Office of Inspector General

Semiannual Report to Congress

October 1, 2001 -- March 31, 2002

FOREWORD

I am pleased to submit the semiannual report on the activities of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the period ended March 31, 2002. The OIG is dedicated to helping ensure that veterans and their families receive the care, support, and recognition they have earned through service to our country. This report is issued in accordance with the provisions of the Inspector General Act of 1978, as amended.

OIG oversight of major VA programs resulted in systemic improvements and increased efficiencies in areas of medical care, benefits administration, procurement, financial management, information technology, and facilities management. OIG audits, investigations, and other reviews identified $579.9 million in monetary benefits, for an OIG return on investment of $20 for every dollar expended.

Our criminal investigators concluded over 350 investigations involving fraud or other criminal conduct in VA's programs or operations. During the semiannual period, special agents effected 215 arrests, and investigations led to almost $15 million in monetary benefits to VA (recoveries or savings).

During this period and in the wake of the September 11, 2001, terrorist attacks on the United States, the Office of Investigations committed significant resources to our Nation's response to this tragedy. Special agents worked on a rotating basis alongside other Federal and local law enforcement teams searching for victim remains, and collecting and cataloging evidence, personal effects, and other items from the World Trade Center disaster. Special agents were detailed to the FBI to assist in investigative activities. Additionally, we detailed members of our law enforcement staff to the U.S. Air Marshal Program.

Our audit oversight of VA, the second largest Department in the Federal Government, focused on determining how programs can work better, while improving service to veterans and their families. For example, at the request of the Secretary of Veterans Affairs, the OIG conducted a special review of large Compensation and Pension (C&P) one-time payments processed by VA regional offices (VAROs). The Secretary requested this review in September 2001 following the discovery that a VARO Atlanta, GA employee had bypassed controls and generated about $11.2 million in fraudulent compensation payments. Our review found that most one-time payments were valid. However, our review found unacceptably high rates of noncompliance with internal

control requirements related to one-time payments of C&P claims. Also, a review of Medical Care Collection Fund (MCCF) collection and billing practices concluded that the Veterans Health Administration (VHA) could have increased collections by about $135 million (24 percent) in Fiscal Year 2000. Our audits of VA's Consolidated Financial Statements and implementation of the Government Information Security Reform Act found that information security controls needed improvement and programs and sensitive data were vulnerable to destruction, manipulation, and inappropriate disclosure.

Our healthcare inspections focus on quality of care issues in VA, which operates the largest health care system in the United States. In the wake of the September 11, 2001 terrorist attacks, and growing concerns of anthrax discovered in the U.S. postal system, the Secretary of Veterans Affairs requested the OIG conduct an inspection of the adequacy of security and inventory controls over selected biological, chemical, and radioactive agents owned by or controlled at VA. Our inspection found significant vulnerabilities in high-risk security areas in research and clinical laboratories and pharmacies. We also conducted a focused review of VHA's compliance programs and coding accuracy at selected VHA medical facilities. VA's 50 percent error rate for coding outpatient visits is notably higher than the Health Care Finance Administration's average of 30 percent, and greatly impacts the amount of third-party reimbursements VA receives. Healthcare inspectors continued visits to facilities in response to Congressional and other special requests, and we inspected patient allegations pertaining to quality of care issues received by the OIG Hotline.

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

I look forward to continued partnership with the Secretary and the Congress in pursuit of world class service for our Nation's veterans.

RICHARD J. GRIFFIN
Inspector General

TABLE OF CONTENTS

Page

HIGHLIGHTS OF OIG OPERATIONS

This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA), Office of Inspector General (OIG) for the 6-month period ended March 31, 2002. The following statistical data highlights OIG activities and accomplishments during the reporting period.

DOLLAR IMPACT	Dollars in Millions
Funds Put to Better Use	$548.7
Dollar Recoveries	$26.3
Fines, Penalties, Restitutions, and Civil Judgments	$4.9

RETURN ON INVESTMENT	
Dollar Impact ($579.9) / Cost of OIG Operations ($28.7)	20 : 1

OTHER IMPACT	
Arrests	215
Indictments	191
Convictions	161
Administrative Sanctions	203

ACTIVITIES	
Reports Issued	
Combined Assessment Program	12
Audits	9
Contract Reviews	31
Healthcare Inspections	15
Administrative Investigations	7
Investigative Cases	
Opened	397
Closed	352
Healthcare Inspections Activities	
Oversight Reviews	106
Clinical Consultations	6
Technical Reviews	44
Hotline Activities	
Contacts	8,036
Cases Opened	681
Cases Closed	776

OFFICE OF INVESTIGATIONS

Overall Focus

This semiannual period, the Office of Investigations concluded 352 investigations resulting in 361 judicial actions and over $14.7 million recovered or saved. Investigative activities resulted in the arrests of 215 individuals who had committed crimes involving VA programs and operations or on VA facilities. Many significant cases were investigated. Examples of these cases follow.

Veterans Health Administration

A VAMC supervisory pharmacist and her uncle were charged in a 10-count indictment. The charges included conspiracy to commit theft of Government property, possession of a controlled substance for distribution, and money laundering. The investigation disclosed the pharmacist illegally diverted over 205,000 schedule two and three controlled substances while acting in her official capacity. The controlled substances included Oxycodone, hydrocodone, hydromorphone, and Percocet that she passed on to her uncle and for which she allegedly received approximately $750,000. The VAMC has a loss of approximately $169,000. The Drug Enforcement Administration (DEA) estimates the street value of the narcotics in this case to be $7.1 million. This was a joint investigation by VA OIG and DEA.

Veterans Benefits Administration

Criminal charges of conspiracy, theft of Government property, and a violation of principles against the United States were filed on 12 individuals involved in a major theft against VA. The charges also seek forfeiture of certain properties identified as purchased by the subjects with illegally obtained VA money. This includes real property, vehicles, household items, jewelry, and a certificate of deposit. An ongoing investigation has disclosed the individuals defrauded VA of approximately $11.2 million between 1993 and August 2001. Investigation disclosed that a VA employee accessed and falsified numerous VBA files to generate hundreds of benefit payments under the accounts of veterans who had died and had no beneficiaries. Subsequently, large retroactive benefits checks were disbursed or electronically deposited into accounts belonging to accomplices. All 12 defendants have entered guilty pleas.

A veteran pleaded guilty to bankruptcy fraud and conspiracy. A joint investigation by the VA OIG and Federal Bureau of Investigation (FBI) disclosed the individual was involved in a type of fraudulent activity known as a real estate "dumping" scheme. The veteran sent advertisements to homeowners facing foreclosures and convinced them he was an attorney specializing in foreclosure relief services and for a monthly fee, he could stop scheduled foreclosures indefinitely. He usually insisted that clients wire the monthly fee payments via Western Union. In furtherance of the scheme to delay foreclosures, partial interests of homes were deeded to unrelated debtors who were in bankruptcy proceedings. This was done without the knowledge of the debtors and the homeowners by using falsified grant deed documents. During a 2-year period, more than 90 homeowners were victimized. The homeowners paid the veteran over $550,000 for this fraudulent service.

OFFICE OF AUDIT

Audit Saved or Identified Improved Uses for $564.8 Million

Audits and evaluations were focused on operations and performance results to improve service to veterans. During this reporting period, 52 audits, evaluations, and reviews, including Combined Assessment Program (CAP) reviews, identified opportunities to save or make better use of approximately $564.8 million. The Office of Audit demonstrated a benefit to cost ratio of about $49 for every dollar spent.

Veterans Health Administration

Our review of Medical Care Collection Fund (MCCF) collection and billing practices concluded that VHA could have increased collections by about $135 million (24 percent) in Fiscal Year (FY) 2000 by effectively implementing our recommendations from our prior review of the MCCF program. Additionally, clearing the backlog of unissued bills that currently totals over $1 billion would result in additional collections of about $368 million.

Veterans Benefits Administration

At the request of the Secretary of Veterans Affairs, the OIG conducted a special review of large compensation and pension (C&P) one-time payments (OTPs) processed by VA regional offices (VAROs). The Secretary requested this review in September 2001 following the discovery that a VARO Atlanta, GA employee had bypassed controls and generated about $11.2 million in fraudulent C&P payments. Our review found that most OTPs reviewed were valid. However, unacceptably high rates of noncompliance with internal control requirements pertaining to OTP three-signature reviews, Benefits Delivery Network (BDN) security, and sensitive VA claims files were disclosed. Another VBA report on the causes of C&P overpayments concluded that overpayments totaling $26.6 million could be prevented by revising procedures and increasing VAROs' emphasis on overpayment prevention.

Office of Management

The audit of the Department's Consolidated Financial Statements for FY 2001 and 2000 resulted in an unqualified opinion. The report on internal controls identified 11 reportable conditions of which 6 are material weaknesses. Two material weaknesses identified were reported last year: (i) information technology security controls, and (ii) integrated financial management system and control issues. The four new material weaknesses relate to: (iii) management ownership of financial data, (iv) reliance on independent specialists, (v) management legal representations, and (vi) loan guaranty application systems. The report also discusses five reportable conditions that, while not considered material weaknesses, are significant system or control weaknesses that could adversely affect the recording and reporting of the Department's financial information. The three reportable conditions that were repeated from last year's report are: (i) application program and operating system change controls, (ii) business continuity and disaster recovery planning, and (iii) operational oversight. The two new reportable conditions identified this year are: (iv) authorization of compensation benefit payments, and (v) the loan guaranty business process.

Contract Review and Evaluation

During the period, we completed 31 contract reviews – 9 preaward and 22 postaward reviews. These reviews identified monetary benefits of about $25.4 million resulting from contractor actual or potential overcharges to VA. Contract reviews returned about $18 in monetary benefits for every dollar spent.

Office of Information and Technology

Our audit of VA information security controls and management found that VA's programs and sensitive data are vulnerable to destruction, manipulation, and inappropriate disclosure. Significant security vulnerabilities continue to place the Department at risk of: (i) denial of service attacks on mission critical systems, (ii) disruption of mission critical systems, and (iii) unauthorized access to and disclosure of data subject to Privacy Act protection and sensitive financial data.

OFFICE OF HEALTHCARE INSPECTIONS

The Office of Healthcare Inspections (OHI) participated with the Offices of Audit and Investigations on CAP reviews and reported on specific clinical issues warranting the attention of VA managers. OHI reviewed health care related issues, and made 54 recommendations to improve clinical operations and activities, and enhance the quality of care and services provided to patients.

OHI conducted one program evaluation and one focused inspection. Based on the request from the Secretary of Veterans Affairs, the OIG reviewed VA's security and controls over selected biological, chemical, and radioactive agents and found significant vulnerabilities in high-risk security areas in research and clinical laboratories and pharmacies. Our findings are important to VA managers as they develop policies and procedures to strengthen security, access, inventory, and oversight requirements for safeguarding high-risk or sensitive materials and agents. Our review of VHA's compliance programs and coding accuracy identified serious coding errors in about 50 percent of outpatient visits we reviewed, significantly higher than the 30 percent error rate reported by the Health Care Finance Administration. Our findings and recommendations should help VHA managers to improve coding accuracy and provide for better management of their compliance programs.

Our inspectors visited a number of facilities this period to respond to Congressional and other special requests, and reviewed patient allegations pertaining to quality of care issues received by the OIG Hotline. OHI completed 17 Hotline cases, reviewed 54 issues, and developed 47 recommendations to correct conditions identified and improve the care and services provided to patients. Findings and recommendations resulted in managers taking action to issue new and revised procedures, administrative actions, resource realignments, and environmental and safety improvements. OHI also oversaw 106 Hotline inquiries sent to VHA for action and resolution. These cases involved 170 allegations of which 117 (69 percent) were substantiated.

OFFICE OF MANAGEMENT AND ADMINISTRATION

Hotline

The Hotline provides an opportunity for employees, veterans, and other concerned citizens to report fraud, waste, abuse, and mismanagement. The identification and reporting of issues such as these are integral to the goal of improving the efficiency and effectiveness of the Government. During the reporting period, the Hotline received 8,036 contacts. We opened 681 cases. We closed 776 cases, of which 180 contained substantial allegations (23 percent). The monetary impact resulting from these cases totaled over $400,000. Hotline staff generated 107 responses to inquiries received from members of the Senate and House of Representatives. The cases we opened led to 58 administrative sanctions against employees and 92 corrective actions taken by management to improve VA operations and activities. Examples of some of the issues addressed by Hotline include: (i) improper disclosure of a veteran's VA benefits information, (ii) misuse of official correspondence and e-mail for personal reasons, (iii) abuse of authority by VA physicians and police officers, (iv) patient safety violations, (v) contracting irregularities, and (vi) instances of misconduct by VA employees.

Information Technology and Data Analysis

During this reporting period, this Division provided OIG personnel with more than 90 enhancements of the Master Case Index (MCI), the OIG's enterprise database. Most notably, the Division implemented an on-line OIG office and employee roster. Additionally, the Division implemented an award tracking component within MCI.

The Data Analysis Section (DAS) analyzes data in VA computer files and systems. The DAS develops proactive computer profiles that search VA computer data for patterns of inconsistent or irregular records with a high potential for fraud. They refer these leads to OIG auditors and investigators for further review. During this reporting period, the DAS completed 120 ad hoc requests for information and data submitted from all OIG operational elements. The DAS supported OIG CAP reviews. Considerable effort was also spent in support of the post-arrest phase of the VARO Atlanta investigation, the national fraud review of all VAROs, matches of VA beneficiary and vendor information against names and addresses contained on the FBI's terrorist watch list, statistical matches to support the "fugitive felon" legislative initiative, and the Philippines beneficiary review currently in progress.

Follow Up on OIG Reports

The Operational Support Division continually tracks the VA staff actions to implement OIG audits, inspections, and reviews. As of March 31, 2002, there were 72 open OIG reports containing 294 unimplemented recommendations with over $4.2 billion of actual or potential monetary benefits. During this reporting period, the OIG closed 55 reports and 340 recommendations with a monetary benefit of $461 million after obtaining information that VA officials had fully implemented corrective actions.

Status of OIG Reports Unimplemented for Over 3 Years

VA management officials are required to provide the OIG with documentation showing the completion of corrective actions taken on OIG reports. In the majority of cases, program offices provide the OIG with documentation of the actions required to implement the reports in a reasonable period. However, the OIG is concerned about nine OIG reports issued in FY 1999 and earlier that remain unimplemented. VHA has seven reports (one report issued in each of FY 1994, 1996, and 1997, and four reports issued in 1999), and VBA has two reports (one report issued in FY 1997 and in 1999). Details about these reports can be found beginning on page 52.

VA AND OIG MISSION, ORGANIZATION, AND RESOURCES

The Department of Veterans Affairs (VA)

Background

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

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

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

Mission

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

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

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

Organization

VA has three administrations that serve veterans:

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

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

- Management (Budget, Finance, Acquisition and Materiel Management (A&MM));
- Information and Technology;
- Policy and Planning (Policy, Planning, and Security and Law Enforcement);
- Human Resources and Administration (Diversity Management and Equal Employment Opportunity, Human Resources Management, Administration, and Resolution Management);

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

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

Resources

While most Americans recognize the VA as a Government agency, few realize that it is the second largest Federal employer. For FY 2002, VA has approximately 207,000 employees and a $50.8 billion budget. There are an estimated 25 million living veterans. To serve our Nation's veterans, VA maintains facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the Philippines.

Approximately 188,000 of VA's employees work in VHA. Health care is funded at almost $22 billion, approximately 43 percent of VA's budget in FY 2002. VHA provides care to an average of 57,500 inpatients daily. During FY 2002, slightly more than 47 million episodes of care are estimated for outpatients. There are 172 hospitals, 137 nursing home units, 206 Vietnam veterans centers, 43 domiciliaries, and 859 outpatient clinics (including hospital clinics).

Veterans benefits are funded at $28 billion, more than 55 percent of VA's budget in FY 2002. Over 13,000 VBA employees at 57 VAROs provide benefits to veterans and their families. Almost 2.7 million veterans and their beneficiaries will receive compensation benefits valued at $21.7 billion. Also, over $3 billion in pension benefits will be provided to veterans and survivors. VA life insurance programs have 4.3 million policies in force with a face value of over $602 billion. Almost 248,000 home loans are expected to be guaranteed in FY 2002, with a value of almost $32.1 billion.

The National Cemetery Administration operates and maintains 120 cemeteries and employs over 1,400 staff in FY 2002. Operations of NCA and all of VA's burial benefits account for approximately $420 million of VA's budget. Interments in VA cemeteries continue to increase each year, with 87,000 estimated for FY 2002. Approximately 347,000 headstones and markers are expected to be provided for veterans and their eligible dependents in VA and other Federal cemeteries, state veterans' cemeteries, and private cemeteries.

VA Office of Inspector General (OIG)

Background

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

Role and Authority

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

The Inspector General Act Amendments of 1988 provided the IG with a separate appropriation account and revised and expanded procedures 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, inspections, or other appropriate actions.

Organization

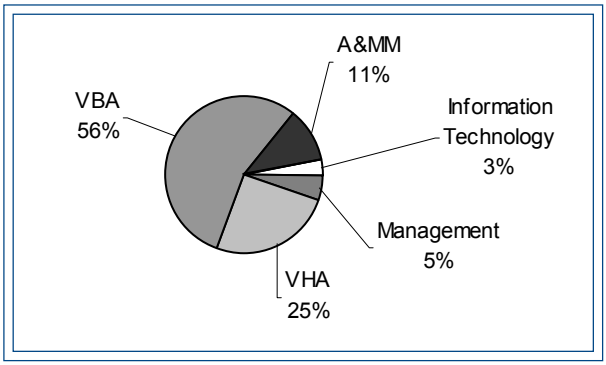
Allocated full-time equivalent (FTE) employees from appropriations for the FY 2002 staffing plan were as follows:

OFFICE	ALLOCATED FTE
Inspector General	4
Counselor	4
Investigations	120
Audit	176
Management and Administration	55
Healthcare Inspections	46
TOTAL	**405**

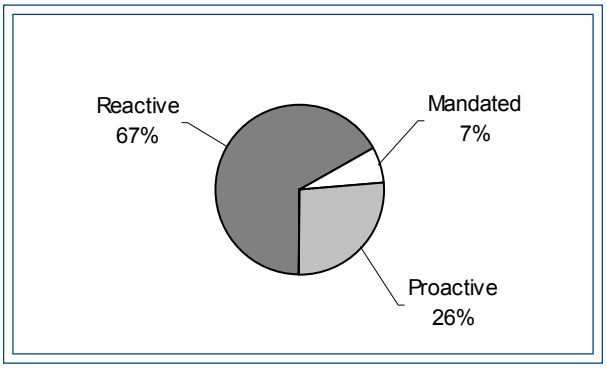
In addition, 24 FTE are reimbursed for a Department contract review function.

FY 2002 funding for OIG operations is $55.2 million, with $52.3 million from appropriations and $2.9 million through a reimbursable agreement. Approximately 77 percent of the total funding is for salaries and benefits, 6 percent for official travel, and the remaining 17 percent for all other operating expenses such as contractual services, rent, supplies, and equipment.

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



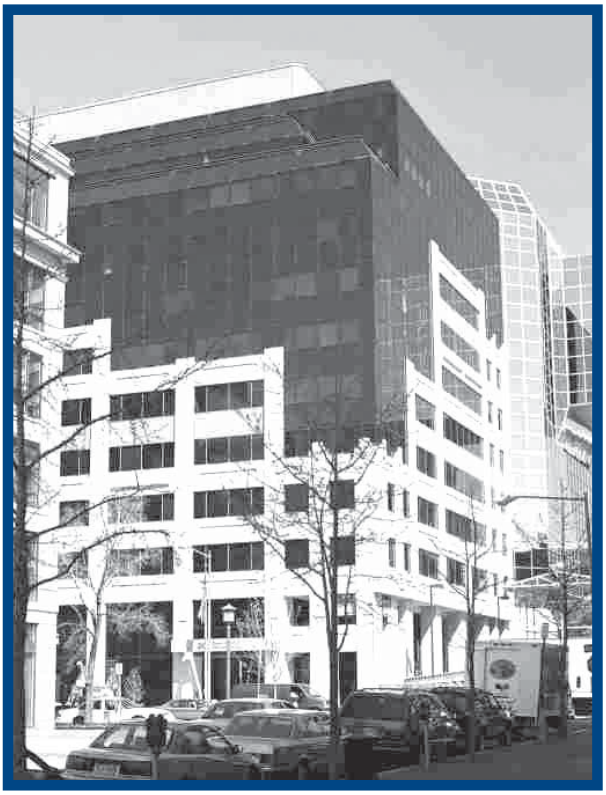
The following chart indicates the percent of OIG resources which have been applied to mandated, reactive, and proactive work.



Mandated work is required by law and the Office of Management and Budget (OMB). Examples include our audits of VA's consolidated financial statements, oversight of VHA's quality assurance programs and Office of the Medical Inspector, follow up activities on OIG reports, and releases of Freedom of Information Act information.

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

Proactive work is self-initiated, focusing on areas where the OIG staff determines there are significant issues.



TechWorld, home to the VA Office of Inspector General

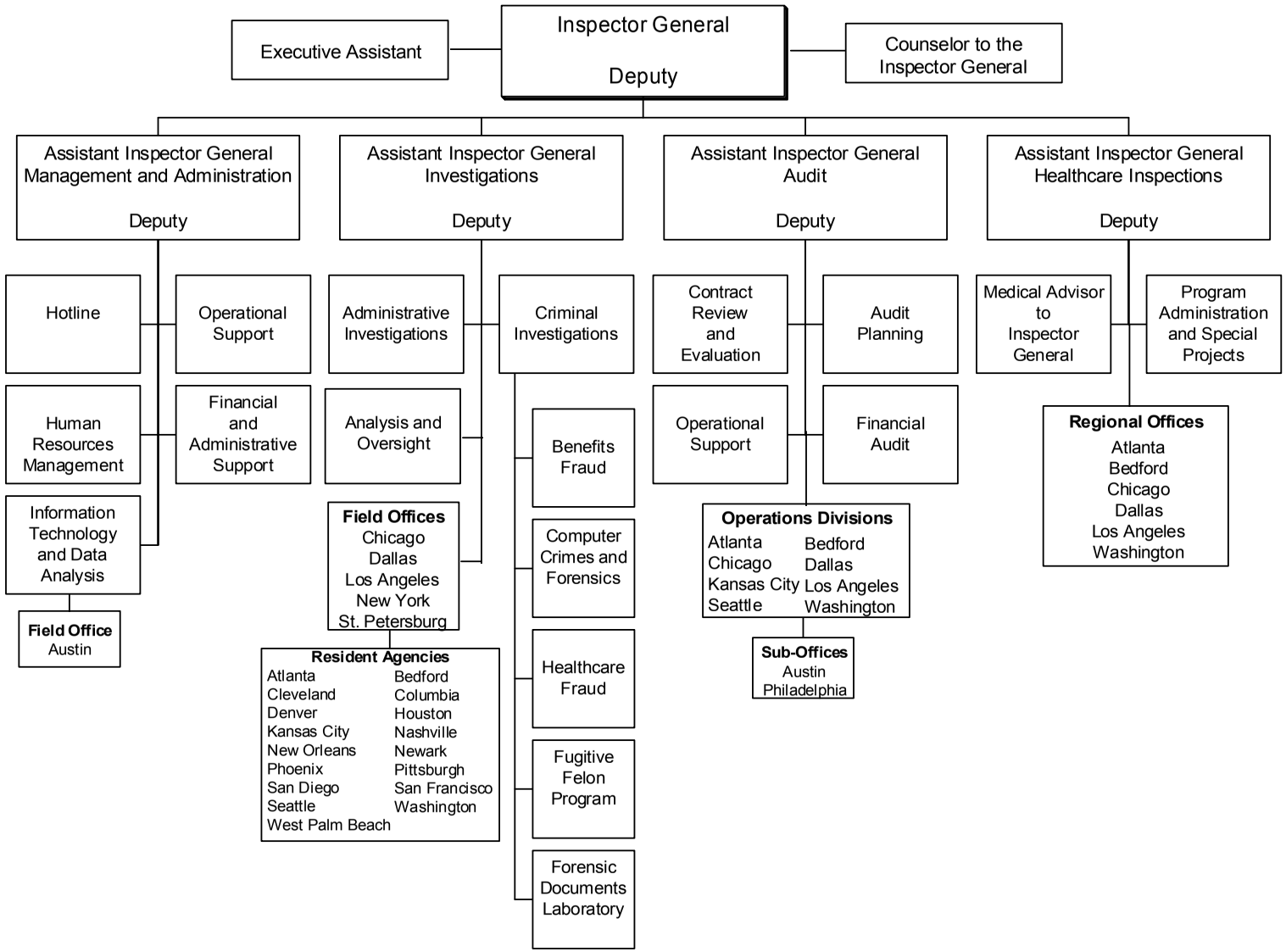
OIG Mission Statement

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

In performing its mandated oversight function, the OIG conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter fraud, waste, abuse, and mismanagement. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer driven and results oriented.

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

Department of Veterans Affairs
Office of Inspector General



COMBINED ASSESSMENT PROGRAM

Reports Issued

During the period October 1, 2001 through March 31, 2002, we issued a total of 12 Combined Assessment Program (CAP) reports. This included a summary report of CAP reviews at VA medical facilities for the period January 1999 to March 2001.

Of the remaining 11 CAP reports, 3 were for VA medical and regional office centers, 6 for healthcare systems/VAMCs, and 2 for VAROs.

Combined Assessment Program Overview - Medical

CAP reviews are part of the OIG's efforts to ensure that quality health care services are provided to our Nation's veterans. CAP reviews provide cyclical oversight of VAMC operations, focusing on the quality, efficiency, and effectiveness of services provided to veterans.

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

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

Auditors conduct reviews to ensure management controls are in place and operating effectively. Auditors assess key areas of management concern, which are derived from a concentrated and continuing analysis of VHA, Veterans Integrated Service Network (VISN), and VAMC databases and management information. Areas generally covered include procurement practices, patient management, financial management activities, accountability for controlled substances, and information security.

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

During this period, we issued nine health care facility CAP reports. Of these facility CAP reports, three were for VA medical and regional office centers. See Appendix A for the full title and date of the CAP reports issued this period. These nine reports relate to the following VA medical facilities:

- VA Medical and Regional Office Center Wilmington, DE
- Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, HI
- Alaska VA Healthcare System and Regional Office
- VA Boston Healthcare System
- John D. Dingell Veterans Affairs Medical Center Detroit, MI
- VA Medical Center, Kansas City, MO

- Samuel S. Stratton VA Medical Center Albany, NY
- VA Medical Center Louisville, KY
- VA Medical Center, Minneapolis, MN

Summary of Findings

Our reviews identified the following areas that required the attention of VHA management.

Financial Management

CAP review results showed that management was not consistently adhering to established financial policies and procedures. VHA management needs to improve oversight in financial management activities in order to provide accurate and reliable financial information.

Accounts Receivable

VA has established policies and procedures for establishing and collecting accounts receivable. However, CAP results show that compliance with these policies and procedures has not been consistent. For example, the lack of management oversight has contributed to inefficient collection efforts and to weaknesses in the management of the Medical Care Cost Fund (MCCF) and other accounts receivable financial activities.

- MCCF controls and collection efforts were deficient at 4 of 9 (44 percent) facilities visited. Deficiencies included untimely billing actions, and collections were not pursued aggressively. Medical coding for MCCF billing was deficient at 3 of 9 (33 percent) facilities visited. VHA needs to ensure that appropriate and accurate claims are filed and that all claims are supported by medical record documentation. Additionally, VHA needs to reduce errors in coding for third-party collections, which lead to delays, or non-payment.

- Accounts receivable procedures (other than MCCF) were also deficient at 4 of 9 (44 percent) facilities visited. VHA needs to aggressively pursue delinquent debts of current and former employees and should also initiate timely collection of Federal accounts receivable.

Other Financial Issues

- At 3 of 9 (33 percent) facilities visited, we found that VHA was not performing an annual means tests for veterans receiving care for nonservice-connected conditions, or did not have required release forms (signed means test) for matching veterans' income information with the Internal Revenue Service. As a result, VHA is not able to verify reported income.

- Agent cashier controls were deficient at 2 of 9 (22 percent) facilities visited. Unannounced audits of the agent cashier activities were not conducted by at least two employees skilled in fiscal or auditing techniques. Audits were not being performed randomly at least every 90 days, and CAP reviews identified instances where the level of an agent's cash advance was not based on actual demand.

- We found that employee travel advances were not being pursued and collected at 1 of 9 facilities (11 percent) visited. While the number of instances where this condition occurred does not indicate the deficiency is a systemic weakness, we have reported similar findings on previous CAP reviews.

Procurement

The OIG has identified the need to improve procurement practices in VA as one of the Department's most serious management challenges. Controls need to be strengthened to: (i) effectively administer the Government purchase card program, (ii) improve service contract controls and avoid conflicts of interest, (iii) improve contract administration, and (iv) strengthen inventory management.

- Government purchase card controls were deficient at 6 of 9 (67 percent) facilities visited. Policy and procedures governing the use of purchase cards, setting purchasing limits, and accounting for purchases were not followed.

- Service contract controls or contract file documentation were deficient at 6 of 9 (67 percent) facilities visited. Controls needed to be strengthened to ensure that officials developing, soliciting, awarding, and administrating contracts comply with conflict of interest statutes. VHA facilities did not ensure that: (i) costs were appropriate and reasonable for the services provided, (ii) all contracted services were received, (iii) VA paid only for services provided in accordance with contract terms, and (iv) potential conflicts of interest in service contracts were eliminated.

- Contract administration efforts also needed improvement. For example, at one facility we found required legal reviews were not obtained on two contracts, and one contract lacked documentation to support a $720,000 contract award.

- Inventory management was deficient at 2 of 9 (22 percent) facilities where we examined non-medical inventories and at 1 of 9 (11 percent) facilities for medical supply inventories. We found that inventory levels exceeded current requirements resulting in funds being tied up unnecessarily in excess inventories.

Information Technology

CAP reviews continue to identify a wide range of vulnerabilities in VA systems that could lead to misuse of sensitive automated information and data. VA has established comprehensive information security policies, procedures, and guidelines, however, CAP reviews found that implementation and compliance were inconsistent. Recent CAP findings show a need to improve access controls, contingency planning, incident reporting, and security training. We found inadequate management oversight contributing to inefficient practices, and to inadequate information security and physical security of assets. CAP results complement the results of our FY 2001 Government Information Security Results Act audit that identified information security vulnerabilities that place the Department at risk of denial and/or disruption of service attacks on mission critical systems, and unauthorized access to and disclosure of sensitive financial data and data subject to Privacy Act protection.

- Information technology security deficiencies were found at all nine facilities visited. We found that: (i) back-up files were not stored at off-site locations, (ii) many personal computers had outdated anti-virus software, (iii) many individuals had access to VHA's Veterans Health Information Systems and Technology Architecture who did not have or no longer needed legitimate access to the system, and (iv) security clearances were not obtained for some employees with high-level access to VHA's Veterans Health Information Systems and Technology Architecture.

Administrative Management

- Part-time physician timekeeping was deficient at all five facilities where this issue was evaluated. We found some part-time physicians were not on duty as required and that absences were not properly charged to these employees.

- Two other administrative management deficiencies were identified. The deficiencies were that: (i) Pharmacy Service use of overtime was excessive with little or no management control in one facility, and (ii) the Decision Support System was not adequately staffed and the System information was considered unreliable at one facility. Similar findings were also reported in previous CAP reviews.

Health Care Management

- We inspected abnormal test and procedure result notifications at 6 of 9 facilities visited. Written policies and management of abnormal test and procedure results, including patient notifications in primary care departments, were deficient at 4 of the 6 (67 percent) facilities. VHA managers needed to improve procedures for notifying providers and patients of abnormal test and procedure results. Providers needed to be vigilant in reviewing the results of the tests and procedures they ordered, communicating the results to patients, documenting the notifications in the medical records, and providing timely follow up instructions and care to the patients.

- We inspected medical record documentation of mental health patients' primary medical conditions at 5 of 9 facilities visited. Documentation was deficient at all five facilities. Clinicians inconsistently documented assessments of mental health patients' co-morbid medical conditions or components of the preventive disease or chronic disease indexes in their medical records, which is required by VHA policy. Mental health patients were consistently enrolled in primary care for their medical conditions, but at one facility, there were delays of 3-8 weeks to get primary care clinic appointments.

- We inspected employee background investigation procedures at 6 of 9 facilities visited. We found deficiencies at all six facilities. Human Resources Management (HRM) did not always request background investigations from the Office of Personnel Management (OPM) for all licensed independent practitioners as required. HRM employees did not always document the dates they sent requests for background investigations to OPM so we could not determine if they were sent within 14 work-days of the employees' appointments as required. Additionally, HRM employees did not follow up with OPM when background investigation results were not returned within 2 months of their submission to OPM.

- We inspected medical record security at 5 of 9 facilities visited. We found security deficiencies at all five facilities. Patient medical information was not protected against deliberate or inadvertent misuse or disclosure as required. Computer terminals were not always positioned in a manner that would prevent unauthorized persons from viewing patient information, and computer privacy screens were not routinely used. Controls were not in place to identify inappropriate access to restricted patient records. Employees were not always aware of computer incident reporting procedures. Confidentiality management training and strategies were inconsistent. Medical records were transported in unsecured envelopes and medical records were left unattended in hallways and examination rooms. Employees did not have access to shredders for disposal of confidential information.

- Security and cleanliness was deficient at 4 of 9 (44 percent) facilities visited. Storage rooms containing medications, needles, syringes, and cleaning chemicals were left unlocked. We found incidents of peeling paint, unclean bathrooms, cracked baseboards, unclean patient room and hallway floors, dirty kitchen and medication room counter tops, and construction sites that were not always properly sealed to prevent unauthorized access.

Pharmacy

VA has established policies, procedures, and guidelines for pharmacy security and accountability of controlled substances and other drugs. CAP results identified weaknesses in the physical security and the narcotics inspection program at all nine facilities visited. The lack of management oversight at the facility, VISN, and national levels has contributed to inefficient practices and to weaknesses in drug accountability and security.

- Unannounced monthly controlled substances inspections procedures were inadequate to ensure compliance with VHA policy and Drug Enforcement Administration regulations. Unannounced inspections and inventories were not properly conducted. Unusable drugs were not disposed of timely or properly, and discrepancies between inventory results and recorded balances were not reconciled in a timely manner.

- Improvements were needed in pharmacy security at 4 of 9 (44 percent) facilities visited. We advised local management that security could be better enforced by restricting and consistently monitoring access to secured pharmacy areas. The use of cameras and electronic alarm systems would improve the physical security over controlled substances and pharmacy vaults.

Combined Assessment Program Overview - Benefits

In FY 2001, we expanded our CAP reviews to include coverage of VBA programs. These reviews focus on the delivery of monetary benefits to veterans and their dependents.

OIG staff assess whether management controls are in place and working effectively in VBA. We evaluate key areas of concern derived from a concentrated and continuing analysis of VBA management information. Our agents conduct fraud and integrity awareness briefings and used a new video tape they developed related to VBA activities.

During this period, we issued five CAP reports on the delivery of benefits, three of which were VA medical and regional office centers. See Appendix A for the full title and date of the CAP reports issued this period. These five reports relate to the following VBA facilities:

- VA Medical and Regional Office Center Wilmington, DE
- Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, HI
- Alaska VA Healthcare System and Regional Office
- VA Regional Office New Orleans, LA
- VA Regional Office Oakland, CA

Summary of Findings

A recent special review of OTP and related security controls disclosed unacceptably high rates of noncompliance with internal control requirements pertaining to significant controls such as OTP three-signature reviews, BDN security, and sensitive VA claims folder (C-file) security. BDN is the computerized system that VAROs use to process benefits claims. BDN security controls are designed to prevent unauthorized access to and fraudulent use of the BDN system, and to protect the privacy of personal data in the system. By March 30, 2002, VAROs submited certifications that they had corrected BDN and sensitive C-file deficiencies found by our special review. The annual certification of compliance with BDN and sensitive C-file security requirements will be permanently incorporated into VBA's internal control system.

CAP reviews also identified the following areas that required the attention of VBA management:

- Security over BDN was deficient at 4 of 5 (80 percent) facilities visited. Physical security over terminals logged on to BDN should be strengthened. Managers also needed to better control access to BDN and to comply with VBA security requirements. VAROs should strive for 100 percent compliance and should have effective procedures for detecting and correcting instances of noncompliance.

- Veterans' C&P claims processing was untimely at all three facilities where we reviewed timeliness measures.

- VBA's processing and timeliness over Vocational Rehabilitation and Employment claims needed improvement. Processing time at these stations exceeded average national processing time at 2 of 5 (40 percent) facilities visited. Management needs to establish and process claims for vocational rehabilitation benefits in a timely manner and enter accurate dates of claims in BDN.

OFFICE OF INVESTIGATIONS

Mission Statement

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

The Office of Investigations consists of three divisions.

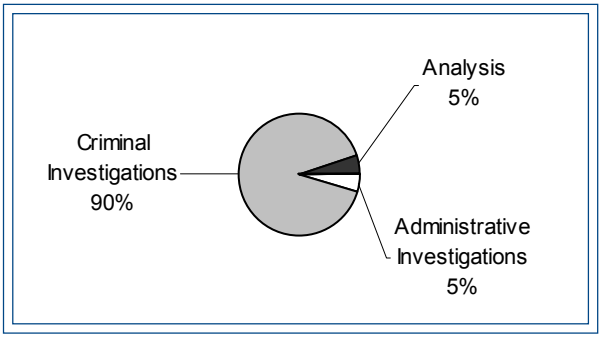
I. Criminal Investigations Division - The Division is primarily responsible for conducting investigations into allegations of criminal activities related to the programs and operations of VA. Criminal violations are referred to the Department of Justice for prosecution. The Division is also responsible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

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

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

Resources

The Office of Investigations has 120 FTE allocated to the following areas.



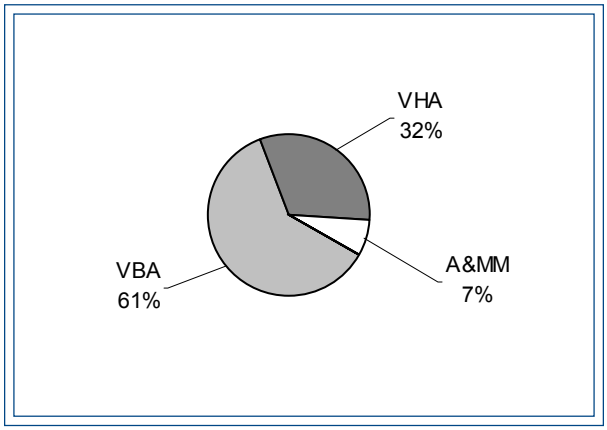
I. CRIMINAL INVESTIGATIONS DIVISION

Mission Statement

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

Resources

The Criminal Investigations Division has 106 FTE for its headquarters and 22 field locations. These individuals are deployed in the following VA program areas:



Overall Performance

Output

- 352 investigations were concluded during the reporting period.

Outcome

- Arrests - 215
- Indictments - 191
- Convictions - 161
- Monetary benefits - $14.7 million ($4.9 million - fines, penalties, restitutions, and civil judgements; $4.4 million - efficiencies/funds put to better use; and $5.4 million - recoveries)
- Administrative sanctions - 136

Veterans Health Administration

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

The Criminal Investigations Division investigates those instances of criminal activity against VHA that have the greatest impact and deterrent value. Working closely with VA police, the office has placed an increased emphasis on crimes occurring at VA facilities throughout the nation to help ensure safety and security for those working in or visiting VA medical centers. During this semiannual period OIG special agents have participated in/or provided support to VA police in the arrest of 35 individuals who committed crimes on VHA properties.

Employee Integrity

Allegations of criminal activity involving Government employees receive our highest investigative priority. Cases investigated this period include instances of theft, embezzlement, and the diversion of VA drugs and pharmaceuticals. During this period over 25 employees were arrested for criminal activity investigated by the OIG. A brief highlight of some of those investigations follows.

Theft/Diversion of Pharmaceuticals

- A former VA registered nurse was sentenced to serve 6 months' imprisonment followed by 6 months' home detention with electronic monitoring. Upon completing her sentence, the individual will serve 36 months' supervised release. The former nurse had previously pleaded guilty to a 4-count criminal information charging her with stealing various narcotics, including OxyContin and morphine, and converting them to her own use. Investigation determined the individual stole liquid morphine from syringes and replaced the drug with saline solution. In addition, on at least 21 occasions, she falsified medical records by stating she had administered various drugs such as OxyContin, Demerol, Oxycodone and Percocet to veteran patients when in fact she had diverted the drugs for her own use. As part of a plea agreement with the Government, the individual agreed to relinquish her nursing license and serve 6 months' incarceration. This was a joint investigation conducted by the VA OIG; VA police; and Food and Drug Administration, Office of Criminal Investigation.

- A VAMC supervisory pharmacist and her uncle were charged in a 10-count indictment. The charges included conspiracy to commit theft of Government property, possession of a controlled substance for distribution, and money laundering. The investigation disclosed the pharmacist illegally diverted over 205,000 schedule two and three controlled substances while acting in her official capacity. The controlled substances included Oxycodone, hydrocodone, hydromorphone, and Percocet, which she passed on to her uncle and allegedly received approximately $750,000 for her efforts. The VAMC has a loss of approximately $169,000. The Drug Enforcement Administration (DEA) estimates the street value of the narcotics in this case to be $7.1 million. This is a joint investigation by VA OIG and DEA.

Theft and Embezzlement

- A criminal information was filed charging a former VA employee and his accomplice with one count each of theft of Government funds. The former employee misused his Government purchase card to buy computers and related devices, which he later sold to pawn shops or to his accomplice for cash. Loss to VA is $177,649.

- A former VAMC audiologist pleaded guilty to 80 counts of theft of Government property. The guilty plea was the result of a VA OIG investigation that determined the audiologist sold hearing aids, purchased by the VA in amounts ranging from $150 to $400, to veterans who were entitled to the hearing aids at no cost. The total loss to the veterans is approximately $20,000. In addition, the individual sold six VA hearing aids to elderly persons who were not veterans. The audiologist received $3,650 from the elderly non-veterans.

Credit Card Fraud

An individual was indicted for financial identity fraud. The individual fraudulently obtained the identifying data of more than a dozen VA psychiatric patients and used the information to obtain credit cards and other instruments in their names. Two associates, who were psychiatric inpatients at a VAMC, apparently stole the identifying data from the VAMC daily reports. The incidents took place in 2000 and created credit problems for the veterans as well as financial losses for the credit card companies. This is a joint investigation by VA OIG, VA police, and a local police department. If convicted, the individual, who has an extensive criminal history, could be sentenced to 112 years in prison.

Other Employee Misconduct

- A VAMC employee was indicted on 12 counts of sexual exploitation of a minor under 15 years of age. A joint investigation with local authorities

The Birmingham News, Birmingham, AL — Friday, January 25, 2002

Ex-VA worker admits selling free hearing aids

By VAL WALTON
News staff writer

A former Veterans Administration audiologist admitted Thursday she charged veterans for hearing aids that were supposed to be free.

Pamela B. Poole, 51, pleaded guilty to 80 counts of a 90-count indictment, acknowledging on at least 74 occasions she sold the Veterans Affairs hearing aids for $150 to $350 and pocketed the money.

She also admitted she sold hearing aids ranging from $450 to $2,000 to at least six elderly Easter Seal of West Alabama clients by using the names of veterans with dementia.

Her attorney, George Andrews, said Mrs. Poole, who worked at the Tuscaloosa Veterans Affairs Medical Center from 1993 until Aug. 1999, chose to change her earlier plea of not guilty after evaluating the evidence. He said Mrs. Poole knows what she did was wrong.

U.S. District Judge Lynwood Smith set a March 20 sentencing date.

Assistant U.S. Attorney James Phillips said prosecutors will recommend that Mrs. Poole receive a sentence in prison at the high end of federal sentencing guidelines. The plea agreement also calls for Mrs. Poole to pay $20,000 toward restitution at her sentencing hearing. It will be up to the federal probation office to determine the full repayment.

Mrs. Poole could face up to 24 months in prison without parole based on the guidelines. In exchange for her plea, prosecutors asked the judge to dismiss the remaining 10 counts against her.

Phillips said Mrs. Poole examined the veterans in Tuscaloosa, placed orders from a Minnesota company, which would mail them back to Tuscaloosa. Mrs. Poole directed the veterans to make the checks to her or leave the payee space blank, according to a statement of facts. Mrs. Poole cashed the checks at a federal credit union.

disclosed that while on duty at the VAMC, the employee had used a VA computer to download child pornography from the Internet. The individual is being held without bond.

- A former VAMC chief of podiatry along with a woman and her husband were indicted on charges of bribery, theft, and wire fraud. The indictments were the result of a joint investigation by the VA OIG and the Federal Bureau of Investigation (FBI) of corruption in the VAMC podiatry program. An investigation revealed the former chief of podiatry received a $25,000 payment from the woman in return for false certification that the woman's husband completed requirements in the VAMC's podiatry residency program. The certification, a prerequisite for participating in managed care organizations and providing patient care in hospitals, allowed the husband and wife to continue to operate a private podiatry service in another state. The husband also received a VA salary though he did not attend the residency program.

Robbery

Two individuals were indicted and charged with robbery of a pharmacy, possession of a firearm in furtherance of such crime, and two additional conspiracy charges for planning a robbery and making false statements. Pursuant to the indictment an arrest warrant was obtained for one of the individuals. The second individual was previously arrested after a criminal complaint was filed. An investigation by the VA OIG, FBI, and VA police disclosed the two individuals participated in robbing a VAMC pharmacy. One individual, a former VAMC employee and co-op student, provided information and assistance concerning the pharmacy layout and daily routine to the second individual who carried out the crime. The robbery resulted in the theft of 3,000 tablets of Oxycontin as well as varying amounts of other narcotic drugs. Street value of the stolen drugs was estimated at over $250,000.

Possession of Illegal Drugs

Working closely with VA police and local law enforcement, OIG special agents have been involved in a number of cases involving the possession or sale of illegal drugs on VA property. A few of these cases are highlighted below.

- A VAMC surgical supply technician was arrested by members of the VA police, VA OIG, and local police on a bench warrant charging the individual with criminal possession of marijuana with intent to distribute. After the arrest, the individual was interviewed relative to his prior application for employment, and he confirmed that he prepared the application falsifying questions concerning prior convictions. A criminal background check determined the individual had at least two felony convictions that he failed to disclose on his Federal job application.

- A visitor to a VAMC was arrested for possession of heroin and possession of drug paraphernalia. A joint investigation with the VA police revealed two sources of supply for the suspect's heroin. Additional arrests of the sources of supply are anticipated in a joint investigation with the DEA.

- A veteran was arrested by VA OIG special agents and the VA police for dispensing a controlled substance. The individual was remanded without bail during his initial appearance in court. The arrest resulted when the veteran entered a VAMC emergency room with wounds to his body and became confrontational. VA police officers responded to a call for assistance to enable the doctors to attend to his wounds. While removing the veteran's clothing in preparation for surgery, zip lock bags containing 84 grams of cocaine were discovered. Special agents from the DEA have joined the investigation.

Theft of Government Property

A Government contract employee at a VAMC was sentenced to 120 days' imprisonment and 4 years' probation after pleading guilty to possession of stolen Government property. An accomplice of the contract employee was also found guilty of possession of stolen property, identity theft, and theft of credit cards. The accomplice was sentenced to 3 years' imprisonment and ordered to pay a $200 fine and a $200 court fee. The contract employee, who worked as a janitor at a VAMC, stole computers and related items. The contract employee, and his accomplice, also engaged in a scheme of using stolen credit card numbers to charge items over the Internet.

Theft of Other Property

- An individual was sentenced to serve 21 months' incarceration followed by 24 months' probation and to pay $460,267 in restitution. The individual previously pleaded guilty to one count of wire fraud. The individual would repeatedly dial into the private branch exchange phone system from his home to a VAMC and attempt to "break" the VAMC's access code allowing unauthorized access to an external line. Once he had the access code, the access code number would be sold to other individuals as part of a call-sell operation. Purchasers of such access information typically make long distance telephone calls from pay phones to avoid detection.

- Two individuals involved in an identity theft ring were sentenced after pleading guilty to identity theft and wire fraud. One individual, a veteran's wife, was sentenced to 51 months in a federal penitentiary and ordered to pay $76,836 restitution. The second individual was placed on 36 months' probation and ordered to pay restitution. An investigation revealed the woman and her husband fraudulently obtained and used the identities of 51 veterans who were patients at a VAMC. The stolen identities were used to obtain over 30 credit cards, cellular phones, and cable television services that were exchanged with others for cash, merchandise, drugs, or food stamps. Five other individuals, including the veteran, were previously sentenced in this matter.

Medical Benefits Fraud

The OIG is often called upon to investigate instances of fraudulent claims for medical services involving stolen and/or misrepresented identities in order to receive medical benefits or payments from VA. An example follows.

- Two individuals were sentenced after pleading guilty to conspiracy to defraud with respect to claims and criminal asset forfeiture. A multi-agency investigation by the VA OIG, Defense Criminal Investigative Service, Health and Human Services OIG, and Internal Revenue Service revealed the individuals, who are husband and wife, devised a scheme to defraud health care benefits programs. The husband, based on his plea of guilty to two counts each of the above charges, was sentenced to 21 months' imprisonment followed by 3 years' probation, fined $300, and ordered to pay $524,877 in restitution to the Government jointly and concurrently with his wife. The wife was sentenced to 6 months' home confinement and 5 years' probation based on her guilty plea to one count of each charge. These individuals were the sole owners and operators of a corporation established to provide individual and group mental health counseling services, although neither individual was licensed as mental health counselors or medical doctors. These individuals, using the provider numbers of mental health professionals with whom they had contracted to rent space in their company's building, submitted fraudulent claims for mental health services as part of a scheme to defraud health care programs. In addition to the false claims for health benefits, these individuals defrauded VBA by misrepresenting themselves as mental health professionals in providing reports and sworn testimony to VA regarding a veteran's application for VA benefits.

Procurement/Contract Fraud

- A civil settlement of $17 million was reached between the Department of Justice, a U.S. Attorney's Office, and a national health care provider. The settlement resolved the Government's contention that the firm submitted false claims to Medicare, VA, and Indian Health Service. Of the settlement amount, approximately $16.5 million was for Medicare, $500,000 for Medicaid, and $60,000 went to VA for its home oxygen program. Investigation showed that a subsidiary of the national firm provided smaller oxygen tanks than was called for by the contract, and then billed VA for the larger tanks.

- The owner and president of a moving and storage company pleaded guilty to one count of mail fraud. An investigation disclosed that from January 1995 through January 1998 the individual devised a scheme to create and submit false move-related documents including phony weight scale certificates, which fraudulently inflated the weight of goods being moved. Payments for moving services were based on the inflated weight scale certificates. The dollar value of the moves performed by the company, wherein either no weight certificates were submitted or known fraudulent weight certificates were used, totaled $885,078. The company charged their clients an average of 17 percent above their quoted estimated costs.

Veterans Benefits Administration

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

Death Match Project

An ongoing proactive project is being conducted by the VA OIG Information Technology and Data Analysis Division in coordination with the Office of Investigations. The match is being conducted to identify individuals who may be defrauding VA by receiving VA benefits intended for veterans who have passed away. When indicators of fraud are discovered, the matching results are transmitted to VA OIG investigative field offices for appropriate action. To date, the match has identified 5,557 possible cases. Over 493 investigative cases have been opened. Investigations have resulted in the actual recovery of $4.7 million, with an additional $6 million in anticipated recoveries. The 5-year projected cost savings to VA is estimated at $15.6 million. There have been 35 arrests on these cases with several additional cases awaiting judicial actions.

Employee Fraud

Criminal charges of conspiracy, theft of Government property, and a violation of principles against the United States were filed on 12 individuals involved in a major theft against VA. The charges also seek forfeiture of certain properties identified as purchased by the subjects with illegally obtained VA money. This includes real property, vehicles, household items, jewelry, and a certificate of deposit. An ongoing investigation has disclosed the individuals defrauded VA of approximately $11.2 million between 1993 and August 2001. Investigation

The Atlanta Journal-Constitution
Atlanta, GA
Wednesday, January 23, 2002

Former VA official pleads guilty in fraud scheme

By BILL RANKIN
brankin@ajc.com

A former Department of Veterans Affairs employee pleaded guilty Tuesday to his role in a scheme that allegedly bilked more than $6 million by fictitiously resurrecting deceased veterans and collecting on false disability claims.

As part of his plea to conspiring to launder money, Ernest Thornton, a former VA program clerk, agreed to forfeit the funds he received to the government.

With money obtained in the scheme, Thornton, 42, bought a cornucopia of motorized playthings, including a hovercraft, a light aircraft, a motor home, trucks and cars.

These will be turned over, along with cash and properties, said his lawyer, Janice Singer.

Thornton also purchased a minisubmarine, which he did not plan to use, only buy it and resell it to turn a profit, Singer added.

Thornton has agreed to cooperate with federal prosecutors in the [illegible] against Sarah Prater, the [illegible] $396 [illegible] ...uded fro...

Another co-defendant, Kathy Eselhorst, 52, a former VA senior claims examiner from Lilburn, also has agreed to plead guilty and is cooperating, Assistant U.S. Attorney Barbara Nelan said.

"We're happy to see the case is starting to move along," Nelan said. "This case touched a lot of people."

Prater, 60, of Atlanta, initially charged in August, was formally indicted Tuesday by a federal grand jury. She has pleaded not guilty.

Prater, a claims examiner and congressional liaison for the VA's regional office in Atlanta, allegedly used her security clearance to access the computer files of deceased veterans and "resurrect" them.

She then made a full disability claim on behalf of those veterans and substituted Thornton's name, the indictment said.

Payments then were sent to post office boxes in the names of Thornton and Eselhorst, the indictment said. All told,

disclosed that a VA employee accessed and falsified numerous VBA files to generate hundreds of benefit payments under the accounts of veterans who had died and had no beneficiaries. Subsequently, large retroactive benefits checks were disbursed or electronically deposited into accounts belonging to accomplices. Judicial actions are pending.

Loan Guaranty Program Fraud

Investigative cases of fraud associated with the VA loan guaranty program are often conducted jointly with other law enforcement organizations. These cases include loan origination fraud through false statements and counterfeit checks. Other loan fraud includes false documentation, equity skimming, and bankruptcy fraud. A total of 23 judicial actions resulted from OIG investigations in the Loan Guaranty Program area during this period. A brief highlight of one such investigation follows.

- Two individuals pleaded guilty to conspiracy to commit wire, mail, and bank fraud. The guilty pleas were a result of a joint investigation conducted by the VA OIG, FBI, and the Department of Housing and Urban Development OIG. The investigation determined the individuals conspired with others to purchase and dispose of foreclosed VA and HUD properties in connection with a "flipping" scheme. "Flipping" properties generally involves conspirators purchasing foreclosed, Government-insured properties at low prices. The conspirators then obtain bogus appraisals and resell or "flip" the properties to unqualified buyers at significantly higher prices based on the bogus appraisals. As part of the scheme, the individuals created fraudulent supporting documentation on a home computer enabling unqualified buyers to obtain mortgage financing. The total monetary loss in this case for both Government and private industry is estimated at over $600,000. Judicial actions are pending.

Beneficiary Fraud

Accounting for over 30 percent of VA OIG investigative case inventory, fraud associated with the VA's benefit payments programs leads to numerous arrests and judicial actions. Over 30 arrests were made this period in this area. Additionally, stopping payments to those not entitled saves the Department considerable sums of money, and the prosecution of those involved may deter others who may be inclined to commit fraud. The following represents a sampling of these cases conducted during this period.

Dependency and Indemnity Compensation Benefits Fraud

The OIG investigated over 40 instances of Dependency and Indemnity Compensation (DIC) fraud during this semiannual period. Cases often involve individuals failing to report deaths of benefit recipients to VA and then diverting the funds. Additionally, cases involve assumed identities, forgeries, and failure to report remarriage to the Department, which would make the individual ineligible for future benefits. A highlight of one case follows.

- The son and daughter of a deceased widow were sentenced to 4 months' home detention, 36 months' probation, and 300 hours' community service, and ordered to each pay $23,245 in restitution. A joint investigation by VA OIG, U.S. Secret Service, and the Air Force Office of Special Investigations revealed that following the 1993 death of their mother the daughter assumed the mother's identity and continued to receive her DIC benefits through February 2000 creating an overpayment of $69,736.

Pension Benefits Fraud

Similar to DIC fraud, pension fraud includes fraudulent acceptance of payments based on false statements and failing to report disqualifying information. A sample case follows.

- A veteran who was granted pension benefits based on his false claim of zero assets and income was sentenced to 5 years' probation, ordered to make restitution of $34,071, and fined $2,000 in addition to reimbursing the cost of his probation. Investigation disclosed the veteran had received interest on personal investments worth approximately $200,000 that made him ineligible for the pension.

Education Benefits Fraud

A college vice president was arrested for bribing VARO vocational and education division employees to refer veterans as students to his college. He is currently on supervised release until September 2003 following 10 months incarceration based on a conviction in 1999 for filing false tax returns and obstructing justice. The president of the college was also arrested for conspiracy to commit a crime and has been released on bond. Preliminary hearings are scheduled.

Fiduciary Fraud

Fraud committed against disabled or incompetent veterans receives special attention by OIG special agents. During this period the OIG conducted over 10 cases of fraud associated with VA's fiduciary fraud programs. Two sample cases follow.

- Special agents from the OIG acted on information received from a U.S. Customs Service employee and the step-daughter of an 80 year old World War II combat veteran. The step-daughter reported that the veteran, a resident of Mexico for the last 10 years, was in poor health and being mistreated and abused by her brother, the veteran's step-son, with whom he lived. In addition, the step-son was allegedly forging and negotiating the veteran's VA benefits checks. At the request of OIG special agents, and in coordination with VARO Phoenix, officials of the U.S. State Department Consulate Office, Mazatlan, Mexico, conducted a "health and welfare check" and found the veteran living in deplorable conditions at his step-son's ranch near Mazatlan. The veteran was found in a locked bedroom lying on a cot in the fetal position, wearing a soiled diaper and suffering from malnutrition and dehydration. Subsequently, U.S. State Department and Mexican Government officials removed the veteran from the ranch and transported him via ambulance to a local hospital. After further coordination, the veteran was airlifted to the United States and admitted to a VAMC.

Upon his admission to the VAMC, the veteran weighed 81 pounds (80 pounds under his normal weight) and was unable to speak. A criminal investigation is continuing.

- An individual pleaded guilty to three counts of misappropriation by a fiduciary. The guilty plea was the result of a joint investigation by the VA OIG and Social Security Administration (SSA) OIG. The investigation determined the individual, an attorney, misappropriated over $400,000 from the estates of six veterans for whom he served as conservator. Judicial actions are pending.

Theft of Benefits

- The nephew of a deceased VA beneficiary was indicted and charged with three counts of wire fraud. A VA OIG investigation disclosed the veteran died in March 1990 and VA benefits continued via electronic deposits into a joint bank account fraudulently opened by the nephew. Over a 10-year period, the nephew used his deceased uncle's automated teller machine card to access the VA funds for his own personal use. Loss to VA is over $147,000.

- A veteran surrendered to authorities to answer charges of criminal wire fraud. Investigation disclosed that the veteran falsified and altered his military records, including his DD Form 214, Certificate of Release or Discharge from Active Duty, to represent himself as a wounded prisoner of war. He further fabricated his military service by claiming receipt of the Distinguished Service Cross, Silver Star, and a battlefield commission. During a major news network interview, he falsely claimed to be a surviving member of a U.S. Army group ordered to fire on Korean civilians during the Korean War. The veteran's false claims enabled him to receive the Purple Heart and collect disability compensation and medical care benefits from VA, to which he was not entitled, for 16 years. Loss to the Government is estimated at over $400,000.

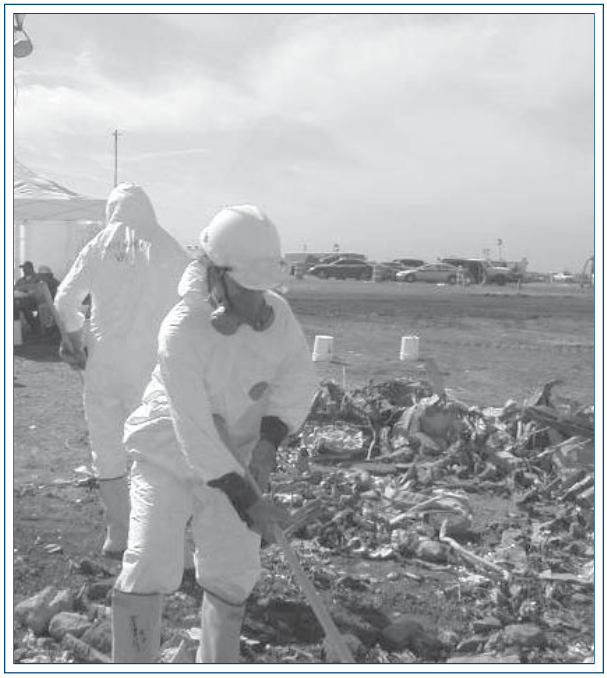
Other Benefits Fraud

- The son of a deceased veteran charged with forging U.S. Treasury checks pleaded guilty to a criminal information. A joint investigation involving the VA OIG, U.S. Postal Inspection Service, and U.S. Secret Service determined the individual cashed VA benefits belonging to his deceased father. The individual admitted he forged the benefits checks for 16 years after his father's death. VA terminated the benefits after being notified by the SSA that the veteran was deceased. Approximately $347,250 in VA benefits was received illegally.

- An unlicensed caretaker and two of her daughters were sentenced for their roles in defrauding various Government agencies and insurance companies. The woman was sentenced to 57 months' incarceration. One daughter was sentenced to 4 months' home confinement with electronic monitoring and 36 months' probation. The second daughter was sentenced to 36 months' probation. A joint investigation by the VA OIG; SSA OIG; Bureau of Alcohol, Tobacco, and Firearms; U.S. Postal Inspection Service; and a state department of insurance fraud division disclosed the women engaged in a scheme to commit fraud, make false claims, and embezzle funds belonging to VA and SSA benefits recipients considered incompetent. The investigation also disclosed the woman and her daughters misused the identity of a 100 percent service-connected disabled veteran and purchased luxury vehicles and jewelry, and obtained credit accounts in the veteran's name. The veteran's identity was also used in connection with fraudulent claims related to bogus automobile accidents. The sentencing judge took into consideration physical abuse that the veteran suffered through alleged beatings by the woman.

Fraud in Connection with the World Trade Center Disaster

- A veteran's sister was indicted and charged with one count of offering a false instrument. An investigation by VA OIG and a local police department determined the sister filed an affidavit for issuance of a death certificate claiming that her brother was at the World Trade Center at the time of the attacks in September. The individual claimed that her brother was a veteran who served in the Army in 1984. VA records were changed to reflect that the veteran died on the date of the attack. Detectives from the local police department determined the veteran was still alive and the veteran's sister received a check for $1,000 from the Disabled American Veterans. Detectives also determined the individual reported two other persons missing who were also alive.



VA OIG investigators participated in World Trade Center recovery operations

Fugitive Felon Initiative

On December 27, 2001, President George W. Bush signed the Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, which, in part, requires VA to withhold specified benefits from veterans and dependents who are fugitive felons. The law requires the Secretary to furnish law enforcement personnel, upon request, the most current address of a veteran or dependent who is determined to be a fugitive felon. Pursuant to this legislation, the Office of Investigations has established a Fugitive Felon Program area that the OIG will administer. Staff members are currently developing necessary procedures and protocols to initiate a program designed to assist law enforcement organizations in apprehending wanted persons and in eliminating those identified as such from the Department's benefits roles. Identifying fugitive veterans and dependents unlawfully receiving VA benefits will primarily be accomplished by conducting computerized matches between VA benefits records and Federal and state active fugitive felon warrant databases. VA OIG will provide information from VA's records to law enforcement agencies to assist them in apprehending fugitive felons where positive identifications have been made. On a case-by-case basis, VA OIG special agents may participate with law enforcement organizations in fugitive felon apprehension efforts. Additionally, the results of VA OIG fugitive felon investigations will be provided to VA to suspend benefits and initiate recovery actions.

OIG Forensic Document Laboratory

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

paper analysis, analysis of photocopied documents, and suspected alterations of official documents.

There were a total of 26 cases completed during this semiannual period.

Laboratory Cases for the Period	
Requester	Cases Completed
OIG Office of Investigations	11
VA Regional Offices	12
Office of Security and Law Enforcement	2
Other	4
TOTAL	**29**

The following is an example of a completed laboratory case:

- A VARO submitted military records to the laboratory that the veteran used as justification for service-connected VA benefits. Laboratory examinations determined some military records were fraudulent based upon information in the records and methods used to create the records. When interviewed, the veteran admitted he had created military records, had not been wounded in combat, and had not been a prisoner of war. The veteran's court sentence is pending. Loss to VA is over $324,000 in compensation payments and $87,000 in medical benefits.

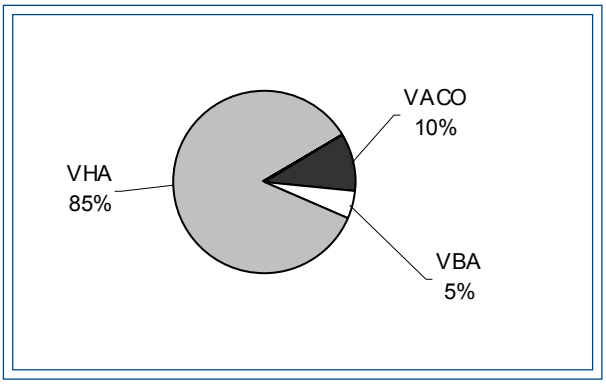
II. ADMINISTRATIVE INVESTIGATIONS DIVISION

Mission Statement

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

Resources

The Administrative Investigations Division has six FTE allocated. The following chart shows the percentage of resources used in reviewing allegations by program area.



Overall Performance

During the reporting period, the Division closed 19 cases.

Output

- During the reporting period, seven reports and four advisory memoranda were issued. Eight cases resulted in administrative closures.

Outcome

- VA managers agreed to take administrative sanctions against 9 officials, and take 14 corrective actions to improve operations and activities as a result of these investigations. The corrective actions included clarifying certain legal issues, issuing new program guidance, clarifying physicians' official duties and time, and charging physicians leave for time not worked.

A sample of the Administrative Investigations Division reports issued during this period are discussed below. These reports address serious issues of misconduct against high-ranking officials and other high profile matters of interest.

Veterans Health Administration

Part-Time Physician Time and Attendance

During this period, the Administrative Investigations Division completed three investigations dealing with part-time physician time and attendance issues. In each of these cases, and based on the reports provided, the Department took necessary corrective actions. A highlight from one of these cases follows.

- An administrative investigation substantiated that a part-time physician routinely worked at a non-VA clinic during his VA core hours, and failed to meet his full VA tour of duty obligation. The investigation also substantiated that the physician's supervisor did not ensure that the physician worked the hours required. In response to our recommendations, appropriate administrative action was taken against the physician and the supervisor, the physician was charged leave for hours not worked, and was instructed to revise his tour of duty at the non-VA clinic. Further, the facility's chief of staff sent a written reminder to other part-time physicians that they are required to be at the medical center during their core hours, unless they are in an appropriate leave status, and must obtain approval when they need to change their non-core hours.

Veterans Canteen Service

- An administrative investigation substantiated that the Director, Veterans Canteen Service (VCS), and various canteen service chiefs did not use funds in the VCS promotional program in accordance with legal restrictions. The Office of General Counsel (OGC) twice stated that these funds may lawfully be used only for activities which have as a primary purpose the promotion of VCS sales or merchandise, as opposed to employee morale or improving a medical center's image. Many of the expenditures reviewed provided no clear evidence that promotion of VCS sales was a primary purpose of the event sponsored. Many did not appear to be logically related to promoting VCS sales, such as providing refreshments purchased at competing businesses, or providing refreshments to individuals at locations that did not have canteens. In response to our recommendations, VHA agreed to discuss with the VCS Director the importance of properly using the promotional fund; to submit recently revised policy guidance to OGC for review; and to ask OGC about the propriety of allocating promotional funds to locations that do not have VCS operations.

Research Funds

- An administrative investigation disclosed that a medical center director certified an agreement to obligate over $414,000 in research funds to the VA supply fund, under the "1VA + Fund" program, without adequately justifying the need for and intended use of the money. The investigation further disclosed that, by using the VA supply fund to carry over research money to another fiscal year, officials circumvented VHA policy requiring field facilities to obtain approval to carry over excess funds, and thereby denied the Office of Research and Development the option of redistributing them. VHA officials agreed to recommendations to discuss with the officials involved the need to properly document supply fund agreements, and the need to adhere to VHA policy requiring approval to carry over excess funds. VHA officials further agreed to ensure the documents obligating the $414,000 were properly amended.

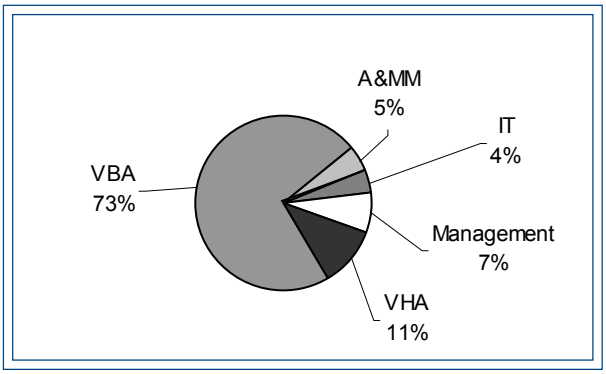
OFFICE OF AUDIT

Mission Statement

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

Resources

The Office of Audit has 176 FTE allocated for its headquarters and eight operating divisions located throughout the country. The following chart shows the allocation of resources used in auditing each of VA's major program areas:



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

Overall Performance

Output

- We issued 21 audits, evaluations, and reviews for an output efficiency of 1 report per 3.9 FTE during this 6-month period. We also issued an additional 31 contract review reports (9 preaward and 22 postaward contract reviews), for an output efficiency of about 2.6 reports per FTE for the 6-month period.

Outcome

- Recommendations to enhance operations and correct operating deficiencies have associated monetary benefits totaling approximately $539.4 million. In addition, contract reviews identified monetary benefits of about $25.4 million associated with the performance of preaward and postaward contract reviews.

Cost Effectiveness

- We achieved a return of about $49 in monetary benefits for every dollar spent on audits, evaluations, and reviews during this 6-month period. We also achieved a return of about $18 in monetary benefits for every dollar spent on contract reviews. Additionally, contracting officers sustained 63 percent of our recommended better use of funds during negotiations.

Customer Satisfaction

- Customer satisfaction with performance and financial audits and evaluations during this reporting period was 4.2 on a scale of 5.0. The average customer satisfaction rating achieved for contract reviews was 4.9 out of a possible 5.0.

Audits completed during the period identified opportunities to improve services to veterans, and identified savings that could be used to increase services. The following summarizes some of the

audits completed during the reporting period organized by VA component: VHA, VBA, Office of Management, Office of Information and Technology, and multiple office action.

Veterans Health Administration

Resource Utilization

Issue: Medical Care Collection Fund (MCCF).
Conclusion: VHA can significantly increase MCCF collections.
Impact: Increase MCCF recoveries by over $500 million.

The purpose of this audit was to: (i) evaluate the implementation of the MCCF program, (ii) follow up on recommendations made in a previous audit, and (iii) determine if there were opportunities to enhance MCCF program recoveries. Results of our audit showed VHA could enhance MCCF collections by requiring VISN and medical facility directors to better manage MCCF program activities. Recommendations made in our prior review of the MCCF program, "Audit of the Medical Care Cost Recovery Program," Report No. 8R1-G01-118, dated July 10, 1998, were not adequately implemented and conditions identified during that audit, including missed billing opportunities, billing backlogs, and inadequate follow up on accounts receivable, were continuing.

We concluded that, by effectively implementing our recommendations, VHA could increase collections by about $135 million (24 percent) in FY 2000. Additionally, clearing the backlog of unissued bills that currently totals over $1 billion would result in additional collections of about $368 million.

We recommended the following actions to improve the MCCF program:

- Communicate MCCF performance goals and expectations to VISN and medical facility directors. Hold them accountable for results by measuring performance and addressing performance gaps.
- Establish performance standards for clinical and administrative staff involved in all phases of the MCCF program (patient registration, coding, billing, collection, and utilization review) and require VISN and medical facility directors to monitor performance results and address performance gaps. Make additional resources available for MCCF functions as justified by the performance standards.
- Improve medical record documentation so that treatments are coded accurately and billed properly.
- Ensure that VA medical facilities use preregistration software.
- Expand training for MCCF personnel (patient registration staff, physicians, coders, billing clerks, collection staff, and utilization review staff).
- Follow up with insurance carriers on delinquent accounts receivable.
- Promote the importance of the MCCF program to veteran patients and staff by demonstrating how MCCF collections benefit each facility's ability to provide medical services to veterans.

The Acting Under Secretary for Health concurred with the audit findings and provided acceptable implementation plans. *(Audit of the Medical Care Collection Fund Program, 01-00046-65, 2/26/02)*

Veterans Benefits Administration

Fraud Detection

Issue: C&P one-time payments and related security controls.
Conclusion: Most one-time payments reviewed were valid. VAROs needed to fully comply with security requirements for the Benefits Delivery Network and for sensitive VA claims files.
Impact: Deterrence of fraud.

At the request of the Secretary of Veterans Affairs, the OIG conducted a special review of large C&P OTPs processed by VAROs. The Secretary requested this review in September 2001 following the discovery that a VARO Atlanta, GA employee had bypassed controls and generated about $11.2 million in fraudulent C&P payments.

The main objectives of the review were to verify the validity of large OTPs and to determine if the type of employee fraud found at VARO Atlanta had occurred at other VAROs. In addition, we reviewed active C&P awards that we considered vulnerable to fraud based on profiles we developed using characteristics associated with employee frauds. We also evaluated VARO compliance with VBA requirements for OTP three-signature reviews, BDN security, and physical security for sensitive C-files. To accomplish these objectives, we conducted onsite reviews at 57 of the 58 VAROs.[1] During these reviews, we also provided fraud and integrity awareness briefings to about 5,150 VARO employees.

We did not find any other instances of employee fraud like that perpetrated at VARO Atlanta. Our review covered 58,129 OTP and 2,129 fraud profile cases, for a total of 60,258 cases. As of March 20, 2002, we had reviewed 59,942 cases (99.5 percent of the total) and had concluded that payments were valid for 59,807 cases (99.8 percent of the cases reviewed). Payments were not valid for the remaining 135 reviewed cases, all of which were OTPs associated with the VARO Atlanta frauds. The 316 unreviewed cases were associated with C-files that could not be located for our review. We will follow up on these cases and report any fraud found to the Secretary.

Our review found unacceptably high rates of noncompliance with internal control requirements related to OTPs and C&P claims processing:

- **OTP Three-Signature Control.** Three-signature reviews were not made for 41,149 (71 percent) of the 57,656 OTPs that were subject to these reviews.
- **BDN Security.** Fifty-three (93 percent) of the 57 VAROs had not fully complied with 6 major controls designed to prevent unauthorized access to and misuse of the BDN system.
- **Sensitive C-File Security.** Seventeen (30 percent) of the 57 VAROs had not transferred all sensitive C-files to other designated VAROs (called sister stations). Of the 49 sister stations, 32 (65 percent) had not securely stored all sensitive C-files.

In September 2001, VBA began requiring that VARO management review all large OTPs to ensure that payments were appropriate and that three-signature reviews were performed. If properly enforced, this procedure can be an effective control for detecting inappropriate OTPs. Accordingly, we did not make any recommendations on OTPs or three-signature reviews.

We recommended that the Acting Under Secretary for Benefits require VAROs to: (i) certify to VBA that they have corrected the BDN and C-file security deficiencies identified by our review, and (ii) annually recertify that they are in full compliance with BDN and C-file security controls. The Acting Under Secretary for Benefits concurred with the recommendations and provided acceptable implementation plans. (*Special Review of VA Compensation and Pension One-Time Payments and Related Security Controls, 01-02957-75, 3/29/02)*

Delivery of Benefits and Services

Issue: C&P overpayments.
Conclusion: VBA needs to implement procedural changes to further reduce benefit overpayments.
Impact: Potential better use of $26.6 million.

The purpose of the evaluation was to follow up on the OIG's Report No. 7R1-B01-105, "Review of the Causes of Compensation and Pension Overpayments," dated December 2, 1996. Another objective of the evaluation was to assess whether VBA's changes in claims processing procedures have helped prevent avoidable C&P overpayments.

C&P benefits are paid to eligible veterans and their survivors. During FY 2000, VA paid about $22.2 billion in C&P benefits to approximately 3.2 million beneficiaries. Overpayments represent debts owed VA and occur when beneficiaries receive payments to which they are not entitled, generally as a result of changes in eligibility status (dependency, income, death, and other changes). The value of the FY 2000 overpayments that were established and remained outstanding as of September 30, 2000 was about $233 million.

Our prior report focused on C&P overpayments, valued at about $120 million that were established and remained outstanding at the end of FY 1995. At that time, we estimated that $26 million in overpayments could have been prevented and we made recommendations to the Under Secretary for Benefits to help reduce overpayments. Two recommendations made were: (i) to revise due process procedures to allow VA to take more timely action to reduce benefit overpayments caused by eligibility status changes, and (ii) to direct VARO and VBA staff to make overpayment prevention a continuous focus area of their quality reviews in order to detect and trend factors contributing to overpayments and take corrective actions.

This review focused on C&P overpayments, valued at $233 million that were established and remained outstanding at the end of FY 2000. We estimated that $26.6 million in overpayments could be prevented annually. While our prior report also estimated that over $26 million of annual overpayments could be avoided, we found that some improvement had been made. In comparison, both the number and value of the overpayments sampled that could have been prevented declined by 4 percent and 10 percent, respectively. Root causes of the preventable overpayments related to: (i) the delay in implementing changes in the due process procedures, (ii) untimely or inappropriate actions taken by VARO staff which often require additional or unnecessary work, and (iii) the need to change claims processing practices that contribute to benefit overpayments. We also found that VARO management had not conducted continuous focused quality reviews to identify opportunities to prevent overpayments.

Since our prior report, VA is designing a number of business process reengineering initiatives including some measures to prevent overpayments. For example, VA is coordinating with the SSA to automate and streamline the process by which VAROs obtain SSA data. Earlier notification and timely processing of changes in Social Security benefits can prevent unnecessary overpayments. Additionally, in November 2000, the Under Secretary for Benefits signed a proposed rule to

amend existing due process requirements, which when implemented, will help prevent overpayments. The final rule was published in the Federal Register with an effective date of December 10, 2001. This allows VA to increase or decrease benefit payments based on information submitted orally or by e-mail, facsimile, or other electronic means, and makes it easier for beneficiaries to submit information that they must provide.

We recommended that VBA management take action to reduce C&P overpayments by: (i) implementing our prior recommendations relating to due process notification procedures and making overpayment prevention a continuous focus area of quality review, (ii) reinforcing and clarifying processing procedures to ensure that timely and complete actions are taken on beneficiary status changes that impact overpayments, (iii) revising VA policy to include all VA entities in the definition of first party, and (iv) revising processing procedures and clarifying VA policy to proactively suspend benefits when bad addresses cannot be resolved. The Acting Under Secretary for Benefits concurred with the findings and provided acceptable implementation plans for the recommendations. *(Follow-up Evaluation of the Causes of Compensation and Pension Overpayments, 01-00263-53, 2/20/02)*

Office of Management

VA's Consolidated Financial Statements

Issue: VA's Consolidated Financial Statements for FYs 2001 and 2000.
Conclusion: Audit resulted in an unqualified opinion, but significant control weaknesses and noncompliance items still remain.
Impact: Improved stewardship of VA assets and resources.

The OIG contracted with the independent public accounting firm Deloitte & Touche LLP to perform the audit. The OIG defined the requirements of the audit, approved the audit plans, monitored the audit, and reviewed the draft reports. The independent auditors' report provided an unqualified opinion on VA's FY 2001 and 2000 consolidated financial statements. We agree with the auditors' opinion, and the conclusions in the related report on VA's internal control over financial reporting and compliance with laws and regulation.

The report on internal control identifies 11 reportable conditions, of which 6 are material weaknesses. Two material weaknesses identified were reported last year: (i) information technology security controls, and (ii) integrated financial management system and control issues. The four new material weaknesses relate to: (iii) management ownership of financial data, (iv) reliance on independent specialists, (v) management legal representations, and (vi) loan guaranty application systems.

The report also discusses five reportable conditions that, while not considered material weaknesses, are significant system or control weaknesses that could adversely affect the recording and reporting of the Department's financial information. The three reportable conditions that were repeated from last year's report are: (i) application program and operating system change controls, (ii) business continuity and disaster recovery planning, and (iii) operational oversight. The two new reportable conditions identified this year are: (iv) authorization of compensation benefit payments, and (v) the loan guaranty business process.

The report on compliance with laws and regulations continues to conclude that VA is not in substantial compliance with the financial management system requirements of the Federal Financial Management Improvement Act of 1996. The internal control issues concerning an integrated financial system and information

technology security controls indicate noncompliance with requirements of the OMB Circulars A-123, A-127, and A-130.

The Principal Deputy Assistant Secretary (PDAS) for Management stated that he had reviewed the report and would share the findings with senior officials in VHA, VBA, and other VA staff and program managers. We will follow up on these findings and evaluate implementation of corrective actions during our audit of VA's FY 2002 consolidated financial statements. *(Audit of VA's Consolidated Financial Statements for Fiscal Years 2001 and 2000, 01-01463-69, 2/27/02)*

Preaward Contract Reviews

Issue: Federal Supply Schedule (FSS) vendors' best prices.
Conclusion: Vendors can offer better prices to VA.
Impact: Potential better use of $2.6 million.

Preaward reviews of three FSS proposals contained recommendations that could lead to cost savings of about $2.6 million. These recommendations were due to the manufacturers not offering the most favored customer prices to the FSS customers when those prices were extended to commercial customers purchasing under similar terms and conditions as the FSS.

Issue: Health care resource contracts.
Conclusion: VA can negotiate reduced contract costs.
Impact: Potential better use of $1.9 million.

We completed reviews of six proposals from VA affiliated medical schools involving scarce medical specialists' services. We concluded that the contracting officer should negotiate reductions of $1.9 million to the proposed contract costs because of differences between the proposed costs for the services solicited and the costs the affiliate could justify during the reviews.

Postaward Contract Reviews

Issue: Contractor overcharges for pharmaceuticals and medical supplies.
Conclusion: Postaward reviews disclosed overcharges.
Impact: Recovery of $20.9 million

- We completed four Public Law 102-585 compliance reviews at pharmaceutical vendors, with recoveries amounting to $885,648.

- We completed 18 reviews of FSS vendors' contractual compliance with specific provisions of their FSS contracts. Recoveries amounted to $20 million.

Maintaining an aggressive postaward contract review program has resulted in numerous companies submitting voluntary disclosures and refund offers for overcharges on their contracts with VA. Contract review recoveries are a major source of revenue to VA's Revolving Supply Fund. These recoveries reflect VA working as a team with Acquisition and Materiel Management and VHA personnel, Office of General Counsel attorneys, and the Office of Inspector General participating in an effort to ensure that VA's contracts are fairly priced.

Office of Information and Technology

Security Controls

Issue: VA's information security program.
Conclusion: VA's programs and sensitive data are vulnerable to destruction, manipulation, and inappropriate disclosure.
Impact: Improved automated data processing security.

The audit evaluated VA information security controls and management and found that significant security vulnerabilities continue to place the Department at risk of:

- Denial of service attacks on mission critical systems.
- Disruption of mission critical systems.
- Unauthorized access to and disclosure of data subject to Privacy Act protection and sensitive financial data.

The following key issues were identified:

- VA has established comprehensive information security policies, procedures, and guidelines, but implementation and compliance have been inconsistent.

- VA has been slow to implement a risk management framework. As a result, VA does not comply with the Government Information Security Reform Act (GISRA); OMB Circular A-130, Appendix III; and Presidential Decision Directive 63 security requirements.

- Penetration tests verified that VA systems could be exploited to gain access to sensitive veteran benefit and health care information.

- VA information security vulnerabilities should continue to be identified as a Departmental material weakness area under the Federal Managers' Financial Integrity Act.

While the Secretary of Veterans Affairs has appointed a Department level Chief Information Officer (CIO) to provide leadership and direction to VA's information security program and to facilitate a "One-VA" approach to information security, additional action is needed. We made a series of recommendations to the CIO to address the information security weaknesses identified by the audit. The CIO concurred with the recommendations and provided acceptable implementation plans.

We also recommended that the PDAS for Management establish centralized information security budgetary control for all information technology initiatives. While the PDAS for Management did not agree with this recommendation, details were provided on other actions to implement control measures over the information technology approval and acquisition process that generally meets the intent of the recommendation.

Recently, VA completed installing the enterprise-wide anti-virus infrastructure. The Office of Cyber Security has worked closely with the OIG to establish priorities for GISRA remediation actions and in the development of a Departmental security plan that is organized by priorities established by the OIG. However, the OIG believes the schedule for corrective and remediation actions is not aggressive enough to ensure timely corrective actions. *(Audit of the Department of Veterans Affairs Information Security Program, 00-02797-01, 10/24/01)*

Multiple Office Action

Issue: VA's HR LINK$ payroll and human resources system replacement project.
Conclusion: HR LINK$ project was not effectively managed, and prior audit recommendations were not implemented.
Impact: Improved project management and better use of funds.

The objectives of this audit were to: (i) follow up on the recommendations of a prior OIG review, and (ii) advise Department officials on the appropriateness of continuing with the HR LINK$ project as the best means of achieving an effective payroll and human resources system in a cost efficient manner.

The original scope of the HR LINK$ project was to replace VA's antiquated payroll system and to automate VA's personnel functions. This was the second OIG review performed after the first evaluation found problems with project management, accumulation of cost data, security controls, and project slippage. The estimated project completion date has slipped from FY 1999 to FY 2003. The estimated project cost was $37 million. New budget estimates projected completion in FY 2006 with an estimated cost of $469 million. As of October 2001, VA still lacked a finished replacement system for its human resource and payroll functions.

This audit identified a number of issues and areas of concern that need improvement and increased oversight by VA officials. Project documentation of plans and goals was insufficient. There was a lack of supervisory control over contractor performance. Managers did not ensure that VA received value for money spent. Stakeholders were not adequately involved in project planning. The project did not comply with the Information Technology Management Reform Act of 1996 (the Clinger/Cohen Act). Project managers did not properly carry out administrative functions.

To address these issues, we recommended no further resources be expended on the HR LINK$ project until a determination is made of what the stakeholders want in a payroll and human resources system. Based upon stakeholder decisions, determine if continuing with the HR LINK$ project will meet the Department's and stakeholders needs and result in a cost effective system for VA, or whether alternatives should be sought.

The PDAS for Management and the Assistant Secretary for Human Resources and Administration concurred with all findings and recommendations in the report and provided acceptable implementation plans.

The Secretary of Veterans Affairs, based on the recommendation of the VA Senior Management Council, approved the shutdown of the HR LINK$ project. All development and software license contracts were terminated by January 2002. The PDAS for Management reported that total HR LINK$ project costs at the end of FY 2002 will be aproximately $240 million and VA avoided the potential additional $229 million of cost to complete the HR LINK$ project. *(Audit of VA's HR LINK$ Payroll and Human Resources System Replacement Project, 01-00949-81, 3/29/02)*

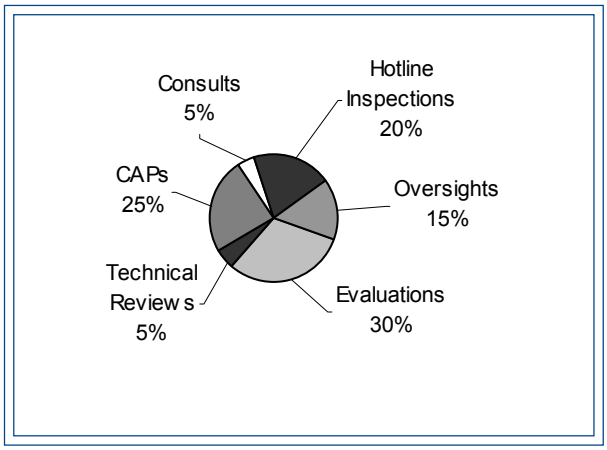
OFFICE OF HEALTHCARE INSPECTIONS

Mission Statement

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

Resources

The Office of Healthcare Inspections (OHI) has 46 FTE allocated to staff headquarters and field operations. Twelve of the 46 FTE are new positions allocated for the activation of two new Healthcare Inspections field offices in Dallas, Texas, and Bedford, Massachusetts. The following chart shows the allocation of resources used in inspecting each of VA's major health care areas.



Overall Performance

Output

Inspectors completed 195 initiatives this reporting period.

- We participated in 11 CAP reviews, evaluated health care-related issues, and developed 54 recommendations to improve operations and activities, and the care and services provided to patients.

- We completed 1 program evaluation and 1 focused review, and developed 21 recommendations to correct conditions identified and improve the care and services provided to patients.

- We completed 17 Hotline cases in which we reviewed 54 issues, and developed 47 recommendations to correct conditions identified and improve the care and services provided to patients.

- We monitored the completion of another 106 Hotline cases by VHA, and reviewed 170 associated issues.

- We provided clinical consultative support to investigators on six criminal cases.

- We followed up on recommendations made at nine medical centers to ensure managers acted on their implementation plans to improve care and services.

- We completed 44 technical reviews on recommended legislation, new and revised policies, new VA program initiatives, and external draft reports.

Outcome

- Overall, we made or monitored the implementation of 122 recommendations to improve the quality of care and services provided to patients and their families. VHA implementation plans will improve clinical care delivery, management efficiency, patient safety, and employees' accountability for their actions.

Veterans Health Administration

Program Review

Issue: Adequacy of security and inventory controls over selected agents.
Conclusion: Managers needed to strengthen security and inventory controls in research and clinical laboratory areas.
Impact: Increased public safety by strengthening security over biological agents, toxic chemicals, and radioactive materials, and improved monitoring of foreign nationals and contractors working in VA medical facilities.

In the wake of terrorist attacks on September 11, 2001, and growing concerns of anthrax discovered in the U.S. postal system, we reviewed the adequacy of security and inventory controls over selected biological, chemical, and radioactive agents owned by or controlled at VA facilities. We obtained and verified inventories and employment information received from 88 VA facilities that had biosafety level (BSL)-2 and BSL-3 research laboratories. A BSL-3 level designation means that a laboratory requires safety precautions to handle indigenous or exotic agents, which carry potential for harm or aerosol exposure. Exposure to these agents may have serious or even lethal consequences.

Common findings included unsecured laboratory entrances, weak key turn-in controls, and unchanged codes to combination locks. There was an absence of security devices such as video-surveillance equipment, key-card or biometric devices monitoring traffic in and out of laboratories, or jimmy plates on doors. We also found unlocked refrigerators and unlocked storage containers that were used to hold sensitive agents. Access controls also varied at VA facilities.

Thirteen percent of the laboratory areas reviewed were not adequately restricting public access. Most laboratories were not using logbooks to monitor individuals accessing the laboratory areas. Two facilities were allowing unescorted vendors to deliver radioactive materials to storage areas after hours. Better controls were needed to account for non-citizen without compensation researchers, employees, and contractors having access to laboratory areas. Tracking of non-citizen employees and contractors was generally not performed.

We made 16 recommendations to strengthen security, access, inventory, and oversight requirements and procedures for safeguarding all high-risk or sensitive materials or agents used in VA facilities, including items on the Centers for Disease Control and Prevention select agents list, other biological agents and toxic chemicals, and those pharmaceuticals that have the potential to become weapons of mass destruction. The Acting Under Secretary for Health concurred with our recommendations and provided responsive implementation plans. *(Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities, 02-00266-76, 3/14/02)*

Focused Inspection

Issue: Effectiveness of VHA's compliance program.
Conclusion: Coding errors were significantly higher than the Health Care Finance Administration's error rate.
Impact: Proper reimbursement for services.

We conducted a review of VHA's compliance programs and coding accuracy at selected VHA medical facilities. Our review of outpatient coding at 15 VA medical facilities showed that employees needed to focus their attention on reducing the coding error rate for outpatient visits and improving

their internal control procedures. About 50 percent of the 570 outpatient visits reviewed contained coding errors - significantly higher than the 30 percent error rate the Health Care Finance Administration reported from its review of private sector billings.

Managers had made progress in implementing the compliance program, but several improvements could be made, including the establishment of a national hotline for compliance reporting. Managers also need to better educate clinicians on the necessary documentation requirements to accurately bill for services rendered. Managers need to evaluate the outcomes of their training efforts, and include their evaluation results in subsequent training sessions.

We recommended the Under Secretary for Health require VHA managers to set incremental goals to improve coding accuracy, train clinicians and coders, and implement a compliance program at all VA facilities. The Under Secretary for Health concurred with the recommendations and provided responsive implementation plans. *(Evaluation of Veterans Health Administration Coding Accuracy and Compliance Program, 01-00026-68, 2/25/02)*

Healthcare Inspections (Hotline Cases)

Issue: Hemodialysis care.
Conclusion: Hemodialysis patients did not always receive prompt and adequate surgical and radiological interventions to support their needs.
Impact: Improved procedures for coordinating care of hemodialysis patients between services.

Complainants made serious allegations about the promptness and adequacy of hemodialysis. We concluded that: (i) patients were not always receiving prompt and adequate surgical and radiological interventions necessary to support the health care needs of chronic hemodialysis patients,

Louis Stokes VA Medical Center
Cleveland, OH

(ii) patients were not receiving permanent vascular access in a timely manner, and (iii) patients who received vascular access experienced serious infections.

We made nine recommendations to improve the quality of care provided to hemodialysis patients. The Director concurred with our recommendations and provided acceptable implementation plans. *(Healthcare Inspection – VA Hemodialysis Program, Louis Stokes Veterans Affairs Medical Center, Cleveland, Ohio, 00-02913-04, 10/2/01)*

Issue: Patients' death in the operating room.
Conclusion: One patient death warranted evaluation by the quality manager.
Impact: Strengthened procedures for conducting boards of investigation.

A complainant alleged that: (i) the Director purposefully withheld the results of a board of investigation he (the complainant) requested, (ii) clinical managers did not investigate two operating room deaths, and (iii) managers did not adequately investigate an allegation that an employee verbally abused a patient. Although we did not substantiate any of the allegations, we did find that one death which occurred in the operating room needed to be evaluated by quality managers.

We recommended the Director initiate a review of the death. The Director concurred with our

recommendation and provided acceptable implementation plans. *(Healthcare Inspection – Board of Investigation and Patient Care Issues, VA Medical and Regional Office Center, Fargo, North Dakota, 01-00981-2, 10/2/01)*

Issue: Patient transfer policies and procedures.
Conclusion: Emergency Room clinicians were unaware of 911 emergency transfer procedures.
Impact: Strengthened understanding of emergency transfer procedures.

An employee of the New York Department of Health alleged that VAMC Emergency Room clinicians transferred an unstable patient to one of their community hospitals without notifying the facility or forwarding the medical records. We found that VAMC clinicians transferred the patient as a 911 emergency to a nearby trauma center. In effecting the emergency transfer, VAMC clinicians did not notify the receiving hospital and neglected to forward the appropriate medical information. VAMC clinicians did not inform the receiving hospital because they did not know where the ambulance personnel were taking the patient. We also found the patient waited an excessive amount of time at the VAMC before being transferred.

We concluded that VAMC Emergency Room clinicians were unaware of alternative trauma unit transfer options when 911 emergency transfers are necessary. We made four recommendations that will strengthen employees' understanding of emergency transfer procedures. The Director concurred with our recommendations and provided acceptable implementation plans. *(Healthcare Inspection – Patient Transfer and Discharge Issues, VA Medical Center, Brooklyn, New York, 01-00809-3, 10/2/01)*

Issue: Reporting to the National Practitioner Data Bank (NPDB).
Conclusion: Director was unaware of reporting requirements.
Impact: Weakening of the NPDB's effectiveness.

Our review found that a VAMC Director did not report a physician's performance related infractions to the NPDB as required by VHA policy. The Director formally agreed not to report the physician in return for the physician's resignation. VHA policy expressly prohibits officials from entering into such agreements. Actions such as these weaken the NPDB in serving as a clearinghouse for information about health care providers.

VA Medical Center
Fayetteville, NC

Action was taken to educate all VAMC directors regarding this requirement, and to report the physician's infractions to the NPDB. Appropriate administrative action was also taken against the responsible Director who did not comply with VHA policy. *(Healthcare Inspection – Reporting Infractions to the National Practitioner Data Bank, Veterans Affairs Medical Center, Fayetteville, NC, 01-00900-11, 10/30/01*)

Issue: Patient abuse.
Conclusion: Clinicians were remiss in documenting treatment and reporting changes in a patient's condition.
Impact: Improvements in documentation and communication procedures.

A complainant alleged that a nurse treated a patient abusively and that this treatment may have contributed to the patient's death. The complainant also alleged that nursing employees were negligent in their care of other patients on the unit. We did not substantiate the complainant's allegation of abuse or neglect. However, we found several instances in which clinicians were remiss in their responsibilities to document treatment and to communicate changes in the patient's condition. We also found significant deficiencies in nursing documentation on the unit and an apparent breakdown in communication between the residents, the nurses, and the family.

VA Medical Center
Houston, TX

We made five recommendations to correct the deficiencies. The Director concurred with our recommendations and provided acceptable implementation plans. (*Healthcare Inspection – Allegations of Poor Care, Veterans Affairs Medical Center, Houston, TX, 01-01345-05, 11/16/01)*

Issue: Quality of care.
Conclusion: Patient received appropriate and timely care.
Impact: Greater awareness of privacy laws.

A complainant alleged that her brother received substandard treatment and that VAMC employees were unresponsive to her inquiries about her brother's medical condition. We did not substantiate the allegation of substandard treatment. We found that the patient received appropriate and timely care.

We concluded that medical center employees properly complied with privacy laws when they withheld the patient's medical information from the complainant. The patient's brother was his legal guardian. Privacy laws prohibited clinicians from discussing anything about the patient's condition with anyone but the legal guardian. *(Healthcare Inspection – Alleged Substandard Care Provided to a Patient at the Department of Veterans Affairs Medical Center, Chillicothe, Ohio, 01-01951-19, 11/19/01)*

Issue: VA-contracted transitional living house.
Conclusion: VAMC and transitional house employees had not implemented collaborative performance improvement initiatives to ensure adequate care for VA contract patients.
Impact: Adequate care for homeless veterans.

We reviewed allegations from several veterans about the services and management at a VA-contracted transitional living house. The complainants alleged that the administrator violated professional and ethical codes of conduct by borrowing money or accepting gifts from residents, using sexually explicit and abrasive language with residents, and discussing confidential resident information in group settings. They also alleged that staff ignored drug sales and usage in

the house, engaged in arbitrary treatment and discharge planning decisions, and did not provide an adequate treatment environment.

We did not substantiate the complainants' allegations. The transitional living house staff generally managed the program in accordance with established policies, and veterans received appropriate transitional housing and case management services. Nevertheless, we found that VAMC and transitional living house employees had not implemented appropriate collaborative performance improvement initiatives to ensure adequate care for VA contract patients.

We made two recommendations to ensure implementation of the improvement initiatives. The Medical Center Director concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection – Homeless Veterans Issues, James H. Quillen VA Medical Center, Mountain Home, Tennessee, 01-01848-57, 2/25/02)*

"I asked the OIG for assistance and appreciated your response. The outcome was beneficial to our patients, our facility, and the community home. Thank you."

Chief
Quality Management & Improvement Service
Mountain Home, TN

Issue: Quality of care to patient on long-term care ward.
Conclusion: Patient's falls could not be associated with employee negligence.
Impact: Increased awareness of restraint-free policy.

A patient's husband alleged that his wife received substandard care during her stay at the health care system's geriatric and rehabilitation center. The complainant alleged that earlier the patient fell twice due to employee negligence, and the facility was pilot-testing a restraint-free policy and used the patient experimentally which resulted in one of the serious falls. He also alleged that physicians never examined the patient during her stay at the center and that medical record documentation was inadequate.

Southern Arizona VA Health Care System
Tucson, AZ

Because the incidents occurred in distant history and critical information could not be reconstructed, it was not possible to associate the patient's falls with employee negligence or the restraint-free policy. The restraint-free policy was in place and consistent with prevailing medical practice at the time the falls occurred. We also concluded that employees followed all Joint Commission on Accreditation of Healthcare Organizations requirements, Omnibus Budget Reconciliation Act regulations, and facility policies. The evidence that was available did not support the allegations. Therefore, we did not make any recommendations. (*Healthcare Inspection – Patient Care Issues, Southern Arizona Veterans Affairs Health Care System, Tucson, Arizona, 02-00078-61, 2/25/02)*

Issue: Quality of care.
Conclusion: Patient's care was appropriate.
Impact: Strengthened procedures for managing advance directives.

The son of a deceased patient alleged that his father's death resulted from poor care at a VA contract nursing home (CNH), and that clinicians at VAMC Gainesville removed his father from ventilator support without his approval. We did not substantiate the complainant's allegations. It appears that the CNH staff appropriately managed the patient's needs. Similarly, we did not substantiate the complainant's allegation that clinicians removed his father from a ventilator without his (the son's) consent.

Northern Florida-Southern Georgia
Veterans Health System
Gainesville, FL

However, we concluded the VAMC staff did not have adequate procedures to ensure that patients' advance directives were consistently recorded in the medical record, and CNH program managers had not implemented appropriate treatment monitors in response to identified deficiencies. We made four recommendations to address identified deficiencies. The Health System Director concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection – Contract Nursing Home Issues, North Florida/South Georgia Veterans Health System, 01-02889-60, 2/26/02)*

Issue: Treatment quality and service issues.
Conclusion: Managers had not adequately communicated their plans to stakeholders.
Impact: Improvements in procedures and communication.

We received several anonymous complaints concerning issues at the two VAMC campuses (Ft. Wayne and Marion, IN) that comprise the VA Northern Indiana Health Care System. We also received a congressional inquiry concerning the adequacy of inter-facility transfers between the two campuses, and acquisition procedures for contracted ambulance services.

Complainants alleged that: (i) some patients who were sent for clinic appointments by shuttle from Marion to Ft. Wayne were dropped off without adequate return transportation arrangements; (ii) managers were closing beds at the Ft. Wayne and Marion campuses without proper discharge planning for hospitalized patients or sufficient stakeholder involvement; (iii) adverse patient outcomes resulted from inter-facility transfers of clinically unstable patients; and (iv) ambulance contracts were not competitively awarded.

Marion Campus
Northern Indiana Veterans Health System
Marion, IN

We found that VA shuttle services between Ft. Wayne and the Marion could be improved to

Ft. Wayne Campus
Northern Indiana Veterans Health System
Ft. Wayne, IN

ensure all patients who are transported for clinical appointments have a means to return to their assigned campuses. VA managers were addressing this issue. Additionally, we substantiated that there was a plan to close all acute medical beds at the Marion campus. A perception existed amongst some stakeholders, that the health care system Director did not fully communicate the justification for the Marion bed closure plan as required by a VHA directive. However, managers subsequently reevaluated the issue and decided not to close the beds. We did not substantiate the allegations of inappropriate patient transfers, inadequate discharge planning, and improper acquisition procedures for awarding an ambulance contract. (*Healthcare Inspection – Treatment Quality and Service Issues at the VA Northern Indiana Health Care System, 01-02748-64, 3/7/02)*

Issue: Nurse licensing.
Conclusion: Nursing supervisor failed to properly notify the nurse executive of a nurse's license suspension.
Impact: Increased awareness of notification requirements.

A complainant alleged that VA managers did not take appropriate actions when a registered nurse practitioner (NP) had her license suspended. The complainant also alleged reprisal by VA managers after she reported the incident, but she had already sought the assistance of the Office of Special Counsel.

The NP was reported to the Maryland State Board of Nursing for falsifying an HIV report. The Board suspended the NP's license; however, the NP believed the suspension was not in effect until the Board president signed it. The NP notified her immediate supervisor of what she believed to be a pending suspension of her license. However, the supervisor failed to promptly notify the nurse executive of the situation. When the nurse executive learned of the Board action, she immediately suspended the NP, and actions were taken to remove both the NP and the supervisor.

We substantiated that the NP's immediate supervisor mismanaged this situation, but health care system senior managers, when informed of the suspension, immediately took appropriate actions. Because the Director acted properly to resolve the issues, we did not make any recommendations. *(Healthcare Inspection – Nurse Licensing Issue, VA Maryland Health Care System, 01-02956-66, 3/13/02)*

Issue: Therapeutic interchange practices.
Conclusion: Patients may have serious adverse reactions from therapeutically interchanging calcium channel blockers.
Impact: Reduce the risk of patients experiencing adverse drug reactions, and educating clinicians on the risks.

Complainants alleged that four patients at one medical center had serious adverse drug reactions caused by physicians therapeutically interchanging the anti-anginal, anti-hypertensive drug felodipine for a similar drug named amlodipine. Both amlodipine and felodipine are cardiovascular drugs known as calcium channel blockers. These drugs generally provide therapeutic effects for many individuals suffering from high blood pressure and chest discomfort.

Therapeutic interchange is an accepted practice in formulary management in managed health care systems and is a valid technique for keeping a

formulary within manageable limits. In and of itself, the practice does not present ethical or clinical obstacles to the practice of good medicine. VHA has suggested that physicians' prescribe felodipine over amlodipine when patients were already using felodipine, when patients for whom a calcium channel blocker was to be newly prescribed, and when it was practicable for patients on amlodipine to be switched to felodipine. VHA cautioned clinicians that these guidelines were not intended to interfere with clinical judgment, but were intended to assist practitioners in providing cost effective care.

At this medical center, physicians informed us they did not feel they had the discretion to decline to make amlodipine to felodipine therapeutic interchanges for their patients. They informed us that they were required to complete a complicated form which listed overly restrictive physiologic parameters to justify permitting patients to stay on amlodipine.

The four patients brought to our attention all had severe cardiac disease manifested by multiple myocardial infarctions, left ventricular dysfunction, and stable angina pectoris. In each instance, clinicians made an amlodipine to felodipine therapeutic interchange. These interchanges were followed by cardiac destabilizations expressed as unstable angina pectoris and acute pulmonary edema. These destabilizing events appeared to occur at varying lengths of time after the prescribed substitutions, therefore, we do not have direct evidence to establish that the cardiac destabilizations occurred in these patients because of a felodipine for amlodipine therapeutic interchange. We concluded, however, that there was a temporal relationship that was worthy of further study, and that these interchanges may not have been prudent given the patients' clinical histories.

Recommendations were made to the Under Secretary for Health to reassure clinicians that they have the discretion based upon clinical judgment to decline therapeutic interchanges. We also recommended the development of educational and informational programs on this subject matter highlighting the risks of therapeutic interchanges. In addition, we requested VHA to review the temporal association between felodipine for amlodipine therapeutic interchanges and worsened cardiac symptoms on a sufficient patient control group that would meet the standards of scientific proof or evidence-based medicine. These studies are necessary to confirm whether these were isolated cases or indicative of a greater problem. *(Healthcare Inspection – Veterans Health Administration Therapeutic Interchange Practices, 00-01362-45, 3/22/02)*

Issue: Quality of care and safety issues.
Conclusion: Quality of care to spinal cord injury unit patients and women veterans could be improved.
Impact: Improved care.

We received allegations concerning the quality of care provided to patients in the Spinal Cord Injury Program, inequitable care for women veterans, and other treatment quality and safety concerns. We found deficiencies in the management of the program. Managers made several organizational changes to meet the program's needs and to focus on making improvements. However, we found that the Spinal Cord Injury unit had a staff shortage and aging equipment. Managers need to resolve a number of women patient-related issues, specifically: (i) privacy and safety, (ii) supervision of gynecology resident physicians, (iii) unavailability of formulary medications for women, (iv) unavailability of equipment for women-related examinations, (v) privacy for women patients receiving radiology services, and

(vi) availability of feminine hygiene products. We also found deficiencies in the VAMC's visitation polices and infection control procedures.

We made 16 recommendations. The Director concurred with the recommendations and provided responsive implementation plans. *(Healthcare Inspection – Quality of Care and Safety Issues, Department of Veterans Affairs Medical Center, San Juan, Puerto Rico, 99-01417-28, 3/26/02)*

Healthcare Inspections (Oversight Inquiries)

During the reporting period, OHI oversaw the completion of 106 Hotline cases referred to VHA for action. These cases involved 170 allegations, of which 117 (69 percent) had merit based on the information available. VA managers acted to create new or strengthen existing procedures, take administrative actions, offer more education and training, improve quality of services, strengthen patient safety procedures, enhance the physical plant environment, and realign resources.

OFFICE OF MANAGEMENT & ADMINISTRATION

Mission Statement

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

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

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

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

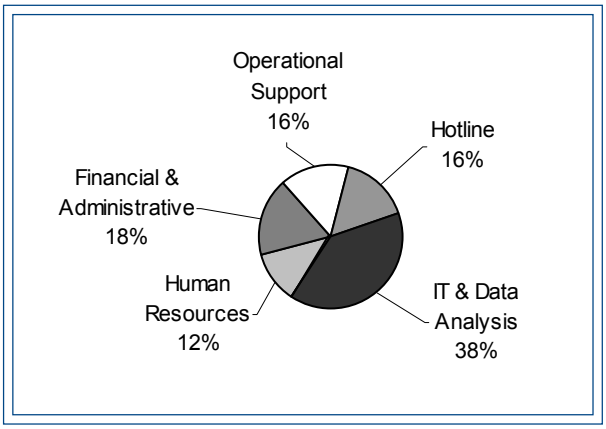
III. Information Technology (IT) and Data Analysis Division - The Division manages nationwide IT support, systems development and integration; represents the OIG on numerous intra- and inter-agency IT organizations; and does strategic IT planning for all OIG requirements. The Division maintains the Master Case Index (MCI) system, the OIG's primary information system for case management and decision-making. The Data Analysis Section, located in Austin, TX provides data processing support, such as computer matching and data extraction from VA databases.

IV. Financial and Administrative Support Division - The Division is responsible for OIG financial operations, including budget formulation and execution, and all other OIG administrative support services.

V. Human Resources Management Division - The Division is responsible for OIG personnel management, which includes classification, staffing, employee relations, training, and incentive awards programs.

Resources

The Office of Management and Administration has 55 FTE allocated to the following areas.



I. HOTLINE DIVISION

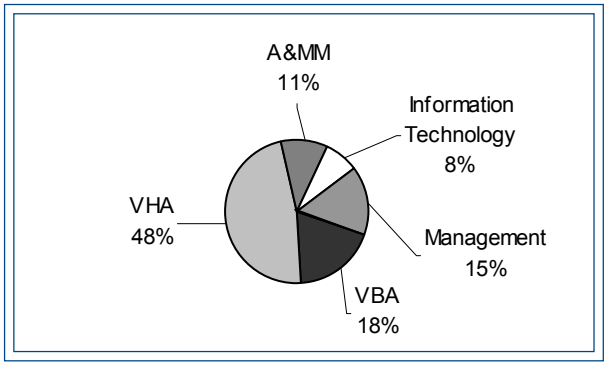
Mission Statement

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

The Division operates a toll-free telephone service 5 days a week, Monday through Friday, from 8:30 AM to 4 PM Eastern Time. Phone calls, letters, and e-mail messages are received from employees, veterans, the general public, Congress, U.S. General Accounting Office, and other Federal agencies reporting issues of fraud, waste, and abuse. Due consideration is given to all complaints and allegations received; mission-related issues are addressed by OIG or other Departmental staff.

Resources

The Hotline Division has nine FTE. The following chart shows the estimated percentage of resources devoted to various program areas.



Overall Performance

During the reporting period, the Hotline received 8,036 contacts. Of this number, 681 cases were opened. The OIG reviewed 220 (32 percent) of these and the remaining 461 cases were referred to VA program offices for review.

Output

- During the reporting period, Hotline staff closed 776 cases, of which 180 contained substantiated allegations (23 percent). The Hotline staff generated 107 letters responding to inquiries received from members of the Senate and House of Representatives.

Outcome

- VA managers imposed 58 administrative sanctions against employees and took 92 corrective actions to improve operations and activities as the result of these reviews. The monetary impact resulting from these cases totaled $411,690.

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

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

Veterans Health Administration

Quality of Patient Care

The responses to Hotline inquiries by VA management officials indicated that 36 allegations regarding deficiencies in the quality of patient care provided by individual facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review found a contract radiologist was compromising patient safety and delaying patient diagnoses by failing to process x-rays in a timely manner. As a result, management terminated the radiologist's contract and hired a new non-VA radiologist. Additionally, the medical center radiology function was organizationally realigned under the chief of staff who will provide direct supervision and coordination of activities of both the contract and the medical center radiologists.

- A VHA review substantiated inappropriate treatment and a delay in the treatment of a patient by pharmacy service. The veteran waited in extreme pain for over 3 hours only to be informed that a non-formulary controlled substance was unavailable from pharmacy inventory. The patient left the facility without a substitute medication. The facility has implemented an inventory check procedure for non-formulary medications with a subsequent referral to the clinic physician in charge should it become necessary to provide a substitute medication for a patient.

- A VHA review substantiated the allegation of an 11-month delay in diagnosis and treatment of a veteran with rectal cancer. The facility failed to notify the veteran's care provider of a positive fecal occult blood result. The facility has instituted a revised policy to include a care provider computer alert system on positive fecal occult blood results with subsequent follow up by the chief of staff.

- A VHA review substantiated a veteran's allegation that a physical therapist attempted to remove the veteran's leg brace in a crowded waiting room. The therapist was counseled on patient privacy and a policy was revised to prohibit such practices in the future.

- A VHA review determined that some VAMC patients received substandard care regarding the timeliness of cancer diagnoses and continued treatment. The review found that in some instances there were inordinate delays in follow up and the scheduling of appropriate diagnostic testing and treatment. The review also determined that possible causes of these delays were the lack of adequate continuity and patient follow up and staff did not respond as quickly and effectively as required to diagnose and initiate timely treatment. A process action team is currently reviewing the issues and has preliminarily identified the consultation process, conversion to electronic medical records, and physician-to-physician communication as contributing factors to the system breakdowns. Additionally, management will monitor the results of the peer reviews.

- A VISN review found that VAMC staff failed to adequately or timely respond to a veteran's needs. Although the veteran was referred to social work and the sleep lab, it was 2 to 3 months before anyone contacted him. The review also found that calls placed to a patient representative were not returned. The staff is developing procedures to ensure timely responses to patients' needs. Management is taking administrative action against the social worker, the patient representative, and the director of the sleep lab.

- A VHA review found that a veteran was prematurely discharged prior to receiving timely and proper treatment. The review also found that three physicians did not properly monitor the patient. Although these conditions were cited as improper care provided to the veteran, they did not cause injury to the patient. Management provided written counseling to the physicians.

- A VAMC review substantiated allegations of inappropriate care by a contract physician. The physician refused to refer a patient for an MRI, suggested he have this diagnostic test done in a private facility and advised the patient he could complain as much as he wished, as she (the physician) did not work for the VA. This same physician also failed to adequately address the veteran's concerns regarding the monitoring of his diabetes. Management counseled the physician who subsequently resigned. The veteran was referred for the requested MRI and his concerns

were addressed by another care provider. The veteran also received follow up primary care appointments.

Employee Misconduct

The responses to Hotline inquiries by management officials indicated that 11 allegations of employee misconduct at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review substantiated an allegation that an employee misused a Government telephone to place 92 personal long distance calls. Management has proposed a suspension for the employee and is billing the employee $379 for the calls. In a similar case at another facility, an employee admitted to making personal long distance calls and agreed to make restitution of $127 for the cost of the calls. The second VAMC is also taking disciplinary action against the employee.

- A VHA review found that a VA employee was unlawfully removing Government office supplies and equipment from the warehouse and providing it to his brother-in-law, who works for a local parts store. Management is taking administrative action against the employee.

- A VHA review found that an employee misused her Government e-mail account by sending a grossly inappropriate e-mail of a personal nature to private citizens. The VAMC is proposing a 14-day suspension for the employee.

Time and Attendance

The responses to Hotline inquiries by management officials indicate that two allegations of time and attendance abuse at individual VA facilities were found to have merit and required corrective action. The summaries follow:

- A VHA review of on-call scheduling and timekeeping procedures at a VAMC substantiated errors in the payment of on-call employees. The facility has corrected all timecard errors and is currently revising the on-call process to avoid a recurrence of this matter.

- An administrative board of investigation found that a supervisor established and implemented an unofficial compensatory time policy, thereby falsifying time and attendance reports. The supervisor was admonished.

Fiscal Controls

The responses to Hotline inquiries by management officials indicate that five allegations of deficit or improper fiscal controls at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VACO review found that a VAMC improperly authorized $54,228 in temporary quarters subsistence expense allowances and advances to eight transferring employees who lived less than 40 miles from their new duty station. The VAMC issued bills of collection to the employees.

- A VHA review confirmed that an employee who traveled and submitted his travel voucher in November 2000 was not reimbursed until November 2001. The VAMC has since instituted a new system comprised of a travel voucher log in/log out system, e-mail capability, and an intensive follow up activity.

Patient Safety

The responses to Hotline inquiries by management officials indicate that five allegations of patient safety deficiencies at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review found that an amputee patient fell out of his wheelchair while being pulled up a ramp by a contract van driver. The driver initially refused to assist the patient. Another patient on the van, along with the driver, eventually returned the patient to his wheelchair. As a result, patient care administrative services requested vendor education for all drivers regarding safe movement of amputee patients.

- A VHA review at a state veteran's home found that a paraplegic veteran did not have access to emergency cords, or a proper wheelchair ramp. The review also found that residents were allowed to smoke alongside veterans using oxygen tanks in the recreation room. The state home's management is working with VAMC officials to correct these deficiencies.

Government Equipment and Supplies

The responses to Hotline inquiries by management officials indicate that two allegations involving misuse of Government equipment and supplies at individual VA facilities were found to have merit and required corrective action. An example follows:

- A VHA review determined that a VAMC employee used an official Department of Veterans Affairs envelope and letterhead to forward personal correspondence to a county judge requesting issuance of a permanent protective order against a then fellow VA employee. The employee was issued a written letter of counseling and advised that future incidents may result in disciplinary action.

Contracting Activity

The responses to Hotline inquiries by management officials indicate that three allegations involving contracting improprieties or problems with contracted services at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review substantiated the allegation of problems with administrative services. The review found that a veteran received two pre-appointment letters notifying him of appointments, after the appointment dates. The review also found the letters were sent by two different firms processing VA appointment letters. As a result, management reorganized and centralized the entire appointment letter program in order to eliminate future duplications and delays.

- Although a VHA review did not substantiate the allegation that a VA employee mismanaged a contract and directed a contractor to perform unauthorized work, the review team recommended several steps to address perceived violations and communications problems. Management is reviewing the current contract to ensure that it accurately identifies work requirements and skills required, that appropriate personnel are hired for the services described in the contract documents or that deviations are properly documented, and that work is assigned appropriately to both VA and contract employees. Management is drafting policies to address computer security issues and will also ensure that all contract personnel have knowledge of VA policies associated with their position.

Personnel Issues

The responses to Hotline inquiries by management officials indicate that six allegations involving improprieties in the personnel practices at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- Prompted by a Hotline inquiry, a VHA review found that an employee was improperly placed in a paid non-duty status as a result of his physical limitations. The review also found that management was unaware the employee was playing golf and vacationing. As a result, management will evaluate the physical limitations

of the employee and will take appropriate disciplinary action if it finds that the employee misrepresented his condition.

- A VISN review found that the inability of two dentists to communicate adversely affected the delivery of patient care. Management has recommended alternate dispute resolution. If the dentists choose not to participate, management will take other corrective action.

- A VISN review team consisting of management from the VISN staff, other VAMCs, and the VHA Human Resources Group found in two instances that VAMC supervisors recommended the hiring of close personal friends without divulging their relationship to the individuals. The team recommended that disciplinary action be taken against those involved. The VISN review also established that personnel actions related to the facility integration were incomplete resulting in multiple nurse executives occupying one slot and the continuation of former service chiefs, not selected for positions in the integration, at their previous grades and pay rates. VISN management directed the VAMC to immediately classify the positions and reassign these individuals or conduct a reduction-in-force as appropriate. VISN management also directed the VAMC to examine staffing methodology to counter the perceptions of staffing inequities.

Ethical Improprieties

The responses to Hotline inquiries by management officials indicate that three allegations involving violations of ethical conduct standards at individual VA facilities were found to have merit and required corrective action. An example of the issue follows:

- A VHA review found that a recently retired executive nurse returned to the facility and held a sale of personal clothing and other items in her former office space. Management counseled the employees involved and staff will attend a comprehensive ethics training course.

Abuse of Authority

The responses to Hotline inquiries by management officials indicate that three allegations involving abuse of authority by employees at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A review by the Deputy Assistant Secretary for Security and Law Enforcement substantiated an allegation that a VA police officer struck a veteran in the face while the veteran was detained in a VAMC holding room and that a police lieutenant may have made a threatening remark. Further, it was determined that a prior review conducted by the VAMC police of the incident was of poor quality and did not appear to have been questioned by management. Recommendations forwarded to VAMC management included appropriate disciplinary action against the police officer, counseling for the police lieutenant who conducted the VAMC review, and implementation of a policy ensuring management review of incidents involving police officers. The reviewers also recommended management examine policies and procedures regarding the detention area and training given to police officers.

- An independent VISN review team substantiated various allegations of impropriety in the operations of a community based outpatient clinic by a VA physician. Specifically, the team established that the physician used his official duty hours and Government e-mail to market a commercial product in which he had a financial interest to VA employees, permitted film crews into the clinic without obtaining prior approval, made physical threats to one VA official, had a heated exchange with another, and intimidated many other employees by alluding to a personal

connection to a U.S. Senator. The review also established that the physician improperly used a local pharmacy to dispense prescriptions, offered sample pharmaceuticals to VA patients, and diverted sample pharmaceuticals to his private practice. The review team recommended that management take appropriate administrative action against the physician and take steps to ensure that the behavior cease. The team further recommended that management review and enforce policies on pharmacy operations, billing, authorized prescription quantities, and the appropriate use of sample drugs.

Facilities and Services

The responses to Hotline inquiries by VA management officials indicated that 24 allegations regarding deficiencies with facilities or the services provided by individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VHA review substantiated an allegation of poor communications with a patient's family. The facility failed to notify the family of the patient's death. The family learned of the patient's death when they tried to reach him by telephone. The staff member involved was disciplined and the facility has apologized to the family. Hospital policy on next of kin death notification has been reviewed with staff.

- A VHA review substantiated that a residential care home providing care for four veterans was operating without a license. VAMC management alerted the state department of health, which notified the appropriate county attorney about the home's failure to comply with state licensing regulations.

- A VAMC review substantiated an allegation of mismanagement of Government resources. The chief executive officer acknowledged that a $100,000 metal detecting system and a radiology transformer purchased several years ago were sitting idle. The metal detector was not installed due to staff shortages. The chief executive officer stated the facility was trying to sell the metal detecting system to another VAMC, however in view of recent terrorist events the VAMC may install the metal detector and hire the additional police officers to operate the system. The radiology transformer was not installed because it did not fit into the allotted space, and the VAMC is attempting to transfer or sell the transformer to another facility in the local area.

- A VHA review determined that restrooms and floors within a VAMC were not maintained in a high state of cleanliness at all times. Also private vendors were dispersed on the first floor of the medical center in a manner that obstructed the safe passage of patients and medical equipment. The staff have been instructed to review their procedures to be more aware and aggressive regarding cleanliness of public areas. Because of continuing concern by the medical center leadership, the chief, canteen service has been instructed to review the policy of allowing vendors in the medical center.

Veterans Benefits Administration

Receipt of VA Benefits

The responses to Hotline inquiries by management officials indicate that 19 allegations involving improprieties in the receipt of VA benefits were found to have merit and required corrective action. Examples of the issues follow:

- A VBA review found irregularities in a 100 percent service-connected veteran's receipt of compensation. The review found the veteran was receiving additional benefits for dependent stepchildren who were no longer in his custody.

The review also discovered that the veteran received full benefits during a 6-year period of incarceration. The VARO created an overpayment of $119,734.

- A VARO review found that a veteran, who has been receiving a VA pension since 1992, ran a construction business for at least 6 years during this period. To prevent the VA learning of his income, the veteran used Social Security numbers belonging to three different individuals. The VARO has terminated the veteran's benefits. The overpayment is $93,611.

- A VBA review confirmed that a veteran in receipt of VA service-connected disability payments reentered active duty in November 2000, but failed to notify the VARO for discontinuance of payments. A due process letter was sent to the veteran, the benefits will be terminated and recoupment action initiated. Overpayment is $4,158.

- A VARO review substantiated a veteran's allegation of a miscalculated overpayment in his VA compensation benefits. In reviewing the veteran's award, the regional office determined he was receiving benefits for an additional child for which there was no documentation. Rather than creating a $31 overpayment, the regional office created a $744 overpayment resulting in a debit to the veteran's monthly benefits check. VARO management corrected the error. A letter of apology and a check for the proper compensation was issued to the veteran. The veteran has since submitted the proper dependent documentation to the VARO.

Privacy Issues

The responses to Hotline inquiries by management officials indicate that four allegations involving Privacy Act violations at individual VA facilities were found to have merit and required corrective action. Examples of the issues follow:

- A VARO review found that a VA employee discussed a veteran's claim with unauthorized parties. The employee knew the veteran outside of the workplace and failed to notify her supervisor of the relationship. Management apologized to the veteran for the unauthorized disclosure and counseled the employee.

- A VARO review substantiated a violation of the Privacy Act when a veteran who had requested copies of his claims folder also received records on three other veterans. Management has removed the misfiled material and has counseled employees to review and verify all records prior to release. The veteran will receive a new and complete copy of the records he originally requested.

Fiscal Controls

A VARO review found a clerical error in the processing of a veteran's direct deposit request. The VARO at which the veteran's claims folder is located correctly processed the veteran's request and forwarded the documents to the VARO closest to the veteran's residence. The other VARO incorrectly input the veteran's data into another veteran's account, causing an overpayment to the second veteran. A replacement check was issued to the complainant, a collection notice was issued to the second veteran for the overpayment, and apologies were made to both veterans involved.

National Cemetery Administration

Facilities and Services

A National Cemetery Administration investigative team found that a national cemetery seriously breached VA regulations by failing to properly document paperwork and computer records on the assignment of two gravesites. Cemetery

management also failed to properly notify family members when a gravesite was moved. Additionally, the facility unknowingly allowed a temporary employee with a suspended driver's license to operate a Government vehicle on cemetery grounds. The National Cemetery Administration is taking formal corrective action on these issues.

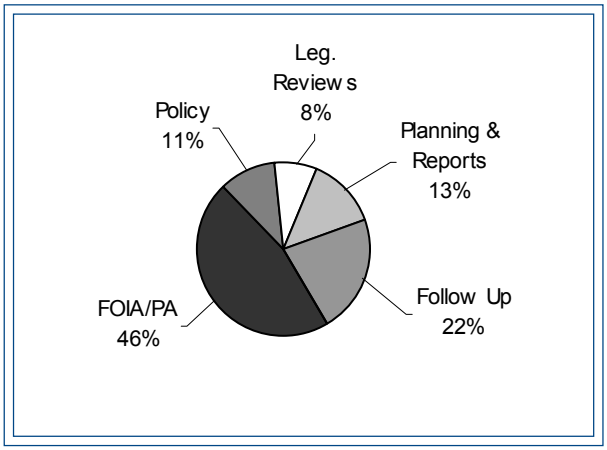
II. OPERATIONAL SUPPORT DIVISION

Mission Statement

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

Resources

This Division has nine FTE assigned with the following allocation:



Overall Performance

Follow Up on OIG Reports

The Division is responsible for obtaining implementation actions on previously issued audits, inspections, and reviews with over $4.2 billion of actual or potential monetary benefits as of March 31, 2002.

The Division is also responsible for maintaining the centralized follow up system that provides for oversight, monitoring, and tracking of all OIG recommendations through both resolution and implementation. Resolution and implementation actions are monitored to ensure that disagreements between OIG and VA management are resolved as promptly as possible and that corrective actions are implemented as agreed upon by VA management officials. VA's Deputy Secretary, as the Department's audit resolution official, resolves any disagreements about recommendations.

As of March 31, 2002, VA had 72 open internal OIG reports with 294 unimplemented recommendations. After obtaining information that showed management officials had fully implemented corrective actions, the Division took action to close 55 reports and 340 recommendations with a monetary benefit of $461 million.

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

The Division processes all OIG FOIA and Privacy Act requests from Congress (on behalf of constituents), veterans, veterans service organizations, VA employees, news media, law firms, contractors, complainants, general public, and subjects/witnesses of inquiries and investigations. In addition, the Division processes official requests for information and documents from other Federal Departments and agencies, such as the Office of Special Counsel, the

Department of Justice, and the FBI. These requests require the review and possible redacting of OIG hotline, healthcare inspection, criminal and administrative investigation, contract audit, and internal audit reports and files. We also process OIG reports and documents to assist VA management in establishing evidence files used to support administrative or disciplinary actions against VA employees.

During this reporting period, we processed 239 requests under the Freedom of Information and Privacy Acts and released 349 audit, investigative, and other OIG reports. Information was totally denied in 9 requests and partially withheld in 148 requests because release would have constituted an unwarranted invasion of personal privacy, interfered with enforcement proceedings, disclosed the identity of confidential sources, disclosed internal Department matters, or was specifically exempted from disclosure by statute.
During this period, all FOIA cases received a written response within 20 work days, as required. There are no cases pending over 6 months.

Review and Impact of Legislation and Regulations

The Division coordinated concurrences on legislative and regulatory proposals from the Congress, OMB, and the Department that relate to VA programs and operations. The OIG commented and made recommendations concerning the impact of the legislation and regulations on economy and efficiency in the administration of programs and operations or the prevention and detection of fraud and abuse. During this period, we reviewed 74 legislative, 64 regulatory, and 49 administrative proposals.

Status of OIG Reports Unimplemented for Over 3 Years

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

The following chart lists the total number of unimplemented OIG reports and recommendations. It also provides the total number of unimplemented reports and recommendations issued in FY 1999 and earlier.

VA Office	Unimplemented OIG Reports and Recommendations			
	Total		FY 1999 and Earlier	
	Repts	Recoms	Repts	Recoms
VHA	36	177	7	14
VBA	10	54	2	5
A&MM	21	29	0	0
HRA	2	18	0	0
I&T	2	14	0	0
OGC	1	2	0	0
Total	**72**	**294**	**9**	**19**

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

We are particularly concerned about the FY 1999 and earlier reports that have not been implemented 3 years after being issued. The status and OIG concerns on these FY 1999 and earlier reports are summarized as follows.

Veterans Health Administration

Unimplemented Recommendations and Status (FY 1999 and Earlier Reports)

Report: *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes, 4R3-A28-016, 1/11/94*
Recommendation: **VHA develop standardized community nursing homes inspection procedures and criteria for approving homes for participation in the program.**
Status: In July 2001, the U.S. General Accounting Office issued a report that had similar recommendations as this 1994 VA OIG report. In September 2001 and again in February 2002, VHA put into their concurrence process a draft directive and handbook on community nursing home evaluation and follow up services that would address both reports.
Concern: The OIG is concerned because in the past 8 years we have received numerous prior draft directives, however none have ever been finalized. No planned completion date has been provided to issue the current draft directive. The final report showed that inspection procedures varied between VAMCs, appropriateness of community nursing homes inspection team makeup could be improved, and annual reinspections should be conducted more timely. These are still issues which need to be addressed to improve care of veterans.

Report: *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients, 6HI-A28-038, 3/28/96*
Recommendation: **VHA managers should explore network flagging systems that would ensure employees at all VAMCs are alerted when patients with histories of violence present for treatment to their medical centers.**
Status: The major obstacle to the implementation of this recommendation has been the inability of VA's computer systems to develop a method for sharing the necessary information in a manner that is timely, ensures accuracy of data, and protects the confidentiality of patient records. A plan to support system-wide computerized advisories was presented to the VA information technology advisory council in August 2001, however it was given a low priority. VHA has requested assistance from the VA Chief Information Officer. No planned completion date has been provided.
Concern: The OIG is concerned because the latest VHA status shows that after 6 years there still is not a plan developed to implement the recommendation. The OIG report included recommendations that were meant to strengthen areas that may reduce the incidence of injury associated with violence in inpatient psychiatric units.

Report: *Internal Controls Over the Fee-Basis Program, 7R3-A05-099, 6/20/97*
Recommendations: **VHA improve the cost effectiveness of home health services by: (1) establishing guidelines for contracting for such services, and (2) providing contracting officers with benchmark rates for determining the reasonableness of charges.**
Status: VHA provided a draft directive to the OIG in January 2001 and the backup data to support the directive in May 2001. However, the OIG has determined this backup data did not support the directive.
Concern: The OIG is concerned because no VHA implementation plan has been provided to implement the recommendation. The June 1997 final report showed that contracting for home health services could save at least $1.8 million annually, however, the recommendations remain unimplemented.

Report: *Evaluation of VHA's Income Verification Match Program, 9R1-G01-054, 3/15/99*

Recommendations:

1. Require the Chief Network Officer to ensure that VISN Directors establish performance standards and quality monitors, and strengthen procedures and controls for means testing activities and billing and collection of Health Eligibility Center (HEC) referrals to include: (a) requiring staff to review and appropriately bill HEC referrals within 60 days of receipt, (b) notifying staff that means testing activities and billing and collection actions on HEC referrals will be actively monitored by VISN and facility management, (c) obtaining quarterly reports from the HEC of the number of cases referred and the number of cases billed and not billed for each facility, and (d) reviewing a sample of cases to verify appropriate billing and compliance with the 60-day billing standard and to determine why unbilled referrals were not billed and taking appropriate corrective action.

2. Requiring the Chief Information Officer to develop performance measures and monitor periodic performance reports to ensure the HEC: (a) performs multiple year income verification, and (b) transmits all billing referrals to facilities.

3. Expedite action to centralize means testing activities at the HEC.

Status: VHA has been making steady progress in addressing the problems documented in the OIG report. The target date to resume income verification has been extended to the first quarter of FY 2003 based on the complexity of the Departmental reviews and the concurrence process for the IRS and SSA matching agreements. VHA has established mechanisms to ensure that income verification match (IVM) conversion cases are referred for appropriate billing action. VHA is developing material for distribution that describes the restart of the IVM process, the new reporting procedures and draft performance standards for field staff involved in IVM means test copayment billing. VHA will provide reports on the number of cases referred, billed, and not billed when the income verification process re-starts. Software under development will generate a bill automatically. Management reports will ensure compliance with standards. The anticipated date for this software to be operational is the first quarter of FY 2003. Once the income verification process is reinstated, VHA will resume transmission of billing referrals to facilities. This is planned to start the first quarter of FY 2003. Implementation of centralized renewal of means test is scheduled for implementation in the third quarter of FY 2003.

Concern: The 1999 audit found the recommendations made in a March 1996 OIG report on VHA's income verification match program were not fully implemented. We are concerned because the 1999 report showed that VHA could increase funding available for health care by $14.2 million and put resources valued at $3.8 million to better use; however, the recommendations remain unimplemented.

Report: *Evaluation of VHA Radiology and Nuclear Medicine Activities, 9R4-A02-133, 7/23/99*

Recommendation: **Take action to standardize staffing guidelines for Radiology Service.**

Status: The targeted completion date for the diagnostic radiology staffing guidelines is October 2002.

Concern: The final report showed that most VHA radiology activities did not use staffing guidelines, and there was a wide variety among those guidelines that were used. The OIG noted that there were large differences in staffing levels of some medical centers with ostensibly comparable workloads.

Report: *A Review of the Policy and Function of VHA's Deans Committees for Academic Year 1996, 9HI-A28-145, 8/11/99*

Recommendation: **Revise M-8, Part I, Chapters 1, 2, and 3 in order to provide standardized guidance for Affiliation**

Partnership Councils and any other similar advisory committees.
Status: The VHA Chief Academic Affiliations Officer has started to develop a handbook that addresses affiliation partnership councils. The draft is expected to be published by October 2002.
Concern: We are concerned that, over time, the deans committee structure and function have changed as a result of affiliation governance. As VHA continues its evolution from deans committees to affiliation partnership councils, VHA top managers need to more stringently oversee council functions to ensure that they adhere to law and VHA guidance. The VHA Chief Academic Affiliations Officer also needs to revise its policy to standardize guidance for council operations.

Report: *Administrative Investigation, Contracting Issues at the VA Chicago Health Care System, Chicago, IL, 9PR-E03-143, 9/15/99*
Recommendation: Issue a bill of collection to a retired VA employee to recoup the amount of her voluntary separation incentive (Buyout).
Status: The individual has recently submitted a hardship request and a request for a compromise.
Concern: The VA Chicago Health Care System awarded a personal services contract to a retired VA employee who had previously received a voluntary separation incentive payment. The statutory provision that authorized the buyout requires repayment when an employee enters into a personal services contract. The OIG is concerned that the final report was issued in September 1999, however VHA/VISN 12 did not issue a bill of collection for $25,000 until January 2001, and delayed the hearing on the waiver request until January 2002.

Veterans Benefits Administration

Unimplemented Recommendations and Status (FY 1999 and Earlier Reports)

Report: *Review of VBA's Procedures to Prevent Dual Compensation, 7R1-B01-089, 5/15/97*
Recommendations: (1) VBA should take action to prevent dual compensation by negotiating a matching agreement with the Department of Defense (DoD) that includes provisions for VBA to solicit waivers from beneficiaries who have not submitted waivers and a formal mechanism for informing DoD of beneficiaries requiring pay offset. (2) VBA should follow up on FYs 1993 through 1996 dual compensation cases to ensure either VBA disability payments are offset or the DoD is informed of the need to offset reservist pay.
Status: The computer matching agreement is in place. VBA has a tape from the Defense Manpower Data Center for FY 2001 with 28,481 names of current beneficiaries who received reserve pay in FY 2001. The tape will be run in May with letters to the veterans to waive compensation in lieu of reserve pay. The Defense Manpower Data Center advised they are incapable of providing accurate drill pay data prior to FY 2001. Also VA does not have current on-line pay data for most drilling reservists back to 1993. Due to these difficulties, VA will write to the Guard Bureau and the Office of the Chief of Reserve Affairs and advise them of the situation. VBA will also provide the Defense Manpower Data Center with a tape of current VA beneficiaries and request the Department of Defense to contact these individuals and advise them of their obligation to waive either their VA compensation or their drill pay.
Concern: The audit's purpose was to determine if VBA's procedures ensured that disability compensation benefits of active military reservists were properly offset from their training and drill

pay. It found that 90 percent of the potential dual compensation cases reviewed did not have offsets from their military reserve pay. We are concerned that an estimated $8 million in annual dual compensation payments continue to be made each year because this recommendation has not been implemented.

Report: *Evaluation of Benefits Payments to Incarcerated Veterans, 9R3-B01-031, 2/5/99*
Recommendations: (1) Initiate and maintain a matching agreement with SSA for prison records. Until such an agreement is made, VAROs should obtain this data from Federal Bureau of Prisons, state, and local prison officials. (2) Identify and adjust the benefits for incarcerated veterans and dependents. (3) Establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted.
Status: A matching agreement is in place with the SSA. However VBA has not completed the programming necessary to conduct the match. The results of the next test run will be received in May 2002. If there are no significant problems, VBA plans to start releasing output to field stations in August 2002. Otherwise, there will be delays while the problems are being fixed.
Concern: The 1999 final report stated VBA officials did not implement a systematic approach to identify incarcerated veterans and dependents, and adjust their benefits as required by Public Law 96-385. While we recommended that such a systematic approach be implemented in our 1986 audit report, no such actions were taken. We estimate that about 13,700 incarcerated veterans have been, or will be, overpaid by about $100 million. The 1999 report stated additional overpayments of about $70 million will occur over the next 4 years for newly incarcerated veterans, if VBA does not establish a systematic method to identify newly incarcerated veterans and dependents.

III. INFORMATION TECHNOLOGY AND DATA ANALYSIS DIVISION

Mission Statement

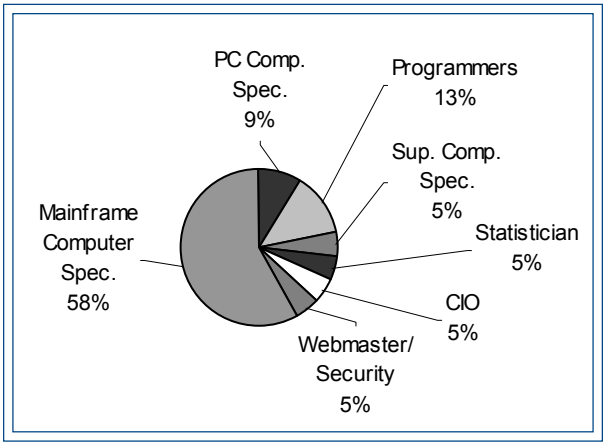
Promote OIG organizational effectiveness and efficiency by ensuring the accessibility, usability, and security of OIG information assets; developing, maintaining, and enhancing the enterprise database application; facilitating reliable, secure, responsive, and cost-effective access to this database,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

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

OIG, as well as VA and other Federal agencies, requesting information contained in VA automated systems. Finally, a member of this division serves as the OIG statistician.

Resources

The Division has 22 FTE currently assigned in Washington, Austin, Chicago, and Atlanta. These FTE are devoted to the following areas:



Overall Performance

Master Case Index (MCI)

During this reporting period, we provided the OIG field personnel with more than 90 enhancements of the MCI, the OIG's enterprise database. Most notably, we implemented an on-line OIG office and employee roster. Additionally, we implemented an awards tracking component within MCI. We will be able to clone this functionality for supply and training allocations before the next fiscal year.

An *Oracle* bug not resolved by the company until the end of March 2002 prevented us from migrating from our current client-server environment to a "web-enabled" *Oracle 8i* or *9i* database. We expect to make more progress on this project during the next reporting period. In April 2002, we also expect to offer our OIG users a secure intranet platform to store, search, and print OIG policies, procedures, directives, and issues of shared concern.

Internet and Electronic Freedom of Information Act

The Division is responsible for processing and controlling electronic publication of OIG reports, including maintaining the OIG websites and posting OIG reports on the Internet. Data files on the OIG website were accessed over 600,000 times by more than 125,000 visitors. Our most popular reports were downloaded over 46,000 times, providing both timely access to OIG customers and cost avoidance in the reduced number of reports that must be printed and mailed. Our vacancy announcements accounted for an additional 32,000 downloads.

We posted two frequently-requested audit reports in our electronic reading room in compliance with the Electronic Freedom of Information Act. Additionally, we published three electronically-redacted CAP reports, 20 other CAP and audit reports, Office of Investigations press releases, and other OIG publications, including this semiannual report to Congress, on our website.

Information Management, Security, and Departmental Coordination

We actively participate in the development of Departmental policies and programs to improve VA information security, IT accessibility, and Internet resources and utilization. We provided review and feedback on the Department's draft system certification and accreditation policies, Internet gateway policies and configuration, public key infrastructure, revised online computer security awareness course, and proposed VA information security officer policy and credentialing program.

The OIG Webmaster received a special contribution award from the VA CIO for his work on the Department's Internet/Intranet services policies development. His contributions included developing proposed warning notices for all VA Internet and Intranet sites to help ensure successful prosecutions of future attacks on VA's

Internet infrastructure. He also added Federal Records Act requirements, rewrote the external links policy, and modified the "cookie" policies to conform to the latest promulgations from the OMB Office of Information and Regulatory Affairs.

Statistical Support

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

For the reporting period, the OIG statistician provided statistical consultation and support on five sampling plans for proposed audit projects and OHI proactive program evaluations. Advice was provided on two internal OIG headquarters projects.

Additionally, the OIG statistician and a computer specialist provided statistical support for all CAP reviews. This support involved preparing and processing the random samples of full-time VAMC employees who were part of the employee survey. The computer specialist also provided data concerning purchase card use at each facility. This computer specialist also provided support to process the CAP data collected while on-site. As well, the office acquired an automated survey software package that the statistician used to create two OIG surveys of employees. These surveys were for information security compliance and an assessment of computer training needs. The statistician is completing conversion into electronic format of the now hard-copy CAP review's employee survey and the OIG audit peer review survey. The completion of these two surveys will drastically reduce employee hours needed for data collection and analysis. Further, research supports that respondents tend to provide more accurate information when an electronic medium for communications is used.

Information Technology Training Initiative

We have contracted with four vendors to provide instructor-led training in a variety of *Microsoft* applications in the classroom in our Washington, DC headquarters office and one vendor with training facilities in each city in which the OIG is located to provide training for our field employees. To date, 113 employees have received 318 days of instructor-led training in Washington, DC, while 87 field employees have received 142 days of training locally.

DATA ANALYSIS SECTION

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

They conduct reviews that identify invalid or erroneous information in VA computer files that can lead to bad results or erroneous conclusions. They provide automated data processing technical assessments and support to all elements of the OIG and other governmental agencies needing information from VA computer files. They also provide automated data processing technical support to preaward and postaward OIG audit reviews that assist VA contracting officers in price negotiations and to ensure reasonableness of contract prices. The support work provided by the DAS staff is reported in many of the OIG audits, inspections, and investigative cases described in other sections of this report.

Collaborative Work

Federal Bureau of Investigations

Following the attacks on September 11, 2001, the OIG received a list of potential terrorists residing in the United States from the FBI. The DAS was asked to compare this list to VA computer files and determine whether anyone on the list had ever used VA services, provided services to veterans, or had conducted any business dealings with VA. Most of the individuals on the list had several aliases, more than one Social Security number, and numerous known or suspected home addresses. Several versions of the list were provided DAS as the FBI continued to update the information on a regular basis. The computer files from 16 VA computer systems were matched and millions of records were processed. Their efforts resulted in several referrals to the FBI for further investigation.

Veterans Benefits Administration

The VBA's Data Management Office provided DAS staff with a list of 1,337 veterans who served during the Gulf War at the Khamisiyah ammunitions dump in Iraq. The list contained the names of those veterans reported by SSA as having died in the 10 years since their presumed exposure to hazardous materials exploded by U. S. forces during an effort to destroy the contents of this ammunitions dump. DAS matched the list of names to several VA databases that record deaths in an effort to increase the accuracy of the reports of death. The results of their efforts showed that more than 90 percent of the deaths reported by the SSA were reported in one or more of the VA databases.

Fugitive Felon Initiative

In an effort to support an OIG legislative initiative to discontinue VA benefits to fugitive felons and permit the VA to share address information with those law enforcement agencies holding felony warrants for VA beneficiaries, the DAS conducted a statistical match of eight VA databases against three state and one federal databases containing information about fugitive felons. The matches numbered in the thousands and the law was changed in December 2001 according to the suggestions contained in the OIG initiative.

New Mexico Adjutant General

In an effort to quell a horrific prison riot at a New Mexico prison in 1980, the Governor called in the New Mexico National Guard. The fighting was very violent and many of the Guardsmen suffered physical and mental effects from their experiences in quelling the riot. Many of these Guardsmen applied for and were granted VA benefits for service-connected disabilities including post-traumatic stress syndrome and medical injuries. A recent review showed these Guardsmen had not been officially activated into Federal service and, therefore, were not eligible for these VA benefits. The Adjutant General office in New Mexico was able to provide the DAS with a paper roster of the 1,012 individuals called-up for service. DAS staff converted the list into an electronic database and developed a software program to identify which Guardsmen were mistakenly receiving VA benefits. This information was provided to VARO Albuquerque for appropriate action.

Special Projects – Fraud Detection

Fraud and other illegal activities committed against VA's programs can amount to millions of dollars. Contracts, procurements, and veterans benefits programs are inherently vulnerable to fraud due to the large expenditures of funds associated with purchasing the items necessary for an agency as large and diverse as VA and for compensating millions of veterans for their service to our country. The DAS takes an aggressive approach to finding and reporting fraud by developing computer profiles that reflect the results of actions taken by employees to defraud the VA. By

reconstructing the fraudulent actions and searching VA files for similar patterns, the DAS continues to provide OIG investigators and auditors with leads to potential fraud or inadequate controls. For example, the computerized death match profile has produced numerous convictions and millions of dollars in recovered funds.

Other Workload

During this reporting period, the DAS completed 120 ad hoc requests for information and data submitted from all OIG operational elements. They supported 14 OIG CAP reviews. Considerable effort was also spent in support of the post-arrest phase of the VARO Atlanta investigation; the national fraud review of all VAROs; and the planned Manila, Philippines beneficiary review.

IV. FINANCIAL AND ADMINISTRATIVE SUPPORT DIVISION

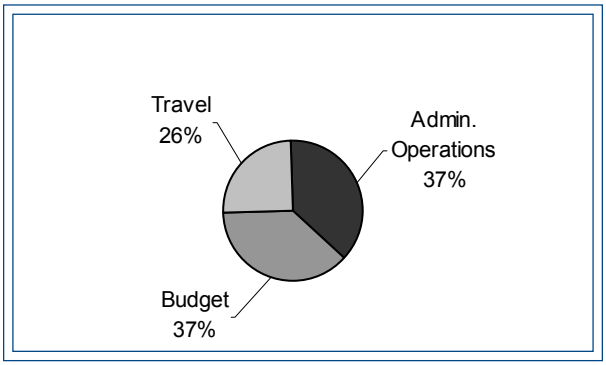
Mission Statement

> ***Promote OIG organizational effectiveness and efficiency by providing reliable and timely financial and administrative support services.***

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

Resources

The Division has 10 FTE currently assigned. The staff allocation for the three functional areas is as follows:



Overall Performance

Budget and Finance Section

The staff assisted in the preparation of the FY 2003 budget submission and materials for associated hearings in the Department, OMB, and with the Congressional Committees.

The budget staff executed 52 percent of the OIG's FY 2002 budget authority.

Travel Section

By the nature of our work, OIG personnel travel almost continuously. As a result, we processed 1,793 travel and 32 permanent change of station vouchers in addition to 11 new permanent change of station authorities and 3 amendments to existing authorities.

Administrative Operations

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

In addition, this component processed 98 procurement actions and reviewed and approved, each month, the 69 statements received from the OIG's cardholders under the Government's purchase card program.

V. HUMAN RESOURCES MANAGEMENT DIVISION

Mission Statement

Promote OIG organizational effectiveness and efficiency by providing reliable and timely human resources management and related support services.

The Division provides human resources management related support services for the entire OIG. It serves as liaison to the Veterans Affairs Central Office for personnel and payroll related matters.

Resources

The Division has seven FTE, which are all committed to human resources management and support.

Overall Performance

Human Resources Management

During this period, 20 new employees were hired. In addition, the staff processed 249 personnel actions and 72 awards.

OTHER SIGNIFICANT OIG ACTIVITIES

President's Council on Integrity and Efficiency

- In the wake of the September 2001 attacks on the United States, our Office of Healthcare Inspections participated on a President's Council on Integrity and Efficiency interagency task force that discussed methods for reviewing the adequacy of security over biological, chemical, and radioactive agents that have the potential of conversion to weapons of mass destruction. OIG representatives from our office, Department of Defense, Health and Human Services, and the Department of Agriculture have been meeting quarterly on this very important issue.

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

OIG Management Presentations

Leadership VA 2001 Program

The Inspector General made a presentation on the work of the OIG to the Leadership VA Class of 2001. This program is VA's premier leadership development program.

IG Academy

Recognizing the experience and expertise of the OIG Office of Investigations, Computer Crimes and Forensics Program, the IG Academy has requested assistance developing and instructing a course for "responding to electronic evidence." Robert Friel, Office of Investigation program director has create lesson plans and teaching slides for the first two classes to be held in Washington, D.C. this summer.

Awards

Executive Office for United States Attorneys Director's Award for 2001

Special Agent Steven J. Plante, VA OIG Bedford resident agency, received the Outstanding Contributions in Law Enforcement award.

PCIE Awards - October 17, 2001

- Ten staff members from the Offices of Investigations and Healthcare Inspections received recognition as part of an interdisciplinary team whose hard work contributed significantly to the successful prosecution of two high-profile murderers. The murder investigative team consisted of Bruce Sackman; Samantha Lockery; Jennifer Pate; Steven Plante; Thomas Valery; Kevin Murphy, Patricia Christ, RN; Linda DeLong, RN; Fidelita Levy; and Rayda Nadal, RN.

- The Central Office Audit Operations Division Director, Steve Gaskell, and staff members Greg Gibson, Henry Hoffman, Jeff McGowan, and Melvin Reid received a PCIE audit team award for excellence in auditing VHA's pharmacy co-payment levels and restrictions on filling privately written prescriptions for priority group 7 veterans that identified potential cost efficiencies of over $1.6 billion.

- Tom Phelps, OIG Central Office Audit Operations Division audit manager, received a PCIE award for exceptional performance as part of the PCIE Information Technology Roundtable Committee that conducted an extensive analysis of OIG community information technology resources.

Association of Government Accountants

Senior Auditor Randall Alley served as President of the Seattle Chapter of the Association of Government Accountants (AGA) for 2001. Under his leadership, the Seattle Chapter received the Platinum Award, the AGA's highest level of recognition, for superior chapter accomplihsments.

OIG Congressional Testimony

In March 2002, the Inspector General testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The testimony provided OIG's assessment of VA's information security program.

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 Public Law 95-452, the IG has authority "… to require by subpoena the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence necessary . . . ." The use of IG subpoena authority has proven valuable in our efforts, especially in cases dealing with third parties. During this reporting period, the OIG issued 27 subpoenas in conjunction with OIG investigations and audits.

APPENDIX A

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
COMBINED ASSESSMENT PROGRAM REVIEWS				
01-00222-7 10/5/01	Combined Assessment Program Review of the VA Medical and Regional Office Center Wilmington, DE			
01-01254-10 10/9/01	Combined Assessment Program Review of the Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, HI			
01-00504-9 10/10/01	Summary Report, Combined Assessment Program Reviews at Veterans Health Administration Medical Facilities (January 1999-March 2001)			
01-02016-13 10/15/01	Combined Assessment Program Review of the Alaska VA Healthcare System and Regional Office	$46,210	$46,210	
01-01253-14 10/31/01	Combined Assessment Program Review of the VA Boston Healthcare System	$486,703	$486,703	
01-01252-37 12/20/01	Combined Assessment Program Review of the John D. Dingell Veterans Affairs Medical Center Detroit, MI	$2,422,878	$2,422,878	
01-01515-40 1/2/02	Combined Assessment Program Review of the Kansas City VA Medical Center	$729,698	$729,698	
01-02123-43 1/17/02	Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, NY	$128,520	$128,520	
01-00686-44 1/24/02	Combined Assessment Program Review of the VA Medical Center Louisville, KY			
01-02213-31 1/28/02	Combined Assessment Program Review of the VA Regional Office New Orleans, LA	$49,000	$49,000	
00-02097-46 1/29/02	Combined Assessment Program Review of the VA Medical Center Minneapolis, MN	$3,421,139	$3,421,139	
01-02124-71 3/21/02	Combined Assessment Program Review of the VA Regional Office Oakland, CA	$503,000	$503,000	

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
INTERNAL AUDITS				
00-02797-1 10/24/01	Audit of the Department of Veterans Affairs Information Security Program			
01-00046-65 2/26/02	Audit of the Medical Care Collection Fund Program	$503,629,350	$503,629,350	
01-01463-69 2/27/02	Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2001 and 2000			
01-00949-81 3/29/02	Audit of VA's HR LINK$ Payroll and Human Resources System Replacement Project	$1,407,000	$1,407,000	$17,834
OTHER OFFICE OF AUDIT REVIEWS				
01-00290-22 10/31/01	Review of Hotline Complaint, VA Programs in New York State Prisons			
01-02655-38 12/28/01	Allegations of Mismanagement in the Biomedical Engineering Section at the East Campus, Central Alabama Veterans Health Care System			
02-00198-42 1/15/02	Report on Promptness of Department of Veterans Affairs' Payments to the District of Columbia Water and Sewer Authority for First Quarter of Fiscal Year 2002			
01-00263-53 2/20/02	Follow-up Evaluation of the Causes of Compensation and Pension Overpayments	$26,634,780	$26,634,780	
01-02957-75 3/29/02	Special Review of VA Compensation and Pension One-Time Payments and Related Security Controls			
CONTRACT REVIEWS *				
00-02087-6 10/3/01	Review of Proposal Submitted by Stanford University School of Medicine Under Solicitation Number RFP V261P-0450, for Anesthesiology Services at the Department of Veterans Affairs Medical Center Palo Alto, CA	$554,705		
00-01709-8 10/3/01	Review of Proposal Submitted by Stanford University School of Medicine Under Solicitation Number RFP 261-0078-00 for Vascular Surgery Services at the Department of Veterans Affairs Medical Center Palo Alto, CA	$174,181		

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

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
01-00141-15 10/26/01	Review of Roxane Laboratories, Inc.'s Disclosures Under Federal Supply Schedule Contract Number V797P-5348X			$35,156
02-00006-16 11/5/01	Verification of Medi-Physics, Inc., Nycomed Amersham Imaging's Self-Audit Under Federal Supply Schedule Contract Number V797P-5741n, and Interim Agreement Number 90NM-00-15			$1,009
01-02708-23 11/9/01	Audit of Termination for Convenience Settlement Proposal Submitted by Inner-City Transit Corporation Under Contract Number V10N3P-0817	$26,283		
00-01721-24 11/9/01	Final Report, Post-Award Review of Federal Supply Schedule Contract V797P-3626k Awarded to Johnson & Johnson Health Care Systems, Inc. on Behalf of the Codman Division of Johnson & Johnson Professional, Inc.			
00-02778-25 11/15/01	Review of Ernst & Young LLP's Analysis of Ortho Clinical Diagnostics Systems, Inc. Federal Supply Schedule Contract Prices on Contract V797P-5033n			$4,193,979
99-00068-26 11/15/01	Settlement Agreement, Lifescan, Inc. Postaward Review			$14,550,000
02-00008-27 11/20/01	Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Numbers V797P-5554m, V797P-5728m, and V797P-5354x, Awarded to Ciba-Geigy Corporation, Sandoz Pharmaceuticals, and Novartis Pharmaceuticals Corporation			$764,564
00-02786-32 12/12/01	Review of Ernst & Young LLP's Analysis of Ortho-Clinical Diagnostics, Inc.'s Federal Supply Schedule Contract V797P-6717a			
00-02785-35 12/17/01	Review of Ernst & Young LLP's Analysis of J&J Depuy, Inc.'s Federal Supply Schedule Contract V797P-3304k			$3,184
02-00289-39 12/26/01	Verification of Alcon Laboratories' Self-Audit Under Federal Supply Schedule Contract Number V797P-5352x			$1,107
00-02787-36 1/9/02	Review of Ernst & Young LLP's Analysis of Ortho-Clinical Diagnostics, Inc.'s Federal Supply Schedule Contract V797P-6565a			
02-00287-47 1/24/02	Verification of Tyco Healthcare LP's (dba Kendall Healthcare) Self-Audit Under Federal Supply Schedule Contract Number V797P-3147k			$211,424

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
00-01720-48 1/24/02	Settlement Agreement, Johnson & Johnson Professional, Inc. (Codman) Under Federal Supply Schedule Contract Number V797P-3032k			$375,821
02-00302-49 1/28/02	Verification of Forest Laboratories' Self-Audit Under Federal Supply Schedule Contract Number V797P-5346x			$6,540
00-02847-50 1/28/02	Review of Voluntary Disclosure and Refund Offer Under Federal Supply Schedule Contract Number V797P-5383x Awarded to Johnson & Johnson Health Care Systems, Incorporated on Behalf of Ortho Clinical Diagnostics, Incorporated			$466
01-02456-51 1/28/02	Review of Federal Supply Schedule Proposal Submitted by United States Surgical Under Solicitation Number RFP 797-FSS-99-0025	$1,765,114		
01-02777-54 1/30/02	Review of Proposal Submitted by the University of Missouri Department of Radiology Under Solicitation Number RFP V15-01-0129 for Imaging Services at the Harry S. Truman Memorial Veterans Hospital Columbia, MO	$829,403		
01-02716-55 1/30/02	Review of Proposal Submitted by the University of Missouri Department of Surgery Under Solicitation Number RFP V15-01-0012 for Vascular Surgery Services at the Harry S. Truman Memorial Veterans Hospital Columbia, MO	$98,834		
01-02676-56 1/31/02	Review of Proposal Submitted by the University of Missouri Department of Surgery Under Solicitation Number RFP V15-01-0105 for General Surgery Services at the Harry S. Truman Veterans Hospital Columbia, MO	$64,902		
01-01342-62 2/13/02	Postaward Review of Pride Mobility Products, Inc.'s Federal Supply Schedule Contract Number V797P-3124k			$17,925
01-01586-63 2/14/02	Review of Sunrise Medical's Voluntary Disclosure and Proposed Refund Offer Under Federal Supply Schedule Contract Numbers V797P-3381k, V797P-3399j, V797P-3141k, V797P-3634j, V797P-3222k			$86,065
02-00274-67 2/21/02	Review of Nycomed Amersham's Implementation of Section 603, Drug Pricing Provisions of Public Law 102-585, Under Federal Supply Schedule Contract Numbers V797P-5982n and V797P-5317x			$119,385

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
CONTRACT REVIEWS (Cont'd)				
02-00393-70 2/27/02	Verification of InterMune Pharmaceuticals, Inc.'s Self-Audit Under Federal Supply Schedule Contract Number V797P-5435x			$690
02-00562-72 3/6/02	Review of Proposal Submitted by the University of Pittsburgh Physicians Under Solicitation Number RFP 646-07-02 for Thoracic Surgeon Services at the University Drive Division of the Pittsburgh Healthcare System	$244,869		
01-02118-73 3/6/02	Review of Standard Textile Company, Inc.'s Voluntary Disclosure and Proposed Refund Under Federal Supply Schedule Contract V797P-3779j			$84,494
02-01033-77 3/21/02	Review of GE OEC Medical Systems, Inc.'s Direct Delivery Pricing Proposal Under Solicitation Number M6-Q1-01	$21,053		
00-01157-80 3/27/02	Review of Watson Pharma, Inc.'s Disclosures Under Federal Supply Schedule Contract Number V797P-5339x			$401,203
01-01541-82 3/28/02	Review of Federal Supply Schedule Proposal Submitted by Allegiance Healthcare Corporation Under Solicitation Number M5-Q52C-00	$724,296		
02-00815-83 3/28/02	Review of Muro Pharmaceuticals, Inc.'s Implementation of Section 603 Drug Pricing Provisions of Public Law 102-585 Under Federal Supply Schedule Contract Number V797P-5377x			
ADMINISTRATIVE INVESTIGATIONS				
01-01661-12 10/16/01	Administrative Investigation, Physician Time and Attendance Issue, Harry S. Truman Memorial Veterans' Hospital Columbia, MO			$9,826
01-02230-17 10/30/01	Administrative Investigation, Physician Time and Attendance Issues, VA Medical Center Kansas City, MO			$5,190
01-01994-34 12/17/01	Administrative Investigation, Physician Time and Attendance Issue, VA Medical Center Philadelphia, PA			
01-02075-33 12/18/01	Administrative Investigation, Burial of Indigent Veterans Issue, Veterans Benefits Administration			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
ADMINISTRATIVE INVESTIGATIONS (Cont'd)				
01-01129-41 1/25/02	Administrative Investigation, Veterans Canteen Service Promotional Fund Issue, Veterans Canteen Service St. Louis, MO			
01-02982-59 2/6/02	Administrative Investigation, Fees for Legal Services Issue, Office of General Counsel and Offices of Regional Counsel			
01-02720-74 3/11/02	Administrative Investigation, Unspent Research Funds Issue, VA Medical Center Washington, DC			
HEALTHCARE INSPECTIONS				
01-00981-2 10/2/01	Healthcare Inspection, Board of Investigation and Patient Care Issues, VA Medical and Regional Office Center Fargo, ND			
01-00809-3 10/2/01	Healthcare Inspection, Patient Transfer and Discharge Issues, VA Medical Center Brooklyn, NY			
00-02913-4 10/2/01	Healthcare Inspection, VA Hemodialysis Program, Louis Stokes Veterans Affairs Medical Center Cleveland, OH			
01-00900-11 10/30/01	Healthcare Inspection, Reporting Infractions to the National Practitioner Data Bank, Veterans Affairs Medical Center Fayetteville, NC			
01-01345-5 11/16/01	Healthcare Inspection, Allegations of Poor Care, Veterans Affairs Medical Center Houston, TX			
01-01951-19 11/19/01	Healthcare Inspection, Alleged Substandard Care Provided to a Patient at the Department of Veterans Affairs Medical Center Chillicothe, OH			
01-01848-57 2/25/02	Healthcare Inspection, Homeless Veterans Issues James H. Quillen VA Medical Center Mountain Home, TN			
02-00078-61 2/25/02	Healthcare Inspection, Patient Care Issues, Southern Arizona Veterans Affairs Health Care System Tucson, AZ			
01-00026-68 2/25/02	Evaluation of Veterans Health Administration Coding Accuracy and Compliance Program			
01-02889-60 2/26/02	Healthcare Inspection, Contract Nursing Home Issues, North Florida/South Georgia Veterans Health System			

Report Number/ Issue Date	Report Title	Funds Recommended for Better Use OIG	Funds Recommended for Better Use Management	Questioned Costs
HEALTHCARE INSPECTIONS (Cont'd)				
01-02748-64 3/7/02	Healthcare Inspection, Treatment Quality and Service Issues at the VA Northern Indiana Health Care System			
01-02956-66 3/13/02	Healthcare Inspection, Nurse Licensing Issue, VA Maryland Health Care System			
02-00266-76 3/14/02	Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities			
00-01362-45 3/22/02	Healthcare Inspection, Veterans Health Administration Therapeutic Interchange Practices			
99-01417-28 3/26/02	Healthcare Inspection, Quality of Care and Safety Issues, Department of Veterans Affairs Medical Center San Juan, PR			
TOTAL:	**74 Reports**	**$543,961,918**	**$539,458,278**	**$20,885,862**

APPENDIX B

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

Report Title, Number, and Issue Date	Questioned Costs	Recommended Better Use of Funds	Reason for Delay and Planned Date for a Decision
OFFICE OF ACQUISITION AND MATERIEL MANAGEMENT			
Final Report Review of Proposal Submitted by University of Pittsburgh Physicians for Anesthesiology Physician Services at the University Drive Division, VA Pittsburgh Healthcare System, Pittsburgh, PA, 00-01584-73, 5/31/00		$297,833	Pending receipt of contracting officer price negotiation memorandum (PNM); no planned resolution date available.
Review of Federal Supply Schedule Proposal Submitted by Omnicell, Inc., Under Solicitation Number RFP-797-FSS-99-0025, 01-00460-39, 1/31/01			Pending receipt of contracting officer PNM; anticipated award date is April 15, 2002.
Review of Proposal Submitted by Department of Radiology, University of Arkansas for Medical Sciences Under Solicitation Number RFP V598P-1092 for Nuclear Medicine Services at the Central Arkansas Veterans Healthcare System Little Rock, AR, 01-01130-93, 6/20/01		$335,160	Pending receipt of contracting officer PNM; no planned resolution date available.
Review of Proposal Submitted by Department of Radiology University of Arkansas for Medical Sciences Under Solicitation Number RFP V598P-1093 for Radiologic Professional Services at the Central Arkansas Healthcare System Little Rock, AR, 01-00706-95, 6/21/01		$760,347	Pending receipt of contracting officer PNM; no planned resolution date available.
Review of Proposal Submitted by University of Miami, Department of Anesthesiology, Under Solicitation Number RFP 546-44-01, for Anesthesiology Services at the Department of Veterans Affairs Medical Center Miami, FL, 01-02074-132, 8/23/01		$395,040	Pending receipt of contracting officer PNM; no planned resolution date available.
Review of Proposal Submitted by Spacelabs Medical, Under Solicitation Number RFP-797-FSS-99-0025, for Medical Equipment and Supplies, 01-01584-136, 9/14/01		$336,520	Pending receipt of contracting officer PNM; anticipated award date is June 1, 2002.

APPENDIX C

FOLLOW UP/RESOLUTION OF OIG REPORTS

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 reports unresolved for over 6 months as of the end of this reporting period. Contract review reports unresolved for over 6 months are included in Appendix B.

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

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

TABLE 1 - SUMMARY OF UNRESOLVED AUDIT REPORTS

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

MONTHS	TYPE AUDIT	NUMBER	TOTAL
Over 6 Months	Internal Audit	0	6
	Contract Review	6	
Less Than 6 Months	Internal Audit	0	8
	Contract Review	8	
	TOTAL		**14**

Tables 2 and 3 show a total of 13 reports that were unresolved as of March 31, 2002. This number differs from the 14 reports shown above because tables 2 and 3 include only reports with monetary benefits as required by the IG Act Amendments. Tables 2 and 3 also provide the reports resolved during the period with the OIG estimates of disallowed costs and funds to be put to better use, including those in which management agreed to implement OIG recommendations and those in which management did not agree to implement OIG recommendations. The Assistant Secretary for Management maintains data on the agreed upon reports and Management estimates of disallowed costs and funds to be put to better use in order to comply with the reporting requirements for the Secretary's Management Report to Congress, required by the IG Act Amendments.

TABLE 2 - RESOLUTION STATUS OF REPORTS WITH QUESTIONED COSTS

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

RESOLUTION STATUS	NUMBER OF REPORTS	QUESTIONED COSTS (In Millions)
No management decision by 9/30/01	0	$0
Issued during reporting period	20	$20.9
Total Inventory This Period	**20**	**$20.9**
Management decision during reporting period		
Disallowed costs (agreed to by management)	20	$20.9
Allowed costs (not agreed to by management)	0	$0
Total Management Decisions This Period	**20**	**$20.9**
Total Carried Over to Next Period	**0**	**$0**

Definitions:

- **Questioned Costs**

For audit reports, it is the 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.

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

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

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

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

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

RESOLUTION STATUS	NUMBER OF REPORTS	RECOMMENDED FUNDS TO BE PUT TO BETTER USE (In Millions)
No management decision by 9/30/01	11	$1,492.7
Issued during reporting period	21	$543.9
Total Inventory This Period	**32**	**$2,036.6**
Management decisions during reporting period		
Agreed to by management	16	$2,025.8
Not agreed to by management	3	$4.9
Total Management Decisions This Period	**19**	**$2,030.7**
Total Carried Over to Next Period	**13**	**$5.9**

Definitions:

- **Recommended Better Use of Funds**

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

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

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

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

APPENDIX D

REPORTING REQUIREMENTS OF THE INSPECTOR GENERAL

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

IG Act References	Reporting Reqirements	Page
Section 4 (a) (2)	Review of legislation and regulations	52
Section 5 (a) (1)	Significant problems, abuses, and deficiencies	1-61
Section 5 (a) (2)	Recommendations with respect to significant problems, abuses, and deficiencies	1-61
Section 5 (a) (3)	Prior significant recommendations on which corrective action has not been completed	75
Section 5 (a) (4)	Matters referred to prosecutive authorities and resulting prosecutions and convictions	i
Section 5 (a) (5)	Summary of instances where information was refused	64
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	65 to 71 (App. A)
Section 5 (a) (7)	Summary of each particularly significant report	i to vi
Section 5 (a) (8)	Statistical tables showing number of reports and dollar value of questioned costs for unresolved, issued, and resolved reports	76 (Table 2)
Section 5 (a) (9)	Statistical tables showing number of reports and dollar value of recommendations that funds be put to better use for unresolved, issued, and resolved reports	77 (Table 3)
Section 5 (a) (10)	Summary of each audit report issued before this reporting period for which no management decision was made by end of reporting period	73 (App. B)
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

APPENDIX E

OIG OPERATIONS PHONE LIST

Investigations

Central Office Investigations Washington, DC ..... (202) 565-7702
Northeast Field Office (51NY) New York, NY ..... (212) 807-3444
Bedford Resident Agency (51BN) Bedford, MA ..... (781) 687-3138
Newark Resident Agency (51NJ) Newark, NJ ..... (973) 297-3338
Pittsburgh Resident Agency (51PB) Pittsburgh, PA ..... (412) 784-3818
Washington Resident Agency (51WA) Washington, DC ..... (202) 691-3338
Southeast Field Office (51SP) Bay Pines, FL ..... (727) 398-9559
Atlanta Resident Agency (51AT) Atlanta, GA ..... (404) 929-5950
Columbia Resident Agency (51CS) Columbia, SC ..... (803) 695-6707
Nashville Resident Agency (51NV) Nashville, TN ..... (615) 736-7200
West Palm Beach Resident Agency (51WP) West Palm Beach, FL ..... (561) 882-7720
Central Field Office (51CH) Chicago, IL ..... (708) 202-2676
Denver Resident Agency (51DV) Denver, CO ..... (303) 331-7673
Cleveland Resident Agency (51CL) Cleveland, OH ..... (440) 526-3030, ext. 6726
Kansas City Resident Agency (51KC) Kansas City, KS ..... 913) 551-1439
South Central Field Office (51DA) Dallas ..... (708) 202-2676
Houston Resident Agency (51HU) Houston, TX ..... (713) 794-3652
New Orleans Resident Agency (51NO) New Orleans, LA ..... (504) 619-4340
Western Field Office (51LA) Los Angeles, CA ..... (310) 268-4268
Phoenix Resident Agency (51PX) Phoenix, AZ ..... (602) 640-4684
San Diego Resident Agency (51SD) San Diego, CA ..... (310) 268-4268
San Francisco Resident Agency (51SF) Oakland, CA ..... (510) 637-1074
Seattle Resident Agency (51SE) Seattle, WA ..... (206) 220-6654, ext 31

Healthcare Inspections

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

OIG OPERATIONS PHONE LIST (CONT'D)

Audit

Central Office Operations Washington, DC ..... (202) 565-4625
Central Office Operations Division (52CO) Washington, DC ..... (202) 565-4434
Contract Review and Evaluation Division (52C) Washington, DC ..... (202) 565-4818
Financial Audit Division (52CF) Washington, DC ..... (202) 565-7913
Operations Division Atlanta (52AT) Atlanta, GA ..... (404) 929-5921
Operations Division Bedford (52BN) Bedford, MA ..... (781) 687-3120
Philadelphia Residence (52PH) Philadelphia, PA ..... (215) 381-3052
Operations Division Chicago (52CH) Chicago, IL ..... (708) 202-2667
Operations Division Dallas (52DA) Dallas, TX ..... (214) 655-6000
Austin Residence (52AU) Austin, TX ..... (512) 326-6216
Operations Division Kansas City (52KC) Kansas City, MO ..... (816) 426-7100
Operations Division Los Angeles (52LA) Los Angeles, CA ..... (310) 268-4335
Operations Division Seattle (52SE) Seattle, WA ..... (206) 220-6654

APPENDIX F

GLOSSARY

A&MM	Acquisition and Materiel Management
BDN	Benefits Delivery Network
C-file	Claims Folder
CAP	Combined Assessment Program
C&P	Compensation & Pension
CIO	Chief Information Officer
CNH	Contract Nursing Home
DAS	Data Analysis Section
DEA	Drug Enforcement Administration
DIC	Dependency and Indemnity Compensation
DoD	Department of Defense
FBI	Federal Bureau of Investigation
FOIA/PA	Freedom of Information Act/Privacy Act
FSS	Federal Supply Schedule
FTE	Full Time Equivalent
FY	Fiscal Year
GISRA	Government Information Security Reform Act
HEC	Health Eligibility Center
HRM	Human Resource Management
IG	Inspector General
IT	Information Technology
IVM	Income Verification Match
MCCF	Medical Care Cost Fund
MCI	Master Case Index
NCA	National Cemetery Administration
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
OGC	Office of General Counsel
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OTP	One-Time Payment
PDAS	Principal Deputy Assistant Secretary
PNM	Price Negotiation Memorandum
SSA	Social Security Administration
U.S.	United States
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VCS	Veterans Canteen Service
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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

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

The report is also available on our Web Site:

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

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

Cover photo of:
Sailor
African American Civil War Memorial,
Washington, DC

Help VA's Secretary ensure the integrity of departmental operations by reporting suspected criminal activity, waste, or abuse in VA programs or operations to the Inspector General Hotline.

(CALLER CAN REMAIN ANONYMOUS)

To Telephone:	**(800) 488 - 8244** **(800) 488 - VAIG**
FAX:	**(202) 565 - 7936**
To Send Correspondence:	**Department of Veterans Affairs** **Inspector General Hotline (53E)** **P.O. Box 50410** **Washington, DC 20091-0410**
Internet Homepage:	**http://www.va.gov/oig/hotline/hotline.htm**
E-mail Address:	**vaoighotline@mail.va.gov**

Department of Veterans Affairs
Office of Inspector General
Semiannual Report

October 1, 2001 - March 31, 2002