasions, the individual diverted for her own use pain medications prescribed for VA patients under her care. She further admitted administering non-prescribed substances, such as Benadryl, to patients in an effort to conceal her activity.

Issue: Investigation of Suspected Fraudulent Claims

Conclusion: Individuals submitted false billings, invoices, and statements.

Impact: Individuals are held accountable for illegal acts.

- A former VAMC licensed practical nurse, who became a home health care provider for veterans, inappropriately billed for certain aspects of home health care which she reportedly was providing to a quadriplegic veteran. She did not provide the services for which she billed and illegally sub-contracted other services to non-licensed individuals who, in turn, cared for the veteran. A grand jury returned a 23-count indictment, charging her with grand larceny, engaging in a scheme to defraud, and offering a false instrument for filing claims. She allegedly filed more than 800 false documents with various entities, including VA. If found guilty, she could be sentenced to up to 15 years in prison. The fraud against the entities involved is estimated to exceed $350,000.

- Pursuant to the False Claims Act, a civil judgment of $11,500 was entered in U.S. District Court against a registered nurse under contract with VA. A VA OIG investigation revealed the nurse, who contracted to provide home nursing services to eligible disabled veterans, submitted fraudulent invoices for nursing care she did not provide. She billed VA for the services at times when, in fact, veterans were hospitalized and improperly billed for services she was not authorized to provide.

- An individual was indicted by a grand jury on six counts of submitting false statements to the Government. The indictment was the result of a joint VA OIG and FBI investigation which determined the individual was submitting false statements to obtain VA medical treatment to which he was not entitled. The individual, who was not a veteran, assumed the identity of an eligible veteran in order to receive medical treatment at VA facilities. Loss to VA exceeds $15,000.

BENEFIT PROGRAMS

1. DELIVERY OF BENEFITS AND SERVICES

Issue: Timeliness and Quality Issues in Compensation and Pension (C&P) Claims Processing

Conclusion: VA's claims processing can be improved.

Impact: Better benefit claims service for veterans.

Since the early 1990's, members of Congress, Veterans Service Organizations, and VA managers have expressed concern about the timeliness and quality of C&P claims adjudication. VBA C&P system involves adjudication and overall administration of benefits totaling $20 billion annually to 3.3 million veterans, widows, children, and parents. Claims for C&P are backlogged due to outdated processing methods which are unable to cope with increasingly complicated adjudication and appellate rules. This report summarizes and consolidates recommendations to improve the claims processing system made by the VA OIG, Congressional commissions, and several task forces established by VA.

From our perspective, the highest priority issues facing VBA are: (i) development of a "corporate" level database which will provide the basis for making informed decisions on the nature of any proposed program changes, (ii) development and coordination of a VBA staffing and re-organization plan in conjunction with VBA's ongoing efforts to reengineer its claims processing methods, and (iii) reform and simplification of the statutes and regulations governing the pension program. In addition to these long-term priority issues, we also recommended specific near-term actions including: (i) improving the timeliness of medical examinations for veterans applying for C&P benefits, (ii) consolidating authority and responsibility for the timely and complete adjudication of C&P claims, (iii) expanding the opportunity for local appeals hearings, and (iv) keeping veterans informed of the status of their claims. The Acting Under Secretary for Benefits generally agreed with the recommendations and provided positive comments and VBA's actions/intentions concerning each recommendation area. (*Summary Report on VA Claims Processing Issues)*

Issue: C&P System Messages

Conclusion: VBA can enhance customer service and prevent benefit payment errors by better managing C&P system messages.

Impact: Enhanced customer service and prevention of annual benefit payment errors totaling $33 million.

We conducted this evaluation to determine whether C&P system messages served as an effective control to ensure the accuracy of C&P benefit payments and quality of service to beneficiaries. We reviewed C&P system messages generated during the 2nd quarter of FY 1997. We found that 44 percent of 159,062 C&P system messages generated did not serve as an effective control to ensure the quality of customer service or the accuracy of benefit payments. These messages were either not timely and properly processed, or were not useful and caused unnecessary work. By better managing C&P system messages, we estimate that VBA can enhance customer service and prevent annual benefit payment errors of $33 million - $19 million in overpayments and $14 million in underpayments.

We recommended the Under Secretary for Benefits improve management of C&P system messages by: (i) requiring VARO management to monitor the timeliness and accuracy of actions taken on C&P messages, (ii) eliminating messages that do not impact payment accuracy and customer service, (iii) encouraging VAROs to identify messages that result in unnecessary work and initiate action to eliminate them, and (iv) gathering and disseminating best practices for managing C&P system messages. The Deputy Under Secretary for Management concurred with the findings and recommendations and provided acceptable implementation plans. *(Evaluation of the Effectiveness of VBA's Controls to Detect and Prevent C&P Benefit Payment Errors)*

Issue: Service-Connected (SC) Disability Determinations

Conclusion: Prior audit recommendations were satisfactorily implemented.

Impact: More accurate and reliable disability determinations.

We conducted a follow-up audit to our 1995 report that concluded that 97 percent of the VBA determinations of service connection we reviewed were appropriate. While our 1995 audit showed that the percentage of questionable determinations was low (3 percent), each determination has significant impact for the claimant. Therefore, we recommended that VBA inform appropriate personnel of the types of deficiencies identified and take corrective action, if warranted.

Our follow-up audit found that the prior recommendations were implemented, and we provided information on the changes observed in disability ratings for use by the Department. Results showed that 33 of 100 veterans reviewed had a total of 61 individual conditions in which disability ratings were either new or had changed since our prior assessment. These changes increased benefit payments by $138,000 annually. Rating changes resulted primarily from: (i) changes in the severity of the veterans' conditions, (ii) new conditions identified, (iii) new evidence related to old conditions, (iv) differing interpretations of old evidence in which the benefit of the doubt was given to the veteran and, in a few cases, (v) errors in the original rating. No recommendations were made. *(Follow-up Audit of the Assessment of SC Disability Determinations)*

Issue: Social Security Administration (SSA) and VA Death Match Procedures

Conclusion: VBA needs to develop and implement an effective method to identify deceased veteran beneficiaries and terminate their benefits timely.

Impact: Expenditures could be reduced by about $4 million.

We conducted an audit to evaluate the effectiveness of VBA's efforts to timely terminate C&P benefits. Based on information about veterans' deaths received from SSA, audit results showed that, only 156 of a sample of 281 veterans reported by SSA as deceased were, in fact, deceased. C&P benefit awards for 42 of 156 deceased claimants were still running; had incorrect termination dates, or had incorrect suspense dates. Overpayments in these 42 cases totaled $340,000. We estimated approximately $4 million in erroneous payments were made throughout VBA. Based on our findings, we recommended that VBA: (i) implement a more effective system for follow-up on claimant death notifications; (ii) correct beneficiary data base problems and link electronic beneficiary data bases where necessary; and (iii) coordinate with SSA officials to improve the accuracy of SSA death reporting.

VBA concurred with all recommendations, and provided acceptable implementation plans. *(Audit of VBA SSA/VA Death Match Procedures)*

2. OTHER BENEFICIARY ISSUES

Issue: Servicemembers' Group Life Insurance (SGLI) Premium Payments

Conclusion: Reserve component reporting and validation procedures need improvement to ensure the accuracy of life insurance premium payments.

Impact: Improved program integrity and assurance of proper insurance coverage for reservists.

We conducted an evaluation of SGLI premium collections for reservists. In FY 1997, 95 percent of 867,000 reservists participated in the SGLI program. In FY 1996, premium collections for reservists totaled $163 million, 34 percent of the $475 million collected for SGLI.

We concluded that reporting systems for seven of eight reserve components were inadequate to verify the accuracy of insurance premiums because they did not separately report premiums for pay and non-pay status reservists. As a result, we could not confirm the accuracy of about $130 million of the $163 million of life insurance premiums (80 percent). Our review found the Air Force Reserve insurance premium reporting system was adequate to assess the accuracy of premium payments. However, at one of two sites visited, we found premiums paid to VA exceeded the amount due by about 30 percent or about $22,000. These overpayments were made for individuals in non-pay status who had left the reserve component.

We recommended that Insurance Service management work with uniformed service organization representatives to improve their reporting systems to ensure premiums paid to VA for all insured reservists can be verified. We also recommended Insurance Service management share our observations regarding premium overpayments with Air Force Reserve management, to assist them in improving the accuracy of SGLI premium payments. The Under Secretary for Benefits concurred with our recommendations and provided acceptable implementation plans. *(Evaluation of Premium Payment and Reporting Procedures for the SGLI Program)*

Issue: Controls Over Disbursements of Matured Endowment Life Insurance Awards

Conclusion: Increased oversight of high risk disbursement will reduce the potential for fraud.

Impact: Reduced vulnerability to fraud.

We conducted this evaluation to determine whether adequate safeguards existed to detect or prevent irregular disbursements of Matured Endowment (ME) awards. The provisions of an endowment life insurance policy direct payment of the face amount to the insured after a certain term (e.g. 20 years) or age (e.g. age 65), or to the beneficiary upon the death of the insured. We reviewed 15,600 ME awards representing disbursements of $136 million and found there was a need for increased internal controls to monitor disbursement of computer generated ME awards.

The evaluation showed that 90 percent of ME awards were disbursed without sufficient oversight to detect or prevent irregularities. Although we did not identify any irregular disbursements, we noted 53 awards, valued at $571,000, that should be categorized as high risk and subjected to management oversight because of their potential vulnerability to fraud. We recommended installing computer software to identify high risk disbursements for review. The Under Secretary for Benefits concurred with our recommendation and provided an acceptable implementation plan. *(Evaluation of Controls Over Disbursements of ME Life Insurance Awards)*

3. LOAN GUARANTY PROGRAM FRAUD

Loan Origination Fraud

- In U.S. District Court, an accountant was convicted on charges of conspiracy, aiding and abetting, and defrauding the Government. The conviction was the result of a joint investigation by VA OIG, FBI, and the SSA-OIG, which disclosed that over a 3-year period, the individual and four co-conspirators engaged in a scheme to secure mortgages for individuals unable to qualify for loans through the normal mortgage process. The scheme involved submitting false documents and statements concerning the purchase of 26 VA owned properties. The individual, in his capacity as the accountant, falsified his clients' employment and credit histories on mortgage qualification documents. One of the co-conspirators has already executed a pre-trial diversion agreement requiring a payment of $12,000 in restitution. Efforts in locating the last two co-conspirators are ongoing. Loss to VA is in excess of $150,000.

- An individual who previously had pleaded guilty in U.S. District Court to charges of providing false information in the process of procuring a VA loan also has pleaded guilty in state court to two felony violations for possession with intent to distribute dangerous drugs and cultivation of controlled substances. This prosecution is the result of evidence seized during execution of Federal search warrants by VA OIG special agents. Included with evidence seized in connection with VA's loan fraud case were multiple kilograms of harvested marijuana and marijuana under cultivation.

- An individual acting in various capacities as president, owner or co-owner of realty, investment and service companies was sentenced in U.S. District Court to 60 months' confinement, 3 years' supervised probation, and to make restitution in the amount of $517,384 to VA, the Department of Housing and Urban Development (HUD) and a bank. In addition, the individual forfeited his personal holdings totaling more than $2 million. The sentencing followed a guilty plea in response to evidence developed during a joint VA, HUD, and FBI investigation, that disclosed the individual purchased low-cost distressed properties, cycled them through front companies to inflate their assessed value, and then sold them to fraudulently qualified applicants.

- An individual was sentenced to 10 months' imprisonment, 3 years' probation, and ordered to pay $31,794 in restitution to VA following an indictment in U. S. District Court on charges of making false statements and false representations. A joint VA OIG and U.S. Secret Service investigation revealed the individual had made false statements to VA regarding his employment, income, and social security number in order to qualify to purchase a VA foreclosed home.

- An individual pleaded guilty in U.S. District Court to a one-count information charging him with making a false statement to the Government. A VA OIG investigation revealed the individual, in

order to qualify for a VA guaranteed home mortgage through debt reduction, divested himself of, and then immediately re-acquired, personal property and provided VA only the documentation reflecting the divestiture. In addition, he had the new finance company delay the normal credit bureau reporting until after the home mortgage closing date. The mortgage is scheduled for foreclosure, with a potential loss to VA of $30,000. Sentencing is pending.

- A real estate sales broker who co-owned a realty company pleaded guilty in U.S. District Court to conspiracy to defraud the U.S., making false statements to VA, and using social security account numbers fraudulently. An investigation revealed the individual and co-conspirators attempted to obtain VA properties and financing under the Department's Vendee Loan Program by using the names and social security numbers of deceased persons and fictitious individuals as nominees and by submitting false and fraudulent financial documents designed to create the appearance that the nominee buyers were credit worthy. The real estate sales broker faces a maximum sentence of 5 years' imprisonment; sentence is pending.

- An individual pleaded guilty in U.S. District Court to one count of making a false statement and three counts of wire fraud. A VA OIG investigation revealed the individual owned a firm through which he fraudulently obtained titles to real property. A co-conspirator pleaded guilty to one count of tampering with a witness, a misdemeanor. The individual and the associate await sentencing.

Equity Skimming

- An individual was sentenced in U.S. District Court to 12 months' incarceration, 36 months' probation, ordered to pay a fine of $2,500 and to make restitution in the amount of $24,220 to VA. A joint investigation by VA OIG and HUD OIG revealed the individual assumed the home loans of VA guaranteed properties and HUD insured properties, and then collected rent money from tenants placed in the homes, while failing to make payments to the lenders. He filed 81 bankruptcies on these properties, using fictitious names, which stalled foreclosure and enabled him to continue collecting rent. Losses to VA and HUD totaled $171,000.

Surety Bond Fraud

- An attorney pleaded guilty in U.S. District Court to 1 count of making a false statement and 3 counts of wire fraud, in response to a 24-count indictment that charged him and two of his associates with violations of Federal statutes. A joint VA OIG and Department of Justice investigation disclosed the individual was part of a real estate development and investment syndicate that used fraudulently acquired titles to real property as collateral on personal surety bonds they issued to contractors doing work for the Government. Loss to the Government amounted to approximately $100,000 when contractors, who had obtained surety bonds from the individuals, defaulted on their contracts. Prosecution is pending on the attorney's two associates. Sentencing is pending.

Compensation Benefits Fraud

- An individual was sentenced in U.S. District Court to 46 months' imprisonment, 3 years' supervised probation, and ordered to pay restitution of $447,182 following his conviction on 40 counts of mail and wire fraud, and false statements. A joint VA OIG and FBI investigation revealed that, over a period of more than 10 years, the individual posed as a wheelchair-bound veteran who had lost the use of his right arm and right leg, collecting over $500,000 in compensation and other benefits from VA. Testimony provided by a number of witnesses during his trial established that he was not disabled and, in fact, ran a successful business painting homes and office buildings.

- An individual pleaded guilty in U.S. District Court to one count of making false statements and was sentenced to 6 months' home confinement, 5 years' probation, and ordered to make restitution to VA in the amount of $30,162. The individual was receiving VA service-connected benefits when he re-enlisted in the Army in 1994 and failed to notify VA of his re-enlistment. His failure to notify VA resulted in the fraudulent receipt of benefits to which he was not entitled.

Dependency and Indemnity Compensation (DIC) Benefits Fraud

- An individual was sentenced in U.S. District Court to 90 days' home confinement, 1-year probation and was ordered to pay $175,118 in restitution to VA. A VA OIG investigation revealed that the individual illegally diverted VA DIC funds directed to her deceased mother.

- A husband and wife were each sentenced in U.S. District Court to 60 months' supervised release and to pay $104,000 in restitution following their guilty pleas. A joint investigation conducted by the VA OIG, Air Force Office of Special Investigations, and United States Secret Service revealed that the individuals conspired to defraud the Government of $207,287 in VA DIC benefits and Air Force pension benefits paid to one individual's deceased mother.

- An individual was sentenced in U.S. District Court to 5 years' probation, 3 months' home confinement, and was ordered to make restitution to VA in the amount of $50,043. The individual previously was convicted on one count of theft of Government property. A VA OIG investigation determined that over a 5-year period, the individual fraudulently endorsed U.S. Treasury Checks representing DIC benefits payable to his deceased mother.

- An individual was sentenced in U. S. District Court to 8 months' incarceration, 36 months' supervised probation, and restitution of $14,035 following a guilty plea to one charge of credit card fraud. Evidence of the credit card fraud was disclosed during the execution of a Federal search warrant by VA OIG agents in connection with the investigation of a VA benefits fraud case involving the individual's spouse. A joint investigation by VA OIG, a state Employment Development Department, and the Postal Inspection Service resulted in charges being filed. The spouse previously was sentenced to 8 months' imprisonment, 3 years' probation, and ordered to pay restitution to VA in the amount of $47,225. In addition, the individual is subject to deportation proceedings because he is now classified as a felon for violating a fraud statute.

- An individual pleaded guilty in U.S. District Court to a four-count indictment charging her with wire fraud in connection with the theft of $83,680 in electronically deposited DIC benefits funds paid to her mother, the spouse of a deceased veteran. A VA OIG investigation revealed the individual, who had power of attorney over her mother's bank account, failed to notify VA or the bank of her mother's death in 1988, thereby causing VA to continue to deposit benefits payments into the account. The individual used the deposited funds for her own use. A sentencing date is pending.

- An individual pleaded guilty in U.S. District Court to a one-count information charging him with theft of public funds. A VA OIG investigation revealed that, over a 15-year period, the individual cashed his deceased mother's DIC checks. Loss to VA totaled more than $100,000.

- A former VAMC housekeeping aide was indicted by a Federal grand jury. The individual did not report his mother's death to VA; instead, he intercepted and cashed $86,511 in VA benefits checks that were intended for his mother. Prosecution is pending.

- An individual pleaded guilty in U.S. District Court to theft of Government property. The individual previously had been indicted on charges of receiving VA widow's benefits totaling $39,162 to which she was not entitled. The individual failed to notify VA of her remarriage, which would have terminated her entitlement to benefits. Sentencing is pending.

- An individual was indicted in U.S. District Court, charged with one count of theft and one count of submitting a false statement to the Government. The charges resulted from a VA OIG investigation which disclosed the individual submitted multiple eligibility verification reports to VA falsely stating she had not remarried since the death of her veteran husband. As a result, she received more than $21,000 in benefits to which she was not entitled.

Pension Benefits Fraud

- An individual pleaded guilty in U.S. District Court to a one-count criminal information charging him with theft of Government property. During a 4-year period, the individual, who was receiving benefit payments from VA under its Improved Pension Program, submitted fraudulent documents relating to his income and marital status. Subsequently, he failed to notify VA of changes to his financial situation, which rendered him ineligible to continue to receive benefits. Loss to VA is in excess of $30,000. Sentencing is pending.

- A former VA rating specialist at a VAMC and Regional Office pleaded guilty in U.S. District Court to one count of mail fraud. The individual had previously served as the Veteran Services Officer and was responsible for the operations of the entire Veterans Services Division. The individual had been indicted in U.S. District Court on one count of mail fraud. The indictment charged that the individual devised a scheme for obtaining VA benefits to which he was not entitled by making false representations to the Government.

Fiduciary Fraud

- An individual who previously pleaded guilty to misappropriation by a fiduciary was sentenced in U.S. District Court to 4 months' imprisonment, 4 months' home confinement with electronic monitoring, 3 years' supervised release, and ordered to pay restitution to the veteran involved in the

amount of $14,682. The individual converted, for her own personal use, funds belonging to a disabled and incompetent veteran for whom she was responsible and who was entrusted to her care.

- An individual pleaded guilty in U.S. District Court to embezzling VA benefits being paid to his grandmother, a widow of a disabled veteran. The individual was appointed as her fiduciary in 1990 and embezzled approximately $6,800 from his grandmother's account.

Educational Benefits Fraud

- The Civil Division of the U.S. Attorney's Office is continuing to obtain civil settlements from student veterans who received VA education benefits but did not attend regularly scheduled classes at a community college. Bribes were paid to faculty staff, including the Chairman of a department at the college, to ensure that high grades would be given with no class attendance required. Most recently, the Civil Division obtained additional settlement agreements in the amount of $249,363 from 14 students, for a total to date of 77 students who have agreed to pay a total of $1,261,400 in restitution. Negotiations are continuing with additional students.

FACILITIES MANAGEMENT

1. FACILITY CONTROLS OVER RESOURCES

Issue: Lease Administration

Conclusion: VA should ensure lease requirements are reasonable and provide lease management training for contracting officers.

Impact: Improved lease management.

We conducted an audit of VA Real Property Leased Space to determine whether leases were established economically and to evaluate the effectiveness of the lease administration process. We also reviewed VBA's leased space to determine if it was reduced commensurate with recent staffing reductions. VA had 654 leases with annual costs of $171 million as of March 1996.

Our review found that VHA and VBA generally established leases economically, administered leased space effectively, and reduced leased space when appropriate. VBA negotiated reduced rental rates when General Services Administration (GSA) billed for more space than VA actually occupied and when commercial rental rates declined. VBA also reduced space when the number of employees declined and established a goal of reducing annual rent expense by $8 million by FY 1999.

VHA is considering increasing the threshold for contracting officer approval of leases from $300,000 to $1 million. However, not all facilities have contracting officers with the proper lease training and experience. The audit also found that VA is paying GSA significantly more than the market rate for some leased space. In five cases, VA is paying $1.6 million more yearly than the current market value. We also found that many contract files did not contain adequate documentation to confirm that competition was solicited.

We recommended that management: (i) develop procedures to ensure that GSA rental rates are consistent with current fair market values and to appeal rates found to be significantly higher, (ii) curtail plans to increase contracting officer lease approval authorities, (iii) improve training for VAMC contracting officers, and (iv) improve documentation of the lease process in the lease files. The Under Secretary for Health agreed with our recommendations and provided acceptable implementation plans. *(Audit of Department of Veterans Affairs Leased Space)*

Issue: VA's Capital Asset Acquisition Practices and Efforts

Conclusion: VA is making good progress towards a comprehensive capital program. Policy is needed for VISN-level investments, and alternative capital funding strategies should be explored.

Impact: A more comprehensive capital program.

The evaluation assessed VA's capital asset acquisition practices and efforts to implement a capital programming process. In FY 1997, VA's capital investment totaled about $1.3 billion. Capital programming is defined as a comprehensive process for planning, budgeting, procuring, and managing

capital assets that include land, structures, equipment, intellectual property, and information technology hardware and software. Historically, VA has not had a comprehensive process. VA did not always consider alternatives to proposed acquisitions and did not use benefit-cost analysis to support decisions.

Recent VA initiatives, such as the establishment of the Capital Investment Board, were steps in the right direction. These efforts have focused on high cost, high risk investments that require VACO approval. To continue progress toward a comprehensive capital program, VA needed to address two issues. First, most capital investment decisions are now made at the VISN level, and existing policy does not specify to what extent capital programming principles and techniques should be applied to VISN-controlled investments. Second, VA's programming efforts have been hindered by a funding process that provides two major sources of funds for capital assets, the medical care appropriation and the construction appropriation. This process has resulted in the selection of more costly capital alternatives simply because funds were available in one appropriation and not in the other.

We recommended the Acting Assistant Secretary for Management and the Under Secretary for Health work together to: (a) develop policy on VISN-controlled capital investments, (b) provide VISN staff with technical guidance in performing benefit-cost analysis and other programming principles and methods, and (c) explore the feasibility of using alternative strategies for funding capital investments. Management concurred with the recommendations and provided acceptable implementation plans. *(Evaluation of VA Capital Programming Practices and Initiatives)*

Issue: Use of Prior Year (PY) Funds to Pay for Work on Nonrecurring Maintenance (NRM) Construction Projects

Conclusion: VAMCs need additional guidance to help ensure appropriate use of PY funds.

Impact: Better use of $3.8 million.

We conducted this audit to evaluate the effectiveness of management controls over the use of PY funds to pay for work on NRM construction projects. PY NRM funds are the residual unobligated funds remaining in an appropriation account at the end of a fiscal year, and are to be used only to pay for work within the scope of NRM project contracts. During the 4-year period FY 1993-1996, $45.9 million in PY funds were approved for use in NRM projects, an average of $11.5 million yearly. Review of 12 NRM projects at 4 VAMCs found that: (i) VAMCs were able to access and use PY funds without obtaining Office of Financial Policy (OFP) approval as required by VA policy; (ii) PY funds were used to pay for additional work that was outside the scope of the contracts in 11 of the 12 projects reviewed; and (iii) VAMCs incurred additional costs by using PY funds to address problems that could have been avoided or mitigated if the VAMCs had followed existing NRM project management guidance. We concluded that improving controls over the use of PY funds could reduce PY funds usage by over $3.8 million a year.

We recommended the Under Secretary for Health and the Acting Assistant Secretary for Management: (i) transfer responsibility for monitoring the use of PY funds from OFP to VHA, (ii) establish controls to ensure that VAMCs obtain approval to use PY funds and use PY funds only for work within the scope of contracts, (iii) provide detailed policy guidance on the use of PY funds to VAMCs, and (iv) provide training on the use of PY funds to VAMC staff. Management concurred with the recommendations and provided planned actions responsive to the recommendations. (*Audit of VAMC Use of PY Funds on NRM Construction Projects)*

2. NEW VARO BUILDING AT BAY PINES, FL

Issue: Structural framing design problems which became apparent during construction.

Conclusion: Architect/Engineering firm and its engineering subcontractor providing VA with structural plans that contained structural framing design errors.

Impact: Would the structural framing design, as modified, result in a building that safely met VA requirements?

In response to requests from former Secretary of Veterans Affairs, Jesse Brown, and from Congressman Bill Young, the OIG reviewed structural framing problems which became apparent during construction of the new VARO, Bay Pines, FL. The purpose of our review was to determine why these problems occurred, whether the design changes would result in a building that safely met VA requirements, and what it will cost to fix the structural framing problems.

The review determined the major cause of the structural design problems was due to a private Architect/Engineering (A&E) firm and its engineering subcontractor providing VA with structural plans for the project which contained structural framing design errors. Although VA communicated serious concerns about the quality of the structural designs during its oversight reviews, VA and the A&E firm did not adequately follow up on these concerns to ensure they were resolved before approving the plans for construction bidding. OIG hired a structural engineering consultant to assess the sufficiency of the structural framing design corrections. The consultant determined the structural framing design, as modified, would safely support VA's standard requirements for VARO buildings in all areas of the building except the mechanical rooms. However, the consultant determined the mechanical rooms' designs were more than adequate for their intended purpose because the equipment in them requires substantially less floor loading capacity than VA specifications require. In regard to the cost issues, the total direct and indirect costs associated with the structural design problems have not been determined. The engineering subcontractor to the A&E firm has reimbursed VA $706,000 to date.

We made recommendations to the Chief Facilities Management Officer, as appropriate, to address issues identified during our review. The Chief Facilities Management Officer concurred with all recommendations and provided implementation plans that meet the intent of all recommendations.

FINANCIAL MANAGEMENT

1. VA'S FINANCIAL STATEMENTS

Issue: VA's Consolidated Financial Statements (CFS) for FY 1997 and 1996

Conclusion: Report delayed due to expanded coverage and other factors.

Impact: Six audit projects were cancelled to reallocate staff to the Financial Statement Audit.

The completion of the audit of VA's FY 1997 CFS has been delayed due to several factors which expanded the workload associated with this year's audit. These factors include the following:

- The audit of the Governmentwide CFS has expanded the scope, depth, and staff hours necessary for auditing VA's statements.

- Weaknesses in VA's automated data processing controls detected during the audit has resulted in the OIG increasing our efforts to audit compensating controls identified by the Department.

- The new Federal Financial Accounting Standard, Accounting for Liabilities of the Federal Government (SFFAS No. 5), expanded the need for actuarial estimates of out-year veterans' compensation payments.

To complete the additional work required, the Office of Audit cancelled 6 audits to make staff available for the financial statement audit. These staff assignments will continue well into FY 1998.

2. OTHER FINANCIAL CONTROL ISSUES

Issue: Collection of Debts Owed VA

Conclusion: VA needs to improve debt collection.

Impact: Collection of debts totaling over $249 million.

In FY 1996, the Office of Audit initiated a multi-phase evaluation of VA's Debt Management Program. The purpose of the evaluation is to help VA management optimize their goals to prevent debts, improve debt collection results, and enhance operational efficiencies. At the beginning of FY 1997, debts owed to VA totaled about $4.2 billion. These debts represent potential revenues to the VA and/or the Treasury Department and include: defaults on VA loan guarantees ($1.4 billion), portfolio/direct loans for housing ($1.1 billion), unpaid medical care debts owed by veterans and third party insurers ($750 million), overpayment of veterans benefits ($600 million), and debts owed by other federal agencies ($400 million).

Through March 1998, audit of VA's debt management program focused on identification, prevention and recovery of overpayments of C&P benefits, and billing and collection of medical care owed by veterans and third party insurers. To date we have made recommendations to:

- Establish debts totaling approximately $53.2 million,
- Prevent new debts caused by benefit overpayments totaling $86.9 million annually,
- Enhance debt collection by about $103 million, and
- Streamline operations and achieve annual cost efficiencies totaling about $6.7 million.

Overall audit results to date identified monetary benefits totaling over $249 million. In addition to realizing significant monetary benefits, these audits identified opportunities to help enhance service to veterans by identifying benefit underpayments of about $14 million, and preventing the inappropriate billing or income verification of 14,000 veterans.

Issue: Medical Care Collection Fund (MCCF) Billing Practices and Collection Results

Conclusion: VAMCs could increase collections through use of collection tools developed by the MCCF Program Office, and by obtaining insurance data from veterans.

Impact: Enhanced revenues.

We conducted this review as part of our nation-wide audit of the MCCF Program, the purpose of which is to assess MCCF billing practices and collection results and to identify the best practices to enhance revenues. The MCCF program at VAMC Brockton/West Roxbury is considered a successful MCCF operation, with FY 1996 collections totaling over $7.9 million, 187 percent of their minimum goal. We evaluated a statistical sample of FY 1996 discharges at the VAMC and concluded that collections could be increased through use of collection tools developed by the MCCF Program Office, and by improved collection of insurance data from veterans, insuring all inpatient care is appropriately billed, and by following up timely on delinquent bills. Management officials took corrective action on the cases we identified. *(Evaluation of the Medical Care Cost Recovery, VAMC Brockton/West Roxbury, MA)*

EMPLOYEE INTEGRITY AND OTHER ISSUES

1. EMPLOYEE AND THIRD-PARTY INTEGRITY

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

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

Impact: Individuals are held accountable for illegal acts.

Employee Theft/Diversion of Pharmaceuticals

- After an extensive VA OIG undercover investigation, two registered pharmacists pleaded guilty in U.S. District Court to a criminal information charging them with numerous offenses, including conspiracy to commit theft, misbranding of pharmaceuticals, and tax evasion, relating to the pharmaceutical business they co-owned. Both individuals admitted in court that they purchased and resold more than $200,000 worth of pharmaceuticals they knew to be stolen from two VAMCs. Sentencing is pending.

- A VAMC pharmacy supervisor was terminated from his employment as a result of information developed by VA police. A VA OIG investigation revealed that, over a 2-year period, the pharmacist accessed a VA computer system; ordered drugs to be sent by mail in the names of inactive VA patients, and had them sent to his home address. A search warrant executed by VA OIG on the individual's residence resulted in the seizure of prescription pharmaceuticals, including controlled substances, prescribed in the names of VA patients.

- A former VAMC staff pharmacist was charged with five felony charges for diverting controlled drugs from a VA pharmacy, sentenced to 4 years' probation, and ordered to pay a special assessment of $500.

Theft and Embezzlement

- One former and two current VA employees pleaded guilty in U.S. District Court to the theft of Government property. The guilty pleas resulted from a 1-year undercover operation by special agents of the VA OIG with assistance from the FBI, VA Office of Administration, and VA Office of Security & Law Enforcement. The three employees were assigned to VACO as laborers and had unfettered access to VA equipment as part of their duties. During the course of the undercover operation, the three employees sold computers, printers, and furniture, among other items, to VA OIG undercover agents, with many of the items contained in their original delivery cartons. The value of the stolen property was approximately $40,000. As part of the plea agreements, the two current employees agreed to resign from Government service.

- A former VAMC biomedical engineering technician supervisor was sentenced to 24 months in prison, 3 years' probation, and ordered to pay $13,132 in restitution to VA. The sentence was the result of a guilty plea in U.S. District Court to one count of theft of Government property. A joint

VA OIG and FBI investigation revealed the individual stole VAMC medical equipment, which he pawned for cash, and also used a Government credit card to purchase personal items.

- A former VAMC chief of environmental services and her accomplice each pleaded guilty to one felony count of filing false claims, resulting from a 35-count indictment charging them with conspiracy, false claims, theft of Government funds, and money laundering. A joint VA OIG and FBI investigation revealed the service chief approved payments of VA funds in excess of $73,760 to a decorating business operated by the accomplice, who was living with her at the time, for services that were not rendered. The payments were kept at a level commensurate with the service chief's approval authority, in an effort to avoid scrutiny. Sentencing is pending.

- A husband and wife, both former VAMC medical ward clerks, were indicted in U.S. District Court on two counts each of credit card fraud. A joint VA OIG and Postal Inspection Service investigation revealed the husband stole pre-approved credit card applications from mail intended for hospital inpatients, accessed the hospital's records to obtain personal patient information, and filled out the applications. He stole the credit cards when they arrived in the mail and then used the cards to acquire cash and merchandise. The couple applied for 12 cards under the names of VA patients and obtained cash and merchandise totaling approximately $26,000. Special agents executed five search warrants on the home, automobiles, and persons named in the investigation. They were able to seize many of the items that had been fraudulently obtained.

- A former VAMC transportation employee was charged with theft of Government funds. A VA OIG investigation disclosed the employee stole a U.S. Government Fleet Services Credit Card and made unauthorized personal gasoline charges on the card totaling more than $4,500.

- A VAMC agent cashier was terminated following an indictment by a Federal grand jury on one count of theft of Government property for stealing approximately $23,000, while acting as agent cashier. A trial date is pending.

- An employee was terminated from his VA position of 14 years in response to evidence that he had embezzled at least $3,100 from the account of a VA Employees Association-sanctioned bowling league at the facility.

Acceptance of Bribes, Gratuities, and Conflicts of Interest

- An individual who served as an uncompensated VAMC employee and on the board-of-directors of the VAMC affiliated non-profit research corporation pleaded guilty to 16 counts of theft by taking, 11 counts of theft of services, 2 counts of false statements, and various charges relating to prescribing drugs. As part of the plea agreement, the individual will serve 5 years in prison, 10 years' probation, pay approximately $175,000 in fines and expenses, and $1.1 million in restitution and forfeitures. The offenses were committed in connection with drug research conducted while the individual was affiliated with a state medical college and the VAMC. The research monies received from pharmaceutical companies should have been remitted to the VAMC and the non-profit corporation to help pay the costs of laboratory services and staff salaries. Instead, the money went directly to the two individuals or shell companies established by them. The individual has agreed to disqualify himself from participating in future drug research and is awaiting trial.

- Two VAMC employees, one the foreman of the engineering service machine shop and the other the foreman of the environmental management service, admitted they had accepted bribes from a government contractor in return for contracts for tools, hardware, landscaping supplies, and services valued at approximately $37,000. They each pleaded guilty in U.S. District Court to a one-count criminal information charging conspiracy to accept unlawful gratuities from the contractor and his wife. A VA OIG investigation revealed that, over a 2-year period, the two accepted cash bribes as well as a chain saw. Each faces a maximum of 5 years in Federal prison, a fine, and an order of restitution at sentencing.

- An employee of a War Veterans Service Office at a VA Regional Office and Insurance Center has resigned from his position following a VA OIG investigation that disclosed that he had been taking money from veterans in return for assisting them with their VA claims. It is alleged the individual requested and received between $200 and $1,000 each from about 86 veterans over a 6-year period. The U.S. Attorney's Office is considering prosecution of this matter.

- A former VAMC psychologist was indicted in U.S. District Court concerning a scheme to defraud the Government in connection with the receipt of workers' compensation benefits. A VA OIG investigation determined that, for more than 13 years, the individual received workers' benefits in excess of $300,000 for a back injury alleged to have occurred while working at the VAMC. During this time, however, he was employed as a co-director of a psychotherapeutic evaluation program, an adjunct professor at a college, and a fiscal director of a school's transportation department. He also was self-employed as a psychologist. In order to avoid detection, he used his son's social security number. At the time of the individual's arrest preceding the indictment, search warrants were executed at the individual's residence and at a business operated by him. Both searches produced numerous documents reflecting employment during the period he was receiving benefits.

- A former VAMC laborer pleaded guilty in U.S. District court to one count of workers' compensation fraud. A VA OIG investigation disclosed the individual submitted false claims indicating an inability to work due to an on-the-job injury, while actually working at a convenience store. Loss to VA is in excess of $130,000. Sentencing is pending.

- An former VAMC pharmacy assistant pleaded guilty to a two-count criminal information charging her with one count of false statements to obtain federal employee's compensation and one count of use of a false social security number. A joint VA OIG and DOL OIG investigation revealed the individual was employed as a retail sales clerk while collecting workers' compensation and reporting no income to the DOL. Loss to VA was in excess of $52,000.

- A former VAMC electrician foreman paid $35,850 to satisfy a civil judgment against him in U.S. District Court. The individual previously pleaded guilty to submitting false statements to the Government purporting that he was unable to work due to an on-the-job injury. He also admitted that, while receiving Federal workers' compensation benefits, he was employed as a licensed electrician.

Employee Misconduct

- A former veterans benefits counselor, who had pleaded guilty to charges of bribery of a public official and tampering with a witness, was sentenced in U.S. District Court to 5 months' incarceration, 5 months' home detention, 36 months' supervised probation, and was ordered to perform 200 hours' community service in lieu of a fine and to make full restitution to the victims. A VA OIG investigation revealed that, while employed as benefits counselor, the individual solicited and accepted payments from widows of deceased veterans in order to expedite and process their VA benefits claims. He was removed from Government service during the course of this investigation.

- A certified VAMC registered nurse anesthetist was sentenced in state court to 2 years' probation, 21 days' incarceration, 100 hours' community service, and ordered to pay $1,200 probation fees following an earlier conviction for practicing medicine without a license. A joint investigation by VA OIG and local police disclosed that from 1993 to 1997, the individual took sick leave from the VAMC while operating a private clinic where she acted as a physician. As part of her sentence, she must make full restitution to all patients of the clinic who filed private insurance claims.

- A former VAMC nurse was found guilty in U.S. District Court of one count of making a bomb threat by telephone, a violation of Title 18, U.S.C. The individual was charged with having made the bomb threat to a particular building at the VAMC in which she had worked, in retaliation against co-workers who reported her as a suspect in numerous deaths. As a result of recurring bomb threats, patients were evacuated from the building which housed the intensive care unit. The individual was held without bail, and on suicide watch, pending a detention hearing. She had been previously held in home detention, but had attempted to remove the monitoring bracelet worn to track her whereabouts.

- An individual pleaded guilty in U.S. District Court to a charge of false statements stemming from the misrepresentation he made concerning the nature of a prior conviction when he applied for a position as a VAMC medical doctor in a psychiatric residency program. As a result of a plea agreement, he was sentenced to 42 months' imprisonment and waived his right to appeal. In 1985, he was convicted of aggravated assault arising from the non-lethal poisoning of his co-workers while employed as a paramedic. In his April 1993 application, he falsely represented that the assault conviction arose from a bar room brawl. He began his residency in July 1993.

- A former VAMC employee was indicted in U.S. District Court on charges of wire fraud and making false statements to VA relating to a fraudulent scheme to obtain salary payments from the VAMC. A VA OIG investigation revealed the individual submitted fraudulent credentials in order to obtain his original appointment as a VAMC staff nurse, and periodically updated those false credentials during his appointment there. He falsely stated he had been a registered nurse in Puerto Rico and received a bachelor's degree in nursing. As a result of the false information the individual provided, he was promoted to nursing care coordinator. He also had applied for the position of VAMC medical care manager, stating that he had a master's degree and that he was certified as a critical care nurse. The investigation into his credentials revealed there is no record of his ever having been licensed as an nurse or even having received a bachelor's or master's degree, and that he is not a certified critical care nurse.

- The U.S. Attorney's Office filed a criminal information in U.S. District Court charging a VAMC histopathology technician with one count each of conspiracy and falsely preparing Federal income

tax returns. The information was filed as a result of a joint VA OIG, IRS, and U.S. DOL investigation into allegations of tax preparation fraud and union embezzlement on the part of VA employees at the VAMC. The individual allegedly conspired to embezzle funds from an American Federation of Government Employees local union, resulting in violations of various statutes including mail fraud, making false statements and concealing material facts from the DOL. It is also alleged that he and another VA employee prepared fraudulent Federal income tax returns for VA employees at an office he established adjacent to the morgue inside the VAMC.

- A VAMC mail center supervisory clerk was arrested by VA OIG special agents on an outstanding arrest warrant related to a felony forgery violation. The outstanding warrant was discovered during the course of a joint investigation conducted by VA OIG and VAMC police into suspected mail center theft.

Drug Trafficking

- An individual was sentenced in U.S. District Court to 12 months in a halfway house and 36 months' probation. The individual, a VA employee and one of two defendants, sold heroin to an undercover agent at a VAMC. Both were arrested by VA OIG and Drug Enforcement Administration agents. At an earlier court appearance, the individual had pleaded guilty to possession with intent to distribute controlled substances.

- An individual pleaded guilty in state court to one count of a three-count indictment charging him with distribution of a controlled dangerous substance in and near a VAMC. The individual was sentenced to 10 years' incarceration with 8 years' suspended, and 3 years' probation upon release from prison. A joint investigation by VA OIG special agents and local police revealed the individual regularly sold drugs on and near the property of the VAMC. The individual also was identified as a heroin distributor who subsequently sold heroin to a VA undercover agent.

Other Criminal Activity

- An individual who volunteered at a VAMC was arrested by special agents of the VA OIG and the Specialized Investigations Regional Task Force (SIRTF) pursuant to a warrant issued charging him with sodomy in the third degree. A joint VA OIG, VA police, and SIRTF investigation determined the individual repeatedly had sodomized an emotionally disturbed individual in the men's room at the VAMC. The individual confessed to the crime and his arraignment is pending.

2. FORENSIC DOCUMENT LABORATORY

Issue: Documents Continue to Play an Important Role in Fraud

Conclusion: State-of-the-Art techniques aid investigators.

Impact: OIG Forensic Laboratory plays critical role in assisting VA.

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 513 documents from various non-OIG sources that required 1,522 laboratory examinations. The laboratory received 614 additional pieces of evidence in 5 OIG criminal investigations, which required 1,303 laboratory examinations. There were a total of 40 laboratory reports issued during the period covered by this report.

LABORATORY CASES FOR THE PERIOD	
REQUESTER	**CASES COMPLETED**
OIG Office of Investigations	5
Regional Offices	29
VA Top Management	6
TOTAL	**40**

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

- Court exhibits and testimony were provided in the trial of a former VAMC registered nurse. Laboratory examinations identified the nurse as the author of signatures on documents used to purchase electronic devices that she used to alter her voice in bomb threats made to the VAMC. The jury found the registered nurse guilty of making bomb threats by telephone. She is awaiting sentencing.

- In one of five similar cases, a veteran submitted medical records in support of his benefit claim. The records were examined to determine if they were executed on the dates appearing on the records. It was determined that the medical records were fraudulent utilizing ink, typewriter, and handwriting examinations. Based upon the laboratory results, the VARO proposed forfeiture of VA benefits.

- Testimony and laboratory exhibits were provided in a U.S. Merit Systems Protection Board hearing pertaining to an investigation conducted by the VA Office of Security and Law Enforcement. An individual authorized the creation of fraudulent identification cards and badges for himself and two other individuals for personal use. The employment of all individuals was terminated based upon the investigation and laboratory results. One individual appealed his termination, which required the VA OIG forensic examiner to testify in this case. The Board upheld the termination of the individual.

- A joint investigation was conducted by VA OIG and HUD OIG of two individuals involved in loan and bankruptcy fraud. The investigation disclosed that titles to 10 VA and HUD properties had been obtained through the use of fictitious names. Over 60 bankruptcies relative to these properties had been filed. Laboratory examinations identified the individuals responsible for the creation of the fraudulent documents. Both individuals were indicted and pleaded guilty to charges of equity skimming and bankruptcy.

Issue: Special Inquiries of Alleged Employee Misconduct or Mismanagement

Conclusion: Various conditions were substantiated, and willful misconduct or mismanagement was at times disclosed.

Impact: Reimbursements, fines, administrative sanctions, and other corrective actions

During the period, we issued 12 reports, that are summarized in the following paragraphs:

- A special inquiry substantiated a physician directed research funds to certain VAMC employees in the form of supplements to their VA salaries. We found that, contrary to Federal law, four employees received a total of $62,459 from a pharmaceuticals company for performing official duties, and that the principal researcher on projects funded by the company directed the company to make these payments. Subsequent to the U.S. Attorney's office declining criminal prosecution on the matter, we recommended that appropriate action be taken against the physician and three of the four VAMC employees still employed. Management planned to take action responsive to the recommendation.

- Another special inquiry found that over 5 years, an employee at a VA facility verbally harassed, intimidated, and was generally abusive and threatening to a number of employees. We identified 13 instances of misconduct, 4 of which involved improper comments of a sexual nature made to female employees. The former Director and Associate Director did not effectively confront the employee's performance problems, which led to staff perceptions that management would not resolve harassment complaints. Based on this review, actions were taken with respect to the employee's misconduct and local manager's inaction.

- A special inquiry found a senior official used insulting and obscene language in conversations about employees under his authority. The senior official admitted to "talking trash [sex]" with those who broached such subjects. The official discussed rumors, personal relationships, and engaged in sexually oriented conversations which did not evidence the courtesy and respect expected among VA employees. The senior official's supervisor concurred with the findings and agreed to take appropriate administrative action.

- Special inquiry staff reviewed 34 allegations received from various sources at one VA facility and found that most of the allegations were not substantiated. However, based on a sampling of staff, we concluded that the senior official's management style and actions warranted his supervisor's attention. We also found that the facility purchased photographic prints totaling $104,316 on a sole source basis without seeking competition as prescribed by VA procurement procedures. There was also a perception among employees who did not support senior management that higher graded positions at the facility were generally filled on a non-competitive basis and that higher graded positions were reclassified to the benefit of staff who were perceived to be in a "inner circle." The Acting Network Director was taking corrective actions.

- Another review found that a senior official used his Government position to accrue over 1.3 million frequent flyer miles while traveling for the VA, and converted them into free airline tickets and upgrades for his personal use and the use of his family. The official also did not follow certain travel regulations and did not restrict the use of his Government credit card to only official purchases. The Chief Network Officer decided not to recertify the senior official who exercised his option to take an early retirement. We were told the General Counsel is preparing guidance on the use of frequent flyer benefits for distribution to all field facilities. The U.S. Attorney and the senior official entered into a plea agreement. The official pled guilty to a misdemeanor violation of Title 18, U. S. C., Section 641, agreed to restitution for the loss to the Government totaling $10,824, was fined $1,000, and agreed to serve 200 hours of community service.

- The U.S. General Accounting Office brought two potential violations to our attention. The special inquiry substantiated that, in both instances, the recipients did not repay their buyouts when they were re-employed by a VAMC. VA is taking action to enhance official's awareness of the buyout requirements.

- A special inquiry substantiated that three VA officials accepted (and, in one case, solicited) a gift of football game tickets from an organization seeking to do business with VA, in violation of the ethical conduct standards. We recommended that the three officials reimburse the organization the full market value of the tickets each received, and that appropriate administrative action be taken against them. The Deputy Under Secretary for Health planned to take responsive action.

- Special inquiry staff requested phone logs and other information to respond to allegations that a senior program official inappropriately used a Government cellular telephone and a Government calling charge card for unauthorized purposes. Program officials assisted us in substantiating the allegations. VA initiated collection efforts and appropriate administrative action.

- In another special inquiry case concerning several senior managers, we found minor misuse of the phone system. Actions were taken by the supervisors to resolve the conditions identified.

- Another special inquiry report found that a mid-level manager was subjected to a prohibited personnel practice when he was not promoted into a position he was selected for in a timely manner. The VA Office of Human Resources Management concurred the employee was entitled to a retroactive promotion and other associated benefits back to his classified position in May 1995.

- We also reported an employee inappropriately filed a false travel claim when he received approval to change his duty station. The employee claimed travel for a spouse and her two children, but the employee was not legally married.

- In response to an allegation that a widow was fraudulently receiving Dependency and Indemnity Compensation benefits, we confirmed with the assistance of the VARO that the recipient remarried and was no longer entitled to the benefits. The award was terminated retroactively to January 1997, and an overpayment was established.

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 5 days a week, Monday through Friday, from 5 AM to 10 PM Eastern Time, 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

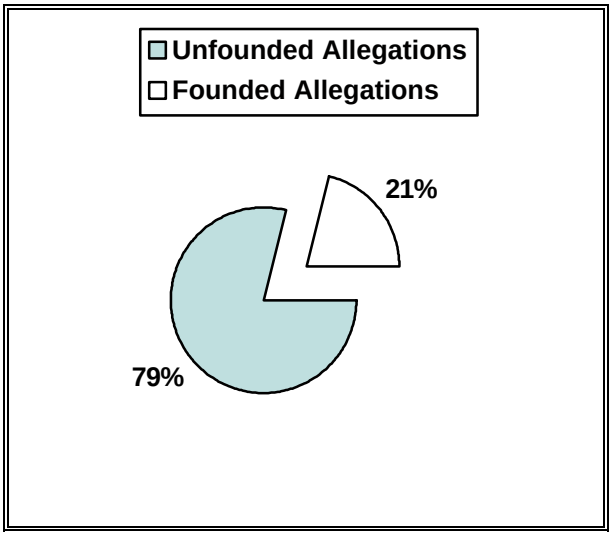
During the period, the Hotline Section received 10,137 contacts, with 401 cases opened and referred, and 284 cases closed, as follows:

HOTLINE WORKLOAD	
Total Contacts	**10,137**
Cases opened and referred*	**401**
OIG Audit	1
OIG Investigations	12
OIG Hotline and Special Inquiries	4
OIG Healthcare Inspections	25
Other OIG	2
VA Program Managers	358
Cases closed	**284**

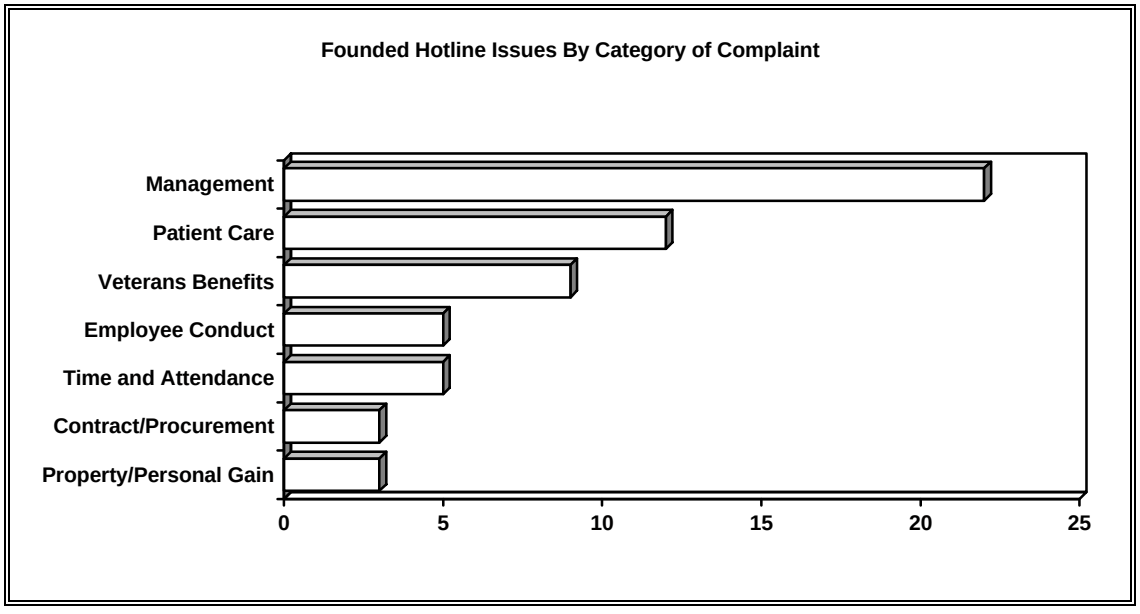
* Some cases referred to more than one office.

2. FOUNDED ALLEGATIONS

Of the 284 cases closed during this period, 59 cases (21 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, patient care, veterans benefits, employee conduct, time and attendance, contract/procurement irregularities, and property and personal gain. The following table illustrates the number of complaints by category for the founded allegations.



As a result of these reviews, VHA managers imposed 32 administrative sanctions (e.g. counselings, admonishments, reassignments, and terminations) against employees during this reporting period. A total of $125,387 in monetary improprieties (questioned costs or potential recoveries) were also identified. Following are examples of allegations that were founded for each of the categories listed on the preceding table.

Management

- A review substantiated the Merit Promotion Policy on the seven-calendar day posting requirement was not followed. The review also substantiated that the Human Resources Management (HRM) Section did not have a consistent procedure for screening or paneling regarding required documents and validation of the screening process. The review also found that 47 qualification determination documents for a job opportunity announcement were deficient and required correction. However, these deficiencies did not impact on the selection. Based on the review, it was recommended that HRM policy and orientation be developed to comply with all aspects of the policy, and that the HRM staff correct the qualification documents for the job opportunity announcement.

Patient Care

- A review substantiated allegations that an Eye Clinic employee was conducting personal business while scheduled patients were waiting long periods of time for treatment. Management disciplined the employee.

Veterans Benefits

- A review disclosed that a veteran worked at a VAMC under a different name and continued to receive VA disability pension benefits. The veteran did not respond to the due process letter sent by the VARO, therefore, action was taken to establish a $6,950 overpayment.

Employee Conduct

- A review substantiated allegations of inappropriate conduct by senior management official. It was disclosed that in spite of the fact the manager was provoked, the behavior was not appropriate for a VAMC official. The manager recognized his actions were not appropriate and received a verbal counseling.

- A review substantiated the allegation that fifteen employees of the Acquisition and Materiel Management service were involved in a football pool. All of the employees were verbally counseled, and periodic reminders will be made to reinforce the policy in this regard.

- A review substantiated two police officers attending 5 days of formal instruction did not attend the final day. The two officers were verbally counseled and charged annual leave for the time they were absent.

Time and Attendance

- A VAMC Administrative Board of Investigation substantiated a service chief: (i) failed to keep proper service staff records for three years of annual and sick leave; (ii) failed to keep proper annual leave records for himself; (iii) failed to request and obtain prior approval from the Chief of Staff for leave to attend seven conferences; (iv) performed research studies on VA premises without proper approval; (v) supplemented the salary of a VA employee with funds from a corporation in violation of 18 U.S.C.; and (vi) directed a VA employee to perform work other than official VA business on VA property and with VA resources in violation of 5 C.F.R. The service chief was reassigned to the position of staff physician and was later given a 30-day suspension from duty and pay.

Contract/Procurement

- A review substantiated allegations that some errors occurred in the contract actions for ambulance service at two VAMC's. Both medical centers have reported appropriate actions have taken place to correct deficiencies since the original contract award.

Property and Personal Gain

- A review, substantiated that a VA employee received gifts from a fee basis physician. It was determined that the gifts were of nominal value and receipt did not violate the ban on receiving gifts. There was no evidence presented that the employee violated ethical conduct rules for an executive branch employee. The investigators did find a limited understanding of the ethical guidelines on the part of the employees interviewed. To avoid the appearance of impropriety, Medical Administration Service employees will receive additional training concerning the acceptance of gifts and ethical behavior rules for executive branch employees. The VAMC Chief of Staff will discuss, with fee basis physicians, VA regulations concerning what constitutes an acceptable courtesy gift to VA employees on appropriate occasions.

PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY (PCIE)

Inspections and Evaluation (I&E) Roundtable

The Assistant Inspector General (AIG) for Healthcare Inspections, has been instrumental in moving the PCIE Inspections and Evaluation (I&E) Roundtable to a point of developing education and training needs and opportunities that will address core skills development for the I&E community. The Deputy AIG/Healthcare Inspections serves as co-chairman of the I&E Roundtable's Education and Training Subcommittee.

Federal Audit Executive Council (FAEC)

The AIG for Auditing was elected Chairperson of the FAEC for 1998. 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. In addition, the AIG represents federal audit principals as a member of the PCIE Audit Committee. Also, the OIG audit staff participated in a FAEC Benchmarking Working Group. The Working Group developed a database

of prior audits and evaluations completed by the Federal audit community that used some form of benchmarking. The database is located in the Benchmarking section of the IGNet "FAEC" page.

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, 49 legislative and 40 regulatory proposals were reviewed and commented on, as appropriate.

OIG MANAGEMENT PRESENTATIONS

Participation in VHA's Non-VA Provided Care Task Force

The OIG audit staff participated in the VHA Chief Financial Officer's task force on "Non-VA Provided Care". The goal of the task force is to document the "as is" state of available data and to develop relevant information on non-VA provided care. As a stakeholder, we contributed information on existing and needed data elements as they related to CHAMPVA, Fee-Basis, and the IMPAC programs.

Presentation at Medical Care Cost Recovery (MCCR) Conference

VA OIG staff participated in the MCCR National Conference held in Denver, CO, with a presentation by an Office of Audit project manager on the OIG's perspectives concerning the MCCR program.

Presentations at Association of Government Accountants (AGA) Conference

The Director of our Kansas City Operations Division conducted a seminar on "Fraud Detection" at the Dallas/FT Worth AGA Professional Development Conference. The seminar included discussions about the environment for fraud and included practical exercises in identifying fraud indicators. The Director also conducted a seminar on electronic workpapers to the Boston Chapter of AGA. The presentation discussed the pilot test of an electronic workpaper system developed by his office. A similar presentation was provided to the Northeast Intergovernmental Audit Forum held in Hyannis, MA.

OIG CONGRESSIONAL TESTIMONY

In October 1997, the Deputy Inspector General testified before the House Veterans' Affairs Oversight and Investigations Subcommittee at a hearing on the results of two Special Inquiry Reports, January 10, 1997, "Alleged Mismanagement of the Housekeeping Quarters at University Drive, VAMC Pittsburgh, PA," and "Alleged Mismanagement at the Ralph H. Johnson VAMC Charleston, SC," and other related matters. The testimony addressed the results and recommendations of allegations of mismanagement against senior officials at both VA facilities.

In October 1997, and again in March 1998, the Assistant Inspector General for Healthcare Inspections testified before the House Veterans' Affairs Committee's Subcommittee on Health and Hospitals about the status of health care quality assurance programs, and the adequacy of quality assurance policies, in VHA. The testimony addressed various aspects of VHA's continually evolving quality management programs, and the need for VHA managers to develop or revise quality management policies to address patient care and patient safety issues as they occur, or as circumstances change. The testimony addressed the Office of Healthcare Inspections involvement with VHA top managers in developing, clarifying, and revising quality management policies that must be maintained in order to provide proper, clear guidance to field facilities and VISNs in a decentralized management environment.

FREEDOM OF INFORMATION/PRIVACY ACT/OTHER DISCLOSURE ACTIVITIES

During this reporting period, we processed 106 requests under the Freedom of Information and Privacy Acts and released 222 audit, investigative, and other OIG reports. In three instances we had no records. We totally denied one request under the appropriate exemptions of the Acts. Information was partially withheld in 62 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, 7 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 March 31, 1998, the Department had no unresolved internal OIG recommendation, 279 unimplemented internal OIG recommendations, and 74 unresolved OIG contract review 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 March 31, 1998. 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 October 1, 1997 – March 31, 1998. 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 March 31, 1998, 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	39
	Contract Audit	39	
Less Than 6 Months	Internal Audit	0	42
	Contract Audit	42	
TOTAL			**81**

Tables 2 through 5 show a total of 67 reports that were unresolved as of March 31, 1998 - no internal audit reports and 67 contract (postaward and preaward) audit reports. This number differs from the 81 reports shown above because tables 2 through 5 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 9/30/97	3	$ 4.5
Issued during reporting period	6	$ 7.0
Total Inventory This Period	**9**	**$ 11.5**
Management decision during reporting period		
Disallowed costs	6	$ 8.4
Allowed costs	0	$ 0.0
Total Management Decisions This Period	**6[1]**	**$ 8.4**
Total Carried Over to Next Period	**3[2]**	**$ 5.5[3]**

[1] Of the 6 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 3/31/98, with a dollar value of $3.8 million.

[3] The beginning inventory amount ($11.5 million) minus the management decision amount ($8.4 million) does not equal the carryover amount ($5.5 million) because of a $2.4 million questioned cost increase during the period on a report issued in a prior period.

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 9/30/97	0	$ 0
Issued during reporting period	6	$ 1.7
Total Inventory This Period	**6**	**$ 1.7**
Management decisions during reporting period		
Disallowed costs	6	$ 1.7
Allowed costs	0	$ 0
Total Management Decisions This Period	**6**	**$ 1.7**
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 9/30/97	0	$ 0
Issued during reporting period	6	$ 95.8
Total Inventory This Period	**6**	**$ 95.8**
Management decisions during reporting period		
Agreed to by management	6	$ 95.8
Not agreed to by management	0	$ 0
Total Management Decisions This Period	**6**	**$ 95.8**
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 9/30/97	42	$102.8
Issued during reporting period	35	$219.5
Total Inventory This Period	**77**	**$322.3**
Management decisions during reporting period		
Agreed to by management	6	$ 1.5
Not agreed to by management	6	$ 1.0
Total Management Decisions This Period	**12[1]**	**$ 2.5**
Total Carried Over to Next Period	**65[2]**	**$319.8**

[1] Of the 12 reports with recommended funds to be put to better use, management fully agreed with the recommended cost reductions for 3 reports, partially agreed with reductions for 7 reports, and did not agree with the cost reductions on 2 reports.

[2] Of the 65 reports carried over, a management decision had not been made for over 6 months on 35 reports with a dollar value of $100.6 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 1998 is $42.7 billion. Full-time equivalent (FTE) employment for the year is 205,931. 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, based on the FY 1998 current estimates reflected in the FY 1999 Presidential Budget.

VETERANS BENEFITS ADMINISTRATION (VBA)

To provide benefits in FY 1998, VBA maintains 58 regional offices and 2 insurance centers.

Compensation for service-connected disabilities and death

2.6 million veterans and survivors will receive continuing benefits valued at about $17.4 billion.

Pensions for income maintenance of veterans and survivors

.7 million veterans and survivors will receive continuing benefits valued at about $3.1 billion.

Education and training assistance

Approximately 480,000 trainees will receive education and training assistance payments valued at about $1.5 billion.

Housing and other credit assistance

VA will grant about 240,000 home loans valued at approximately $24.8 billion.

Veterans' and servicemens' life insurance

The 4.8 million policies in force in VA life insurance programs have a total face value of about $480 billion.

VETERANS HEALTH ADMINISTRATION (VHA)

To provide medical care in FY 1998, VHA maintains 172 hospitals, 602 outpatient clinics (includes independent, satellite, community-based, and rural outreach clinics), 40 domiciliaries, and 132 nursing home units.

Hospitals, medical, dental, and outpatient care

The average daily census for inpatient facility care is expected to be 63,446. The locations of the patients are shown in the table.

Also, there will be approximately 35.1 million outpatient visits.

LOCATIONS	PATIENTS
Acute hospital care	8,523
Rehabilitative care	1,154
Psychiatric care	6,424
Nursing home care	34,088
Subacute care	3,118
Residential care	10,139
TOTAL INPATIENT CARE	**63,446**

Medical and prosthetic research

The research appropriation is $272 million.

NATIONAL CEMETERY SYSTEM (NCS)

To provide interment services in FY 1998, the NCS operates 115 cemeteries and 34 other sites.

There will be approximately 76,200 interments in national cemeteries and 332,000 headstones or markers will be 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 1998 funding for OIG operations is $33.4 million, with $31 million from appropriations and $2.4 million through reimbursable agreements. Approximately 85 percent of the total funding is for personnel salaries and benefits, 5 percent for official travel, and the remaining 10 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

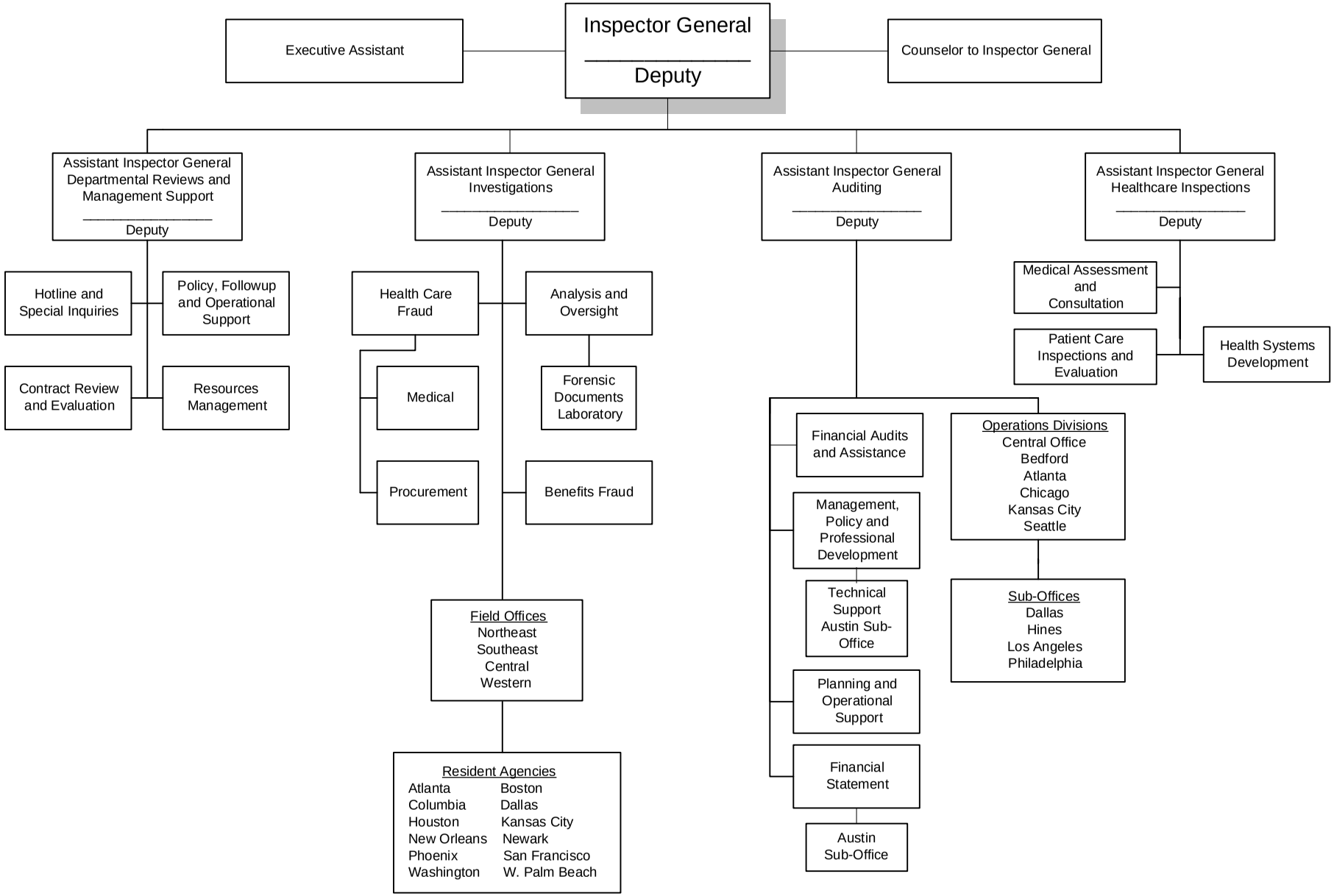
Staffing

The OIG average employment estimate for FY 1998 is 343 FTE. Employees on board as of March 31, 1998, and the distribution:

OFFICE	PERSONS EMPLOYED
Inspector General's Office	4
Office of Counselor to IG	4
Office of Investigations	66
Office of Audit	169
Office of Departmental Reviews and Management Support	56
Office of Healthcare Inspections	19
TOTAL	**318**

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	Management	Questioned Costs
INTERNAL AUDITS				
8R5D05004 10/8/97	Audit of Department of Veterans Affairs Leased Space	$6,000	$6,000	$1,641,389
8R8D04013 10/10/97	Audit of VA Medical Center Use of Prior Year Funds for Nonrecurring Maintenance Construction Projects	$3,810,000	$3,810,000	
8R4A01032 10/27/97	Audit of Allegations Concerning a Research Physician at Edward Hines, Jr. Veterans Hospital Hines, IL			$7,483
8R5B01039 11/17/97	Follow-Up Audit of the Assessment of Service-Connected Disability Determinations			
8R5E02046 12/5/97	Audit of Sole Source Contracts VA Medical Center Las Vegas, NV			
8R4A01048 12/31/97	Audit of Veterans Health Administration Medical Care Usage Patterns and Availability of Resources			
8R8A08054 12/31/97	Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs	$4,493,229	*	
8D2E01002 1/22/98	Audit of VA Procurement Initiatives for Computer Hardware, Software, and Services (PCHS/PAIRS) and Selected Information Technology Investments	$58,000,000	$58,000,000	
8R4B01069 2/6/98	Audit of Veterans Benefits Administration SSA/VA Death Match Procedures	$3,964,234	$3,964,234	
8R3A01085 3/25/98	Audit of Pathology and Laboratory Medicine Service's Laboratory Management Index Program (LMIP)			
8R4E01092 3/31/98	Audit of VA's Pharmaceutical Prime Vendor Program			

* Management did not provide an alternative estimate.

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
OTHER OFFICE OF AUDIT REVIEWS				
8R1G01008 10/3/97	Evaluation of Medical Care Cost Recovery Program, VA Medical Center Brockton/W. Roxbury, MA			
8R4A07027 10/20/97	Review of Multi-State Nursing Home Contracts			
8R1B12036 10/31/97	Evaluation of Premium Payment and Reporting Procedures for the Servicemembers' Group Life Insurance Program			
8D2B01001 12/9/97	Summary Report on VA Claims Processing Issues			
8R1B12056 1/16/98	Evaluation of Controls Over Disbursements of Matured Endowment Life Insurance Awards			
8R8A19061 1/28/98	Evaluation of VA Capital Programming Practices and Initiatives			
8R1B01083 3/24/98	Evaluation of the Effectiveness of Veterans Benefits Administration's Controls to Detect and Prevent Compensation and Pension Benefit Payment Errors	$25,531,991	*$19,487,635	
SPECIAL INQUIRY				
8PRA99003 10/3/97	Alleged Inaction by Management to Resolve Sexual Harassment Complaints VA Medical Center Grand Island, NE			
8PRA19040 12/2/97	Management Practices and Other Issues at the Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, HI			
8PRA19045 12/23/97	Alleged Receipt of Improper Salary Supplements, Department of Veterans Affairs, Edward Hines Junior Hospital Hines, IL			
8PRA03058 1/14/98	Hotline Inquiry Into an Alleged False Travel Claim by an Employee at the VA Medical Center Decatur, GA			$9,283
8PRG02065 2/13/98	Alleged Prohibited Personnel Action at the Harry S. Truman Veterans Memorial Hospital, Columbia, MO			

* Management disagreed with OIG estimate.

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
SPECIAL INQUIRY (Cont)				
8PRB18071 2/13/98	Alleged Misuse of Government Resources by a Senior VBA Official			$291
8PRA99076 3/6/98	Conduct Issue Concerning a Veterans Health Administration Program Official in VA Central Office, Washington, DC			
8PRG07079 3/9/98	Alleged Mismanagement and Misuse of the Federal Telephone System by VHA Officials			
8PRF03077 3/16/98	Alleged Violations of the Federal Workforce Restructuring Act of 1994 by Department of Veterans Affairs Employees			
8PRG03078 3/16/98	Alleged Misconduct and Misuse of Resources Emergency Management Strategic Healthcare Group VA Martinsburg, WY			
8PRF05057 3/25/98	Use of Government Earned Frequent Flyer Miles by a Senior Official at the Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, HI			$10,824
8PRB01087 3/25/98	Hotline Inquiry Into the Alleged Fraudulent Receipt of Dependency and Indemnity Compensation Benefits			$4,998
HEALTHCARE INSPECTIONS				
8HIA28017 10/9/97	Quality Program Assistance Review, VA Medical Center Iowa City, IA			
8HIA28018 10/27/97	Inspection of Selected Clinical and Administrative Issues, Department of Veterans Affairs Medical Center Lake City, FL			
8HIA28035 11/3/97	Oversight Review of the Veterans Health Administration's Use of Advanced Practice Nurses in Primary Care			
8HIA28031 11/5/97	Inspection of Alleged Inappropriate Proposed Extended Care Discharge Department of Veterans Affairs Medical and Regional Office Center Cheyenne, WY			
8HIA28042 11/18/97	Quality Program Assistance Review, Department of Veterans Affairs Medical Center Dublin, GA			

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont)				
8HIA28047 12/10/97	Quality Program Assistance Review VA Medical Center Loma Linda, CA			
8HIA28051 12/29/97	Quality Program Assistance Review VA Medical Center Tucson, AZ			
8HIA28041 1/16/98	Inspection of Alleged Inappropriate Patient Care and Misdiagnosis of a Patient's Illness, Department of Veterans Affairs Medical Center Northampton, MA			
8HIA28060 1/29/98	Followup Inspection of Selected Clinical and Administrative Issues on Anesthesiology Service, Hunter Holmes McGuire VA Medical Center Richmond, VA			
8HIA28069 2/4/98	Review of Veterans Health Administration's National Customer Feedback Center, Department of Veterans Affairs Medical Center West Roxbury, MA			
8HIA28072 2/17/98	Quality Management in the Department of Veterans Affairs, Veterans Health Administration			
8HIF03073 2/23/98	Quality Program Assistance Review, Department of Veterans Affairs Medical Center Lexington, KY			
8HIA28075 2/23/98	Inspection of Alleged Patient Neglect and Inadequate Care, Department of Veterans Affairs Medical Center Syracuse, NY			
8HIA28080 3/9/98	Inspection of Alleged Patient Sexual Molestation by a Physician at a VA Outpatient Clinic			
8HIA28090 3/26/98	Inspection of Alleged Mismanagement of a Nursing Home Patient's Discharge, Department of Veterans Affairs Medical Center Biloxi, MS			
8HIA28091 3/26/98	Inspection of Alleged Improper Leg Ulcer Treatment, Jerry L. Pettis Memorial Veterans Hospital Loma Linda, CA			

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS				
8PEE02005 10/2/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Ortho Biotech, Inc., Piscataway, NJ		*	
8PEE02006 10/2/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Roxane Laboratories, Inc., Columbus, OH	$3,684,555		
8PEE02007 10/2/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Hoechst Marion Roussel, Inc., Kansas City, KS			
8PEE02012 10/8/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Alcon Laboratories, Inc., Forth Worth, TX			
8PEE02009 10/9/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Bristol Myers Squibb, Oncology Division, Princeton, NJ	$723,320		
8PEE02010 10/9/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Ortho McNeil Pharmaceutical, Piscataway, NJ			
8PEE02011 10/9/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Nycomed, Inc., Princeton, NJ	$2,702,463		
8PEE02014 10/9/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Bristol Myers Squibb, Primary Care Division, Princeton, NJ	$7,538,677		
8PEE02021 10/16/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefield, CT	$7,893,240		
8PEE02024 10/17/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Schering Corporation, Union, NJ	$92,037,146		
8PEE02015 10/20/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Ortho Pharmaceutical Corporation, Raritan, NJ	$17,084,449		

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

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont)				
8PEE02022 10/20/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Bracco Diagnostics, Inc., Princeton, NJ	$1,512,098		
8PEE02025 10/20/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Zeneca Pharmaceuticals, Wilmington, DE			
8PEE02020 10/21/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Fujisawa USA Inc., Deerfield, IL			
8PEE02028 10/21/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Teva Pharmaceuticals USA, Sellersville, Pa	$4,144,520		
8PEE02029 10/21/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) SmithKline Beecham, Philadelphia, PA	$1,266,297		
8PEE02030 10/21/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Abbott Laboratories Pharmaceutical Products Division, Abbott Park, IL			
8PEE02016 10/22/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Eli Lilly and Company, Indianapolis, IN			
8PEE02026 10/30/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Novartis Pharmaceuticals Corporation, East Hanover, NJ	$7,869,022		
8PEE02033 11/4/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Rugby Laboratories, Inc., Norcross, GA			
8PEE02037 11/5/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Glaxo-Wellcome, Triangle Park, NC	$41,002,848		
8PEE02038 11/5/97	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) Abbott Laboratories Hospital Products Division, Abbott Park, IL	$5,932,784		

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont)				
8PEE09043 11/26/97	Audit of Equitable Adjustment Claim Submitted by American Imaging Services, Inc., Contract Number V672p-2172 and V672p-2196, Clearwater, FL	$518,677		
8PEE02044 12/1/97	Review of Hoffman LaRoche, Inc.'s Voluntary Disclosure of Pricing Violations Under Federal Supply Schedule Contracts V797p-5759m and V797p-5524m			$3,109,926
8PEE02050 12/8/97	Review of Voluntary Refund Offer by Behring Diagnostics, Inc., Federal Supply Schedule Contract No. V797p-5150n			$908,166
8PEE02052 12/24/97	Review of SCA Molnlycke's Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797p-3572j			$993,270
8PEE02049 1/5/98	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Zenith Goldline Pharmaceuticals, Fort Lauderdale, FL	$7,507,421		
8PEE02055 1/26/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97) Dentsply Caulk, Milford, DE			
8PED02062 1/27/98	Review of Architect Engineer Proposals, VA Project Number 541-039b, Spice Costantino Architects, Inc., Cleveland, OH			
8PEE02063 1/28/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92) Graphic Controls Corporation, Buffalo, NY	$294,535		
8PEE02064 2/9/98	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97) McGaw Incorporated, Irvine, CA	$9,207,294		
8PEE02068 2/9/98	Review of Federal Supply Schedule Proposal (Solicitation Number M5-Q50-97), Mallinckrodt Medical Inc., St. Louis, MO			
8PEE02059 2/20/98	Review of Pfizer Pharmaceuticals' Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797p-5547m			$40,844

Report Number/ Issue Date	Report Title	Funds Recommended For Better Use OIG	Management	Questioned Costs
CONTRACT REVIEWS (Cont)				
8PEE10070 2/20/98	Postaward Audit of Federal Supply Schedule Contract V797p-5543m Awarded To Burroughs Wellcome Co., Research Triangle Park, NC			$223,478
8PEE02074 3/4/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Gendex Dental X-Ray, Division of Dentsply International, Inc., Des Plaines, IL	$91,969		
8PEE02053 3/16/98	Review of Structural Design Problems at the New VA Regional Office Bay Pines, FL			
8PEE02084 3/19/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q4-97) Medrad, Inc., Indianola, PA	$2,468,847		
8PEE02081 3/23/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-92, Open Season IV) Howmedica, Inc., Pfizer Hospital Products Group, Rutherford, NJ	$3,126,441		
8PEE10082 3/25/98	Audit of Claims and Requests for Equitable Adjustments Submitted by Bay Construction Company, Contract Number V662c-1439	$394,154		
8PEE10088 3/25/98	Postaward Review of Federal Supply Schedule Contract V797p-5548m Awarded to Schein Pharmaceutical, Inc., Florham Park, NJ			$1,700,000
8PEE02089 3/31/98	Review of Federal Supply Schedule Proposal (Solicitation Number M3-Q3-97), Midwest Dental Products Corporation (a Wholly Owned Subsidiary of Dentsply International, Inc.) Des Plaines, IL			
TOTAL:	**87 Reports**	***$312,806,211**	**$85,267,869**	**$8,649,952**

* The difference between the OIG and Management estimates is $227,538,342. The difference is explained as follows: Pending receipt of contracting officer's decision - $217,000,757; Management disagreed with OIG estimate - $6,044,356; Management did not provide an alternative estimate - $4,493,229.

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
7PEN03122 11/13/97	Claims, Contract No. V101p(93)-1401, Telephone System, VAMC Kansas City, MO, American Business Communications, Kansas City, MO	$72,566	
7PEN03148 11/13/97	Proposal, RFP 640-118-97, Renovate Building 7, Palo Alto Div., VAMC Mountain View, Ratto Construction, Palo Alto, CA		
7PEN03011 12/1/97	Proposal, Exchange of Use, RFP 657-10-97, Pet Scanner Services, VAMC St. Louis, St. Louis Univ. Health Science Center, St. Louis, MO	$20,049	$517,850
7PEN03012 12/1/97	Proposal, RFP 598-29-97, Cardiac Surgery/Perfusionist Service, University of Arkansas for Med. Service, Little Rock, AR	$45,064	$478,687
7PEN03013 12/1/97	Proposal, RFP 527-25-97, Radiology Services, State University of New York (SUNY), Brooklyn, NY	$10,346	$13,076
7PEN03014 12/1/97	Proposal, RFP 648-23-97, Radiation Oncology Services, Oregon Health Sciences University, Portland, OR	$17,850	$127,920
7PEN02007 12/9/97	Proposal, Project No. 672-045, Change Order Outpatient Clinic Addition, VAMC San Juan, J. A. Jones Construction Co., San Juan, PR	$284,827	
7PEN03135 12/9/97	Proposal, Project No. 532-97-125, Telecom Infrastructure, VAMC Canandaigua, Telecommunication Bank, Inc., Rochester, NY	$28,910	
8PEN03102 12/15/97	Proposal, RFP No. 689-94-97, Const. Outpatient Pharmacy, VAMC W. Haven, United Stone America, Inc., Hartford, CT		
8PEN03103 12/15/97	Proposal, RFP No. 688-58-97, Renovate Patient Privacy, VAMC Washington, AEC Services, Inc., Rockville, MD		
7PEN03127 1/5/98	Proposal, RFP No. 688-51-97, Renovation & Expansion, VAMC Washington, Venus Construction Corporation, Temple Hills, MD		
7PEA11003 1/6/98	A-128, Fiscal Year Ended 6/30/96, State Home Construction and Nursing Home Care, Maine Veterans' Homes, Augusta, ME		

Report Number/ Issue Date	Report Title	Questioned Costs	Unsupported Costs
7PEN03126 1/6/98	Proposal, Solicitation No. 561-25-96, Telephone Conduit, VAMC East Orange, NJ, Imperial Construction & Electric, Inc., Hillside, NJ	$32,286	
7PEN03147 1/6/98	Proposal, 516-090-97, Replace Roof, VAMC Bay Pines, FL G.E.C. Associates, Inc., Miami, FL	$38,652	
8PEA11038 1/7/98	A-128, Fiscal Year Ended 6/30/96, Domiciliary & Nursing Home Care Grant, Arkansas Dept. of Veterans Affairs, North Little Rock, AK		
8PEG06039 1/7/98	A-128, Fiscal Year Ended 6/30/96, Domiciliary & Nursing Home Care, State Approving Agency Contract, State of South Dakota, Pierre, SD		
8PEG06046 1/7/98	A-128, Fiscal Year Ended 6/30/96, State Approving Agency Contract, Statehome Construction & Nursing Home Care, State of Idaho, Boise, ID		
7PEG06058 1/8/98	A-128, Fiscal Year Ended 6/30/95, State Approving Agency Contract, Statehome Construction and Nursing Home Care, State Of Idaho, Boise, ID		
8PEG06040 1/8/98	A-128, Fiscal Year Ended 6/30/96, State Home Construction, Vocational Training, State Approving Agency Contracts, State of Wisconsin, Madison, Ws		
8PEN02103 2/23/98	Proposal, Project No. 612-100 A/E, VAMC Matherfield, Nacht & Lewis Architects, Sacramento, CA	$58,206	
8PEN03104 2/23/98	Proposal, Contract No. V689P-2356, Ambulance Service, VAMC West Haven, Hunter's Ambulance Service, Inc Meriden, CT	$127,909	
8PEN02104 2/23/98	Proposal, Project No. 506027F, A/E, VAMC Ann Arbor, Harley Ellington Design, Southfield, MI	$86,111	
8PEN03108 3/19/98	Proposal, RFP No. 688-57-97, Renovate Main Entrance, VAMC Washington, William D. Euille & Associates, Inc., Alexandria, VA	$21,962	
8PEN03110 3/19/98	Proposal, Project No. 543-015, Sprinkler & Fire Alarm Project, VAMC Columbia, Fire Security Systems, Inc., Bossier City, LA	$503,356	
TOTALS:	**24 Reports**	**$1,348,094**	**$1,137,533**

The Defense Contract Audit Agency (DCAA) completed 18 of the 24 reports issued, with Questioned Costs totaling $1.3 million. This data is also reported in the DoD OIG's Semiannual Report to Congress.

APPENDIX C

CONTRACT AUDIT REPORTS FOR WHICH A CONTRACTING OFFICER DECISION HAD NOT BEEN MADE FOR OVER 6 MONTHS AS OF MARCH 31, 1998

Report Title, Number, and Issue Date	Questioned Costs	Better Use of Funds	Reason for Delay and Planned Date for a Decision
Contract Reviews by OIG			
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson & Johnson Healthcare Systems, Inc., Codman Division, Piscataway, NJ, 7PE-E12-081, 5/6/97		$1,755,575	Pending receipt of Contracting Officer Price Negotiation Memorandum (PNM).
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Inc., Ethicon Inc., Piscataway, NJ, 7PE-E12-088, 5/20/97		$4,570,800	Pending receipt of PNM.
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Inc., Ethicon Endo Surgery, Inc., Piscataway, NJ, 7PE-E02-092, 6/6/97			Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q53-97) Ecolab Inc., St. Paul, MN, 7PE-E02-093, 6/13/97		$964,241	Pending receipt of PNM.
Preaward Review of Federal Supply Schedule Proposal Submitted by Johnson and Johnson Healthcare Systems, Johnson and Johnson Medical Inc., Piscataway, NJ, 7PE-E02-094, 7/11/97		$10,806,808	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M3-Q3-92) Johnson and Johnson Healthcare Systems Inc., Cordis Corporation and J&J Interventional Systems, Piscataway, NJ, 7PE-E12-107, 7/24/97		$5,918,105	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Pharmacia & Upjohn, Kalamazoo, MI, 7PE-E02-123, 9/3/97		$1,919,827	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Wyeth-Ayerst Laboratories, Philadelphia, PA, 7PE-E02-127, 9/4/97		$5,484,450	Pending receipt of PNM.

Report Title, Number, and Issue Date	Questioned Costs	Better Use of Funds	Reason for Delay and Planned Date for a Decision
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT (Cont)			
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Sanofi Pharmaceuticals, Incorporated, New York, NY, 7PE-E02-120, 9/5/97			Pending receipt of PNM
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97) Dupont Merck Pharmaceutical Co., Wilmington, DE, 7PE-E02-132, 9/16/97		$733,529	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Schein Pharmaceutical Inc., Florham Park, NJ, 7PE-E02-134, 9/17/97		$2,718,799	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Rhone-Poulenc Rorer, Inc., Collegeville, PA, 7PE-E02-136, 9/17/97		$2,791,444	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Bayer Corporation Pharmaceutical Division, West Haven, CT, 7PE-E02-130, 9/23/97		$3,580,134	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Janssen Pharmaceutical Inc., Piscataway, NJ, 7PE-E02-138, 9/24/97		$522,415	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Roche Laboratories, Inc., Nutley, NJ, 7PE-E02-141, 9/24/97		$69,091	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), Parke-Davis Division of Warner-Lambert Co., Morris Plains, NJ, 7PE-E02-142, 9/24/97		$8,624,775	Pending receipt of PNM.
Review of Federal Supply Schedule Proposal (Solicitation No. M5-Q50-97), G. D. Searle and Co., Managed Care Contracts, Chicago, IL, 7PE-E02-147, 9/30/97		$2,525,457	Pending receipt of PNM.

Report Title, Number, and Issue Date	Questioned Costs	Unsupported Costs	Reason for Delay and Planned Date for a Decision
Contract Reviews by Other Agencies			
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	$3,800,000		Resolution planned for next reporting period.
Claim, Contract No. V554C-684, Laundry Chute, VAMC Denver, CO, Hughes-Groesch Construction Co., Inc. Denver, CO, 7PE-N03-130, 3/31/97			Claim under review; no planned resolution date available.
Proposal, RFP 614-51-96 Radiologists, VAMC Memphis, University of Tennessee, Memphis, TN, 7PE-N03-003, 5/2/97	$6,167	$541,483	Negotiation not finalized; resolution planned for next reporting period.
Proposal, RFP 614-41-96, Anesthesiologists, VAMC Memphis, University of Tennessee, Memphis, TN, 7PE-N03-002, 5/5/97		$906,586	Pending receipt of CORR documenting disposition of unsupported cost.
Claim, Contract V101DC-0048, Expand/Renovate Bldg-1, VAMC Salt Lake, Interwest Construction, Salt Lake City, UT, 7PE-N03-114, 9/30/97	$1,469,934		Claim in appeal; planned resolution date not available.
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	Pending receipt of information documenting disposition of questioned and unsupported cost.
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.

Report Title, Number, and Issue Date	Questioned Costs	Unsupported Costs	Reason for Delay and Planned Date for a Decision
OFFICE OF FACILITIES MANAGEMENT (Cont)			
Claim, Contract No. V101BC0026, 120 Bed Nursing HCU/Parking, VAMC New Orleans Broadmoor/BOH, Metairie, LA, 4PE-N02-102, 8/9/94	$727,576		Pending receipt of information documenting disposition of Questioned and unsupported cost.
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.
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; no planned resolution date 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, 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; no planned resolution date available.
Claim, Project No. 553-808, Replacement Hospital VAMC Detroit, MI, Bateson/Dailey, Dallas TX, 6PE-N02-204, 12/11/96	$11,952,726		Negotiation not finalized; 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; no planned resolution date available.
Claim, Project No. 690-035 MFI Addition, VAMC Brockton, Saturn Construction Co., Inc., Valhalla, NY, 6PE-N02-001, 5/19/97	$724,755		Negotiation not finalized; 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 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; no planned resolution date available.
Claim, Equitable Adjustment, 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; no planned resolution date available.
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; no planned resolution date available.
Proposal, Project No. 549-085, Clinical Addition, VAMC Dallas, Centex Construction Company, Inc., Dallas, TX, 7PE-N02-303, 5/20/97	$14,804,392		Negotiation not finalized; no planned resolution date available.

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 1-37
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-1 to 1-37
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	2-6
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-2
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-5
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