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CHAPTER I

EXECUTIVE SUMMARY

In the development of this first semi-annual report, and in the management of audit and investigative resources, we have considered two basic questions which are the focus of interest from the Administrator and from Congress.

1. What is the extent of fraud, waste and mismanagement in VA programs, activities and functions?

2. What has been done, particularly by the Office of Inspector General, and what additional steps can be taken to prevent and detect such fraud, waste and mismanagement?

No overall answer yet exists for the first question, and, in fact, it may always be that partial and sometimes surrogate measures are the best we can provide. Audits, investigations, and other analyses have identified the following programs and activitiess as those of greatest concern to us.

Education Benefits. This program, funded at $2.6 billion for FY 1979 had a rate of overpayment in FY 1978 of 11.7 percent. While this rate was down 28 percent from FY 1977, thereby avoiding overpayments of $153 million, further analysis is needed to determine the causes and further opportunities for reducing the overpayment rate. Such analysis is currently being performed by the Office of Inspector General.

Serious irregularities by some educational institutions, particularly trade schools, have been a recognized problem for many years. Compliance survey activities by VA program officials have been increased in the past two years, but nonetheless an audit currently in process has identified additional flight schools involved in serious irregularities. This same audit is showing another problem -- over half of the veterans in flight schools checked were pursuing avocational rather than vocational interests. VA is again pursuing legislative changes which would eliminate flight school training as an eligible benefit. We believe such legislation is needed. A draft bill to accomplish this purpose was submitted to the Congress on March 26, 1979, and introduced in the House as H.R. 3272 and in the Senate as S. 870.

We also experienced problems with the Predischarge Education Program (PREP). PREP was established in 1970 by PL 91-219 to provide high school completion and remedial courses for certain in-service military personnel. Because of subsequent legislative changes, VA has not been involved in funding this program the past 2-1/2 years. However, a 1977 GAO review found that nine schools and two consultants had received an estimated $10 million in surplus VA funding under this program because reimbursement rates exceeded actual costs. We have completed most of the audit work necessary to determine the actual amounts of surplus and

collection action has been or will be initiated. Our audit results have also shown the need to audit some of the other schools involved in the program as well because of the likelihood they also have significant surpluses which VA should seek to recover.

Another concern is the extent to which fraudulent military discharge certificates may have been used to qualify for education benefits. Specific instances of the use of fraudulent military discharge certificates have been detected from time to time. The most significant case to come to light involved an individual who was recently indicted and pled guilty to using 60 false discharge certificates to illegally gain about $150,000 in education benefits. This case was initially detected by VA program staff, and was investigated in a multi-agency effort of the FBI, Postal Inspection Service, Secret Service and the VA Office of Inspector General.

The Office of Inspector General has an investigation in process to (i) measure the extent to which fraudulent discharge certificates have been used to obtain education benefits; and (ii) identify the specific individuals involved for referral, investigation and prosecution. This investigation required computer matches between various VA automated records and also with automated records of Department of Defense. Approximately 15,000 suspect cases, out of 1,097,418 beneficiary records checked, were identified through the computer match process and these are currently being examined on a sampling basis through a match of VA and DoD record files. Results to date show that virtually all of the suspect cases identified by the computer match process are attributable to computer record error, or incompatible information between the computer systems, with a likelihood that of the 1,097,418 beneficiaries, only a very small fraction, probably about 300, received benefits based on fraudulent DD-214s.

Meanwhile, Department of Defense has taken action to change discharge certificates so that if certain key information is altered, the alteration will be detectable. Also, VA has adopted cross-checking procedures in lieu of accepting the certificate or a copy at face value for establishing eligibility for education benefits.

Accounts Receivable. The major source of accounts receivable stems from education overpayments. An analysis was made of $379 million out of the $403 million in education accounts receivable on hand at September 30, 1978. Almost $22 million of the accounts receivable had been referred to the Department of Justice for collection. (By January 31, 1979 the cumulative referred amount had increased to almost $35 million.) Another $32 million were in a repayment status. Collection was being pursued

on the remaining, except for $93 million (123,000 accounts) where collection action was not aggressively pursued due to lack of valid address information. We recommended, and action has been taken by VA, to obtain address information from Internal Revenue Service records on these debtors. It was recognized, however, that this information obtained from IRS cannot be redisclosed to credit bureaus or other non-government sources to obtain assistance or the type of credit information needed in order to refer the cases to the Department of Justice for collection. VA has a legislative proposal, which we support, to permit redisclosure of address information obtained from IRS. OMB approval is pending on this legislative proposal.

Although the potential dollar losses are less from loan defaults than benefit overpayments, the education loan program through December 31, 1978 experienced a 44.1 percent default on the $13.8 million of loans which had matured. Legislative changes adopted January 1, 1978 to reduce the predominate high risk nature which originally existed in this loan program and improved procedures adopted for acquiring permanent address information should result in a decline in the default rate in FY 1981. Further, the Office of Inspector General has an audit in process to determine if current collection efforts are as aggressive as possible within the previously cited constraints that inhibit VA's debt collection efforts.

Acquisition and Utilization of Equipment by VA Medical Centers. The acquisition and utilization of expensive, specialized equipment for research and patient care has been subject to extensive GAO review for several years. We have continued to find utilization problems with this type of equipment during the past six months. Also, we have been finding similar problems in equipment acquired primarily for administrative and training purposes as the result of our special initiatives in addressing this area.

An investigation was undertaken of alleged irregularities in the acquisition of optical character reading equipment and planned expansion of an Outpatient Reporting and Statistical Activity System supported by this equipment. The investigation determined that pilot system performance was unsatisfactory and that the planned expansion had not been subject to cost benefit analysis. As a result of the investigation, expansion plans were abandoned and the existing leases on equipment were terminated, avoiding $431,000 of planned expenditures.

An audit is being made of audiovisual/medical media activities which provide facilities to produce or otherwise furnish all types of audiovisual aids required for medical care, medical, dental and nursing education, and medical research. As of September 1978, 99 VA medical centers employed 443 personnel in audiovisual/medical media related

activities at an annual cost of over $6.7 million. Equipment involved totals $16.6 million. This audit, which is still in progress, has already identified opportunities for substantial resource savings, through elimination and consolidation of television production operations.

Serious allegations have been made regarding the improper acquisition of mini-computers at 22 medical centers and the related acquisition of software programs, and the hiring of support personnel. This matter is under investigation.

Loan Guaranty Program. In selected target geographic areas -- three during this reporting period -- teams of investigators looked into defaulted guaranteed home loans for evidence of fraud by the veterans, brokers or lending agencies. During the last six months, 406 cases, primarily default cases, were investigated. Of these, 18 cases have been referred to the Department of Justice and about 100 more are being prepared for referral. The findings will also serve as a basis for denial of liability by VA.

At one location where these investigations were conducted, we also found and referred to Department of Justice, evidence that some VA loan program employees were receiving personal benefits from or had a financial interest in contractors or brokers who would benefit from the actions of these employees. Most of the employees under investigation resigned or retired while the investigation was in progress. For the remainder, appropriate disciplinary action has been recommended. We have also recommended suspensions of program participants.

Additional programs and activities are under review or are scheduled for review but we do not yet have sufficient information to determine whether these are subject to serious problems of fraud, waste or mismanagement.

Further, in considering the previously described problem areas, it is important to consider them within the context of the size and breadth of VA operations scheduled for FY 1979. VA is the second largest governmental employer, with 215,000 employees. Of these, 181,000 work in medical care programs carried out primarily through VA's 172 medical centers, 220 outpatient clinics and 16 domiciliaries. The total funding of these medical programs is almost $5.7 billion to provide inpatient care for 1.3 million eligible beneficiaries and to provide 17.7 million outpatient visits.

VA benefit programs total almost $13.2 billion, including compensation and pension to almost 5 million veterans or survivors and education benefits for 1.3 million. Also, guaranties for home loans totalling $16.1 billion will be made for 376,000 beneficiaries. VA operates 140 cemeteries. In addition, VA has a large construction program for medical care, cemetery and other facilities funded at $452 million this year.

CHAPTER II

IMPLEMENTATION OF THE INSPECTOR GENERAL ACT IN THE VETERANS ADMINISTRATION

HISTORICAL PERSPECTIVE

On January 1, 1978, the Administrator of Veterans Affairs established the Office of Inspector General with reporting responsibilities directly to the Administrator. The Inspector General Act of 1978 gave a legislative foundation to the Office which had already been assigned organizational, mission and reporting relationships which closely paralleled those subsequently called for in the Act.

Prior to January 1, 1978, audit and investigation were small -- in fact, GAO, in a November 1976 report, cited VA as having the least number of auditors per dollar expended and per staff employed of any of the 49 Federal audit agencies studied. Organizationally, the audit and investigative activities reported to an Assistant Administrator, three organizational levels below the Administrator. Further, audit and investigative activities were not linked together in a joint mission effort to address fraud, waste and mismanagement.

By January 1, 1978 there had been some staff growth, up from 102 in FY 1977 to 155. The greatest growth occurred from April through September 1978. FY 1978 ended up with an on-board strength of 356 and an average staff for the year of 218. The planned staff for FY 1979 will provide an average of 339. The sudden growth in FY 1978 placed inordinate demands on key management and supervisory personnel because of the recruitment and training load created, and this training impact carried over into the first three months of FY 1979.

Another major change in FY 1978 was to decentralize into four field offices of audit from a single centralized audit group located in Washington, D.C. Four field offices of audit were established on January 1, 1978 at Hyattsville, Maryland; Atlanta, Georgia; Chicago, Illinois; and Los Angeles, California. These field offices established resident audit sites at data processing centers in Washington, D.C.; St. Paul, Minnesota; and Los Angeles, California; and expanded the residencies at Philadelphia, Pennsylvania; Chicago, Illinois; and Austin, Texas. Also, during the year investigative temporary task forces were established in Denver, Colorado; Atlanta, Georgia; and Jacksonville, Florida. One was already in existence in Los Angeles, California. These actions also impacted temporarily on management and supervisory capabilities of both the Offices of Audit and Investigation to determine needs and acquire space, equipment, etc. to support decentralization and to develop the formalized procedures, guidelines and management information needed to direct and control the operations of an enlarged, decentralized staff.

ORGANIZATION

Consistent with the Inspector General Act of 1978, the organizational structure provides for two separate subunits -- the Office of Audit and the Office of Investigation. Each is headed by an Assistant Inspector General. Routine coordination between these offices is carried out directly between these two Assistants and their staffs. Coordination of special initiatives or unique situations is accomplished under the leadership of the IG or his Deputy.

A third organizational unit was established in August 1978 and staffed beginning in November 1978. This unit is called the Risk Analysis Staff which is responsible for:

1. Developing composite analyses of the vulnerability of VA programs, functions and activities to fraud, waste and mismanagement.

2. Reviewing new legislation and regulations and making recommendations for changes which will affect the future resulting programs and activities.

3. Operating a "hotline" to receive employee complaints of fraud, waste and mismanagement.

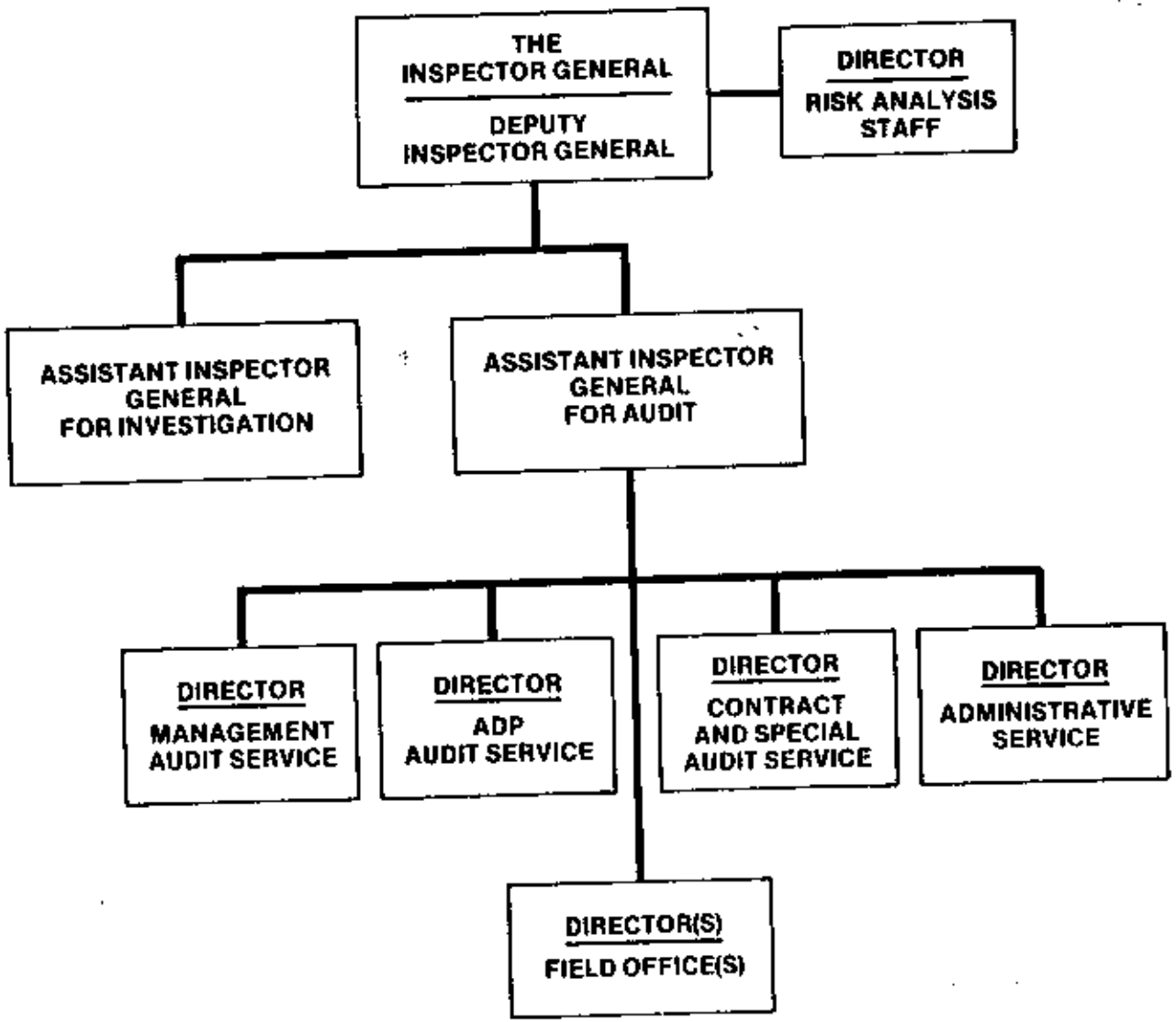
An organizational chart for the Office of Inspector General is on page 9.

STAFFING

Audit and investigative activities have experienced a significant growth rate between FYs 1977 and 1979. For the Office of Audit, staff size is more than three times as large. The Office of Investigation is more than twice as large. The staffing as of March 31 is as follows:

	Total	Headquarters	Field
Professional			
IG	3	3	--
Risk Analysis	4	4	--
Audit	259	79	180
Investigation	33	19	14
Subtotal	299	105	194
Clerical	36	19	17
Total	335	124	211

OFFICE OF THE INSPECTOR GENERAL



The professional staff of the Office of Audit is multidisciplinary, consisting of 45 percent management analysts, 36 percent accountants and 16 percent ADP systems analysts. The professional staff of the Office of Investigation consists primarily (93 percent) of individuals who had prior criminal investigative experience with a military or civil agency, and the total investigative staff provides diverse experience in criminal and administrative areas.

RESOURCE APPLICATION

Five key objectives have been established by the Inspector General. A description of these objectives and the resources applied to each objective are set forth below:

	Staff Assigned*	Percentage of Effort
Objective 1: Vulnerability Assessments		
To analyze major existing systems and programs, based on the results of investigations, audits and other studies, to determine primary weaknesses permitting fraud and abuse, or impacting on efficiency, economy or effectiveness, and to obtain preventive measures and improvements.	3.5**	1.6
Objective 2: Preinstallation Reviews		
To review new legislation and regulations and major new systems, projects and organizational units to identify and obtain correction of control weaknesses and other problems which may affect future integrity, efficiency, economy or effectiveness. (Note: Review of legislation and regulations added January 1, 1979.)	10.0	4.4
Objective 3: Special Initiatives on Fraud, Waste and Mismanagement		
To initiate timely and effective special audits and investigations to actively seek out fraud, abuse and waste and other serious problems.	78.0	34.4

*All references to staff assigned represent the average number of professional staff dedicated to these activities during the six month period.
**These activities started during the reporting period and the assigned staff shown represents the current level of effort.

	Staff Assigned	Percentage of Effort
Objective 4: Cyclical Audits		
To maintain recurring oversight of programs, functions, activities and organizations with sufficient frequency to encourage quality management and operations and to assure that out-of-line situations are timely identified and corrected.	118.5	52.3
Objective 5: Reactive Investigations		
To investigate complaints of serious administrative and criminal irregularities and to assure that corrective actions are taken.	16.5	7.3

The first two objectives and 75 percent of the third objective (in terms of resource investment) reflect new initiatives started during this six month period. Also, an employee "hotline" was established during this period for employees to report significant irregularities to the Office of Inspector General.

In addition to these activities, staff resources are applied to carry out the following other activities:

	Staff Assigned
Liaison with GAO, including coordination of responses to GAO reports	3.0
Personnel and document security programs	1.5
Employee hotline	2.0*

The six months results from application of these resources are described in the subsequent chapters of this report.

INTRA-AGENCY RELATIONSHIPS

Pending confirmation of an Inspector General with authorities provided in the Inspector General Act of 1978, our Office of Inspector

*These activities started during the reporting period and the assigned staff shown represents the current level of effort.

General has continued to operate under the existing delegations of authority prescribed by the Administrator. The principal differences from the Act are:

1. Exercise of selection and appointment authority for all staff members (Section 6(a)(6) of the Act). Currently, such appointment authority for GS-14s and above is reserved to the Administrator, although he has not used such authority to disapprove or hold back on any of the Inspector General's recommendations.

2. Employment of consultants (Section 6(a)(7) of the Act). This authority, which we have had no occasion to use in the past six months, was not delegated to the Inspector General.

3. Entering into contracts (Section 6(a)(8) of the Act). The circumstances are the same as for the preceding item.

4. To authorize investigations (Section 6(a)(2) of the Act). While this authority has been reserved to the Administrator, he has not in the last six months refused a proposed investigation.

These authorities will pass to the Inspector General upon confirmation. Also, all of the other authorities set forth in Section 6 (a) of the Act already exist for the administratively appointed Inspector General, although the subpoena power derives from Section 3311 of Title 38, United States Code, rather than Section 6(a)(4) of the Act. Further, the administratively appointed Inspector General has been given full freedom and support to carry out all the duties and responsibilities, reporting requirements and employee complaint handling provisions of the Act.

Separate personnel, contracting, legal and other support activities have not been established in the Office of Inspector General, nor is it likely that they will be so long as adequate support is available from other staff offices of VA. In some areas, the workload is insufficient to justify such additions to the Inspector General staff. In other cases, the right expertise and background could not easily be brought to bear on the variety of issues which arise.

Section 4(d) of the Act requires the Inspector General to report expeditiously to the Attorney General whenever the Inspector General has reasonable grounds to believe there has been a violation of Federal criminal law. We are currently carrying out this responsibility for those cases which originate as the result of complaints to, or investigations by, the Office of Inspector General. However, a large number of referrals to the Department of Justice (1,200 last fiscal year) originate as a result of irregularities by employees, contractors, beneficiaries and others which are detected at VA's 490 field facilities scattered throughout the United

States and territories. The Office of Investigation is not decentralized to handle this workload, whereas the Office of General Counsel has this capability. Therefore, to expedite referral to the local U.S. Attorneys and FBI, these cases are initially referred by local VA District Counsels to local Department of Justice officials with a copy of the referral to the Inspector General. There are exceptions when the cases are referred to the Inspector General first, who in turn makes the referral to Department of Justice. These would involve particularly serious allegations, sometimes requiring preliminary investigation to determine if there are reasonable grounds to believe there has been a violation of Federal criminal law.

An important facet of intra-agency relationships involves those between the Office of Inspector General and the Administrator, his key staff and other senior management officials of the Department. We believe that it is important, without sacrificing either independence, objectivity, or any of the authorities under the Act, to build a relationship with the top management team of VA whereby they view the audit and investigative capabilities of the Office of Inspector General as a major source for management information and control. We have worked at enhancing these relationships over the past six months, and will continue to do so. Management officials have accepted the increased overview and exposure to outside surveillance that has occurred as the result of establishing an Office of Inspector General, increasing the audit and investigative activities, and implementing the Inspector General Act of 1978.

INTER-AGENCY RELATIONSHIPS

The Act sets forth specific relationships with the Department of Justice for referral of potential criminal cases, as described in the previous section of this report. A major effort to establish broader relationships is being carried out by the Department of Justice, the Office of Management and Budget and the 14 agencies affected by the Inspector General Act of 1978 or earlier legislation. This group is currently active in providing orientation and implementation guidance to the Inspectors General or nominees and their key staffs. The group is also working on an inter-agency basis to (i) address the procedures for referring cases to the Department of Justice, (ii) enhance inter-agency training capabilities for auditors and investigators, and (iii) pursue other projects of mutual interest. The top management team of VA's Office of Inspector General is an active participant in these activities.

In the past six months, the Office of Inspector General has been involved in two major inter-agency projects:

1. A computer match between the Department of Health, Education and Welfare and VA to identify veterans receiving VA education benefits who failed to disclose this information in qualifying for the Basic Education Opportunity Grant Program of DHEW.

2. A computer match program and a subsequent "hard copy" file match on a sampling basis, between VA and Department of Defense records to measure the frequency and identify specific instances where fraudulent military discharge certificates have been presented to qualify for VA education benefits.

Relationships have also been established with the General Accounting Office and Office of Special Counsel, Merit Systems Protection Board, to inquire into allegations received via GAO's hotline and complaints filed with the Merit Systems Protection Board. Thus far, we have received 31 cases from GAO and 2 cases from the Office of Special Counsel.

CONGRESSIONAL RELATIONSHIPS

Confirmation hearings were held on April 5, 1979, for the Presidential nominee for Inspector General of the Veterans Administration. Congressional confirmation is pending.

In the oversight hearings conducted by the Senate Veterans' Affairs Committee, the nominee for Inspector General was challenged by the Chairman to meet a set of specific goals, as follows:

> "The total outstanding Veterans Administration overpayments at this point stand at around $400 million -- a really incredible figure. I think dealing with this should be your top priority. Let's reduce that level by 50 percent over the next year! Also when you report back to me next year, I want you to give the Committee a definite plan showing how the remaining problem will be resolved.
>
> "The Veterans Administration's pension payments error rate is 26.2 percent according to a Veterans Administration report. Let's get that rate down by one half over the next year. When you come back next April, I want you to give us a definite plan, in this respect also, showing the further actions that are needed.
>
> "According to the General Accounting Office, the Veterans Administration has failed to audit grants for Health Manpower Training entailing commitments

of $256 million over the past seven years. Let's complete audits of half those grants in the next 12 months.*

"Let's complete audits of one third of Veterans Administration medical centers over the next year, specifically focusing on the effectiveness of DM&S efforts to correct the deficiencies you've uncovered in security, medication handling, and patient records, and to prevent patient abuse.

"The General Accounting Office has issued numerous reports about serious underutilization of Veterans Administration specialized medical programs, such as cancer therapy, renal dialysis, and cardiac procedures, among others. The recent National Academy of Science's study also highlighted this problem. I challenge you to be the in-house advocate for reducing underutilization by promoting increased sharing of resources within the Federal Government and with the community.

"You have already found substantial instances of fraud in nearly 10 percent of your loan guaranty investigations. Let's get remedial measures in place within the next 3 months to deal with the problems uncovered.

"Let's continue a close monitoring of implementation of the TARGET System and report back next year on what you've achieved in terms of lasting corrections of the deficiencies you've already found and those you find in the next year.

"Also regarding TARGET, I'd like to have from you within 60 days and a followup report next year on the extent to which individual privacy of records is being properly protected and only authorized disclosures are being permitted. I am not satisfied that this is the case today. The President has announced his intention to submit legislation to protect individual privacy in Federal computerized records, so there is clear recognition that this is a serious and pervasive problem."

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*It should be noted that the GAO report is in error. Audits have been conducted of 18 grantees which received grants of about $87 million. These audits were performed under cognizant arrangements by the Department of Health, Education and Welfare. However, more audit coverage is needed and is being arranged.

Some of the goals include specific reporting requirements; progress against all of the goals will be included in subsequent semi-annual reports; and the Senate Veterans' Affairs Committee has indicated its intention to conduct further hearings in one year to explore the Inspector General's accomplishments.

CHAPTER III

AUDIT RESULTS

During the past six months, audit activities have been primarily directed to three of the five previously described objectives -- namely, preinstallation reviews, special initiatives, and cyclical audits. The breakout of resources between these objectives was:

	Staff Assigned	Percentage
Preinstallation reviews	9.5	5
Special initiatives for fraud, waste and mismanagement	60.5	32
Cyclical audits	118.5	63

PREINSTALLATION REVIEWS

A preinstallation review was conducted of major modifications to the automated Fee-Basis System used to make payments to medical care providers. Principal findings, since corrected, related to the need to strengthen management of this system development project and purify the data base to be entered into the modified system.

A preinstallation review was started in August 1978 of the new TARGET system, which is a major redesign effort (hardware and systems cost of about $81 million) for existing compensation, pension and education programs. The redesigned system will provide real-time capabilities to substantially improve the response time for handling claims and status inquiries, while simultaneously reducing the personnel requirements. TARGET is a phased project which was scheduled for initial implementation in 1978 and completion in 1983. Our audit effort, closely coordinated with GAO oversight, is planned to continue throughout this period at about the current annual resource investment of five staff years.

Initial audit results of the TARGET system audit have dealt with the inadequacies in system documentation, standards and practices, deficiencies in specifications and performance standards for outside contractors, gaps in implementing Privacy Act controls, and weaknesses in the risk analysis study plan. Actions have been initiated to correct these problem areas. Our continuing review of TARGET will followup to assure the effectiveness of these actions.

A third effort is a strategy for auditing replacement medical center major construction projects which provides for a continuing review of projects as they reach various critical stages of development. This includes reviews of projects that are underway and nearing completion. Since there is not sufficient staff to audit each project on a regular cyclical basis, the strategy requires a survey of major replacement medical center projects at six month intervals to assess the status of project development and to identify specific projects which require an indepth audit. This strategy, if successful, may be expanded to include all major construction projects.

The first survey was conducted in December 1978. As a result of this survey, an indepth review of the construction approval process is now underway.

SPECIAL INITIATIVES FOR FRAUD, WASTE AND MISMANAGEMENT

Most of these audit efforts were undertaken during the six month period, are currently in process, and are scheduled for completion within the next several months. The several projects which have been completed, or segments completed, during this six months are:

PREP Audits. In 1977 the GAO reviewed nine schools and two private consulting firms which had participated in the Predischarge Education Program. GAO estimated that approximately $10 million in surplus funds had accrued by the schools and recommended that the VA conduct indepth audits.

The IG audits started in May 1978 and field work was recently completed. Two of the audits have been finalized and collection action has been initiated by VA to collect $886,223 from these two schools. It is expected that collection action will have been initiated for the remaining seven schools, and if appropriate, the two consultants by June 30, 1979.

Audit of VA Regional Office, Manila. The purpose of the audit was to insure that only eligible beneficiaries were receiving benefits, to assess the controls used to prevent program abuse, and to address issues raised by the GAO report entitled, "VA Benefits Programs in the Philippines Need Reassessment."

The audit included a review of the controls used in the processing of applications for benefits; and a review of randomly selected claims folders of beneficiaries receiving disability compensation, pension, dependency indemnity compensation, education benefits, and burial benefits. The audit team requested a reexamination of individual cases by regional office personnel when information in the claims folder appeared questionable. The VA Outpatient Clinic was reviewed to assess controls over the submission of medical evidence.

The audit team found that the lucrativeness of VA benefits in relation to the economy, the presence of claims fixers, and the availability of false documentation provided a climate for potential program abuse. However, the audit team's review of 1,162 active claims folders did not disclose any case of beneficiaries who did not have basic service eligibility.

The audit team found that controls over the education benefits program requires substantial improvement to assure proper payment to beneficiaries in active pursuit of approved training programs. Also, added emphasis was needed on the verification of evidence submitted to support dependency claims due to the availability of false documentation. Field examinations and education compliance survey visits are the major controls over the submission of evidence and the verification of pursuit of education. The audit team found supervision was poor in both of these areas. Controls over fee-basis medical examinations should also be improved to verify medical evidence.

To improve supervision of the Field Unit and the Education Services Unit, the Chief Benefits Director has agreed to fill the Assistant Veterans Services Officer position with an American, while staying within the Department of State's prescribed limit of 12 American employees in Manila. The Chief Benefits Director has also agreed to send program officials from the Education and Rehabilitation Service to Manila to provide necessary training and guidance. The audit team recommended the use of a "claim fixer" list, currently used for the Social Security benefit claims in Manila, which provides the names of municipal, church, and other public officials known to have submitted false documentary evidence. The Adjudication Division has implemented this recommendation. The Manila Office has been instructed to adjust staffing to maintain effective control of the education benefits program.

In addition to the initiatives discussed in the Executive Summary, there are others described in the following paragraphs:

VA Contract Administration and Procurement. One of the early Inspector General initiatives was to provide for oversight of the contract administration and procurement function within the VA. This initiative gave recognition to both the sensitive nature and the dollar magnitude of the procurement process. A survey was conducted of all phases of the procurement cycle so that priorities could be established for audits to assess and provide overview of the contract and procurement function. A prioritized audit plan was designed to meet this objective. Audit priorities were established based on survey results giving consideration to the following:

(1) potential for fraud
(2) extent of monitoring by the VA Central Office
(3) extent of audit coverage currently provided by the Inspector General
(4) extent and validity of internal controls
(5) dollar magnitude
(6) GAO/congressional interest.

At the present time, there are two ongoing audits: (1) a determination of the extent of competition in procurement, and (2) a review of the disposition of claims submitted to contracting officers. Both these audits were identified as high priority subjects.

Overtime. During FY 1978, VA paid out, in personal services and benefits, $3.8 billion of which $31.6 million was for overtime. We have undertaken an audit to determine (i) if adequate controls exist to preclude or minimize overtime abuse or fraud, and (ii) whether the amount of overtime being worked at some high incident locations is justified.

Patient Abuse. A major priority of the Veterans Administration is that veterans who use VA medical centers receive the best possible care and treatment. This area has not previously been systematically reviewed as part of our medical center audits. Audit guides were developed in September 1978 and are being applied to each medical center reviewed. It is expected that sufficient coverage will be obtained by the third quarter of FY 1979 to develop an analysis of the adequacy of medical center activities to deal with and resolve individual patient abuse complaints, and to take fundamental corrective action where the need is indicated.

Improper Use of VA Health Care Facilities by VA Employees. During FY 1978, audits at three VA medical centers and investigations at two other medical centers turned up instances of questionable use of these facilities for both inpatient and outpatient care for non-service connected medical problems. To receive inpatient care under such circumstances, an individual must be a veteran and must certify that he or she cannot afford the cost of care. In addition to these stipulations, outpatient care is only available to prevent or as a followup to inpatient care. A computer match was used to compare VA payroll and inpatient care records. This audit, which is in the final stages, has identified 465 highly questionable cases, out of a total of 21,188 instances of inpatient care of VA employees for non-service connected care since 1971. We are recommending disciplinary action and reimbursement of patient care costs for the individuals concerned, and better enforcement of admission standards.

CYCLICAL AUDITS

During this six month period, 27 audits of medical centers, regional offices, programs and other VA activities were completed. Estimated savings, primarily in the nature of cost avoidance or future reduction in annual operating costs totalled $1.5 million. The single most significant incident related to the opportunity to reduce costs of pathology services by about $450,000 annually by eliminating unnecessary use of commercial laboratories. Numerous other findings and recommendations resulted from these audits. Many were significant, but volume is not yet sufficient to determine whether these relate to localized situations or are part of an overall trend. In a few instances, where a trend appeared likely, special audits were started to probe those problem areas at multiple locations. These include the previously described audits of: improper use of VA medical care by VA employees; excessive investment of $16.6 million for medical media (audiovisual) equipment provided primarily for training purposes; and the extent of employee abuse of leave and overtime.

Audits of contractors, grantees and other external organizations participating in VA programs resulted in recommended cost adjustments of $562,000, in addition to the $886,000 attributable to PREP schools.

OTHER INFORMATION REGARDING AUDIT ACTIVITIES

Three attachments to this Chapter provide further details regarding the audit universe (Attachment 1); significant audit findings and recommendations of the past six months (Attachment 2); and a list of audit reports issued during the six month period (Attachment 3).

Responsible Agency officials are generally receptive and positive in their responses to audit findings and recommendations. In no instance during the past six months has the Administrator been requested to arbitrate a nonconcurrence between Office of Audit and other VA organizational elements. Disagreements, when they arise, have been resolved before the audit reports are finalized without compromising the intent of the audit findings or conclusions. We request and receive comments from Department and Staff Office heads on each audit recommendation made. We frequently require progress reports on recommendation implementation. While improvements are being made to establish a more tightly controlled system to track and follow through on actions taken in response to audit recommendations, we feel that the Agency, as a whole, has been and will continue to make improvements in response to our recommendations. We have initiated policy development to assure the VA is in full compliance with Office of Management and Budget directives for audit followup and the GAO report of October 25, 1978, "More Effective Action is Needed on Auditors' Findings --

Millions Can be Collected or Saved," FGMSD-79-3, The Administrator is supporting these efforts.

In addition to receiving written comments from responsible agency officials on actions planned and taken on audit recommendations, the Office of Audit may determine that onsite followup audit review is necessary to assess progress being made. Two of the followup audits completed during the past six months are highlighted in the following paragraphs.

In response to employee complaints regarding personnel policies and procedures, the U. S. House Committee on Veterans' Affairs requested an audit of the Chillicothe, Ohio medical center. As the result of this audit, conducted in 1977, seven recommendations were made to correct the following:

- ineffective personnel management programs
- inadequate personnel management evaluations
- staffing problems in Nursing Service
- no special funding for the Alcohol Treatment Program
- insufficient surgical workload
- operational deficiencies in Fiscal Service
- inadequate security and control of patient valuables
- improper maintenance of patient fund accounts.

Because of the seriousness of deficiencies found and the high level interest in this audit, we decided to perform an onsite followup audit to determine how well management had implemented our recommendations. We found that six recommendations had been substantially implemented. Actions had been taken to improve personnel management programs, conduct comprehensive personnel management evaluations, close the inpatient surgical activity, request special funding for the Alcohol Treatment Program, correct deficiencies in Fiscal Service, secure patient valuables and maintain patient fund accounts.

The remaining recommendation regarding staffing shortages in Nursing Service had been partially implemented. While the ratio of professional to non-professional nursing staff and the staff/patient ratio had improved, action was still needed to increase registered nurse coverage on psychiatric wards during the evening shift, closely monitor decubitus ulcer cases, review overtime usage and study the use of nursing staff. We will continue to monitor the medical center's progress until all recommendations have been fully implemented.

A followup audit was conducted to determine if control over the use of Postgraduate and Inservice Training Program funds had improved since our audit in 1977. We found that it had. A new Department of Medicine and Surgery manual had been published and distributed. General Counsel

decisions had clarified the use of appropriated funds. Committee responsibilities had been clearly delineated. Fund controls had been improved and reconciled with Controller and Department of Medicine and Surgery records. Instructions to Central Office elements for estimating and requesting education funds were revised. Assistant Chief Medical Director discretionary funds were reduced in Fiscal Year 1978; in Fiscal Year 1979 no reserve funds were allocated to Assistant Chief Medical Directors other than the Assistant Chief Medical Director for Academic Affairs.

ATTACHMENT 1

AUDIT UNIVERSE

Efforts to identify the VA's audit universe have received priority and a preliminary description of the universe has been completed. We are currently able to describe 1,422 auditable entities in the VA. The audit universe serves as a basis for workload definition, provides essential data for budgeting, audit planning and prioritizing audit projects. We have defined the major programs as health care, benefits, national cemetery, and administrative and management. We have categorized the components of each major program by type of auditable entity. These types have been defined as field facilities; intermediate level management activities; central office level management activities; data processing centers; state approving agencies, state homes, grantees and others; other field activities; and contractors.

It is expected that during the next six months, further refinements will be made which will affect the numbers of auditable entities and their distribution by major VA program. In this respect, there is a whole set of subprograms, functions and activities which we have not yet included in the universe. We anticipate that audit staffing and related funding requirements may be significantly affected as the audit universe evolves if we are to fully comply with pertinent Office of Management and Budget directives and General Accounting Office guidance and standards.

The audit universe identified to date is set forth on the following page.

AUDIT UNIVERSE

Type of Entity	NUMBER OF ENTITIES				
	Health Care	Benefits	National Cemetery	Admin. & Management	Total
Field Facilities	207	75	105	70	457
Other Field Activities	26	1			27
Intermediate Level Management Activities	37	3	3		43
Central Office Level Management Activities	174	85	14	28	301
Data Processing Centers				6	6
State Approving Agencies, State Homes, Grantees and Other	200	228			428
Contractors	89			71	160
TOTAL	733	392	122	175	1422

ATTACHMENT 2

SIGNIFICANT AUDIT FINDINGS AND RECOMMENDATIONS

While determining significance is a highly judgmental process, we have developed the following criteria for purposes of this report:

- Significant short fall in the quality of service rendered to veterans or which put veterans at serious personal or financial risk
- Serious danger to health or safety
- Potential gain in efficiency or economy of $100,000 or more
- Significant short fall in achieving desired program results or benefits
- Erroneous policies, procedures, or practices which may allow fraud and abuse by veterans in the obtaining of services or benefits, by program personnel in the awarding of benefits, or in the providing of services, or by third party providers in the delivery of services
- Other serious system-wide policy or procedural defects
- Conclusion that management, in one or more of the major areas audited, is ineffective or inefficient
- Non-compliance with statutory requirements
- Findings which were included in previous audit reports and found not to be corrected
- Unaccounted for, lost, or stolen cash, drugs, supplies or property in excess of $100,000
- Serious financial management weaknesses which may permit loss of appropriated funds, or expenditures of funds in excess of statutory or program limitations.

Based on these criteria, audits completed during the last six months have resulted in some significant findings and recommendations. However, it is noteworthy that none reveals a significant short fall in the quality of service provided to veterans, a significant short fall in achieving desired program results, non-compliance with statutory requirements, or serious danger to health or safety. Our findings generally involve potential gains in efficiency or economy through improved use of resources.

Following are significant audit findings and recommendations issued during this six month period:

HEALTH CARE PROGRAMS

FINDINGS	RECOMMENDATIONS
Pathology Service	
Fee-for-service (i.e., commercial) laboratory tests, while representing only .5 percent of all tests, cost $3-4 million annually, which probably can be reduced $450,000. Most fee-for-service tests are the same as those done by VA laboratories. This cost reduction opportunity was identified by GAO in 1973. Department of Medicine and Surgery's response was to require the medical districts to work out sharing arrangements between VA labs and other government labs, using fee-basis as a last resort. However, Pathology Service has not monitored implementing actions by the medical districts. Utilization of fee-basis in FY 78 will apparently be almost double that of FY 72.	Determine current status of medical district efforts to coordinate sharing of resources, provide guidance on reducing fee-basis tests, and establish standards and a feed-back system to monitor fee-basis utilization.

FINDINGS	RECOMMENDATIONS
VA Medical Center Brooklyn, NY	
Management has not monitored quality assurance functions. The Clinical Executive Board was not meeting and its subordinate committees were ineffective. As a result, we found a lack of retrospective medical care audits, over 600 delinquent hospital summaries and operations reports, and excessive lengths of stay in medical and surgical services.	Reactivate the Clinical Executive Board and its subordinate committees and provide the direction necessary to identify and resolve quality of care issues.
Lack of a coordinating effort by the Chief of Staff has impeded successful integration of inpatient and outpatient activities. We found admission policies being published by service chiefs without review or concurrence by the Chief of Staff. We also found delays and inappropriate block scheduling for clinic patients.	Provide the direction and control needed to assure effective processing of admission applicants and outpatients.
Surveys by the Joint Commission on Accreditation of Hospitals, Systematic External Review Program staff and other surveyors in the two years preceding the audit contained 146 recommendations for improvements at the medical center. We found approximately 60 percent of these not implemented.	Establish controls to monitor progress toward implementation of recommendations.
Deficiencies noted in prior fiscal audits of the center conducted in 1972 and 1975 have generally not been corrected. Thirty-one of forty-six recommendations tested had not been implemented. In addition, internal reviews performed by Fiscal Service were ineffective and poorly documented. Many deficiencies noted during the audit were in areas subject to internal reviews, which had failed to identify them.	Monitor self-evaluation efforts within the service and assure that identified deficiencies are corrected.

FINDINGS	RECOMMENDATIONS
VA Medical Center Brooklyn, NY (Cont.)	
Outstanding bills for collection, for a total amount exceeding $70,000, showed no evidence of collection followup action. In addition, vouchers for transfers between appropriations and/or funds, representing over $442,000 due the VA, showed no attempts to collect. The documents involved included several outstanding since 1971.	Implement aggressive followup action to collect amount due the Veterans Administration.
VA Medical Center Saginaw, MI	
The six bed general purpose intensive care unit and the eight bed respiratory intensive care unit were underused. During a 202 day period more than eight intensive care beds were needed only 31 days. The respiratory intensive care unit was not equipped to treat critically ill patients. By modifying plans for renovating the general purpose intensive care unit to include four beds for respiratory care patients, the respiratory intensive care unit could be closed at a savings of $100,000 per annum.	Close the respiratory intensive care unit, and modify the general purpose intensive care unit renovation plan to add four beds for respiratory care patients.
Some employees were receiving medical care inappropriately through the employee health program. Twenty-seven of 200 employees reviewed had received excessive treatment. Eight had received multiple physical or respiratory therapy treatments. Five employees had received a total of 68 prescriptions during the period reviewed.	Restructure the existing employee health program and eliminate the abuses.

FINDINGS	RECOMMENDATIONS
VA Medical Center Saginaw, MI (Cont.)	
Space use was inadequate. There were five services with space deficiencies which adversely affected operations, yet there was unoccupied or underused space throughout the center. Two construction projects, one for $50,000 and one for $250,000, were cosmetic and did not provide adequate operating space for the Supply and Laboratory Services in spite of acknowledged space deficiencies.	Develop a master space plan to include priorities and use of existing space.
Manila Grant-In-Aid Program	
Medical staff at the VA Outpatient Clinic are not reviewing and controlling the length of hospital stay for grant beneficiaries at the Veterans Memorial Medical Center. Without controls we cannot insure that grant beneficiaries are receiving maximum benefits with the grant funds available.	Have VA physicians review and control length of hospital stay.
Hospitalization expenses are paid for patients whose medical records show hospitalization is no longer required. There is no administrative verification of patient days reported. Variances were found between the date the physician authorized discharge or the patient left and the reported discharge date.	Terminate payment for hospitalization expenses effective the day the patient is medically ready for discharge.
Some outpatient expenses of the hospital are included when calculating inpatient costs resulting in overcharges to grant funds of about $119,000 in calendar year 1977.	Review expenses claimed to ascertain that only actual inpatient expenses are used in determining the per diem rate.

FINDINGS	RECOMMENDATIONS
Manila Grant-In-Aid Program (Cont.)	
Expenses incurred by the VA at the outpatient clinic are not reimbursed at actual rates. Underpayments from grant funds to the VA in Fiscal Year 1978 totalled about $100,000.	Reimburse the VA for actual outpatient expenses incurred.
Salary expenses are incurred for four VA employees performing clerical and administrative duties associated with providing supplies to the hospital and grant administration. The VA is reimbursed for salary expenses of only two of the four employees.	Reimburse the VA for actual salary expenses incurred.
Supply Fund Management Staff	
A total of $4.1 million or 9.6 percent of the field station inventories are in inactive/long supply. Procedures to improve these conditions have shown no progress.	Improve procedures to control inactive/long supply inventories.
Automated Fee-Basis System	
Overall project management was weak. No overall project manager or chairman was assigned from the joint Department of Medicine and Surgery/Office of Data Management and Telecommunications working committee that was formed to effect the new system. A detailed milestone chart was not prepared. There was an overall work plan, but it did not show certain tasks necessary for system completion and their dates. There was a lack of formal documentation of meetings.	Establish overall program management for the automated system. Prepare a detailed milestone chart. Insure minutes of meetings are documented and distributed to appropriate personnel.

FINDINGS	RECOMMENDATIONS
Automated Fee-Basis System (Cont.)	
No plans were made for verifying the data in the newly merged fee-basis vendor file. The merging of the six Data Processing Centers' fee-basis vendor files without verifying their content would allow current errors to be transferred to the single fee-basis file. Such errors have been a cause for delays in payments to the vendors.	Verify the data in the new fee-basis vendor file.
Evaluation of Pricing Proposal by the University of Florida to Provide Anesthesiology Services to the VAMC Gainesville	
The medical center was purchasing anesthesiology services via bimonthly purchase orders at a rate equivalent to $212,000 annually. The review determined that $84,084 of the proposed $212,000 cost was allowable. The remaining $127,916 represented proposed salary and fringe benefits exceeding University base rates for the same services. In essence the medical center was contracting with the Academic Enrichment Fund and not the University, since VA payments were made to an individual in the Anesthesiology Department for inclusion in the AEF. On that basis the audit questioned whether the University was responsible for contract performance. The $212,000 cost was apparently based on a VA letter stating that amount would be requested for fiscal year 1978. The medical center was without a contract from September 30, 1977 to March 18, 1979.	Reduce the proposed cost of $212,000 by $127,916 to $84,084 which constitutes allowable costs.

FINDINGS	RECOMMENDATIONS
Evaluation of Pricing Proposal by the University of Florida to Provide Anesthesiology Services to the VAMC Gainesville (Cont.)	
The results of a desk review of a proposed fiscal year 1979 contract were issued on January 4, 1979 questioning approximately $150,000 of a proposed annual cost of $256,500. An unacceptable record of price negotiation was received on April 10, 1979 which did not show the disposition of the $150,000 questioned costs. A contract had been negotiated to cover the period March 18, 1979 through September 30, 1979 at a cost of $138,115.	Provide a record of price negotiation detailing the disposition of questioned costs.
Evaluation of Cost Proposal by the University of Pennsylvania, School of Medicine, Department of Radiology to Provide Radiology Services to the VAMC Philadelphia	
The total costs proposed of $545,537 included salaries for two radiologists paid under a separate working agreement by VA. The audit questioned the salaries and employee benefits for these individuals totalling $143,706. Since the University was unable to provide documentation supporting $32,000 for general administrative charges, the audit set aside these charges for consideration by the Contracting Officer. The University's accounting system was determined adequate for a cost reimbursement contract.	Reduce salaries and employee benefits by $143,706 and resolve the unsupported $32,000 general administrative charges.

FINDINGS	RECOMMENDATIONS
Evaluation of Price Proposal Submitted by Telesensory Systems, Inc. Palo Alto, California	
Unsupported costs of $100,000 for equipment to be used for development of an optical character recognition, speech output accessory for the blind were determined in a pre-award audit of the proposed contract which totalled $730,546. Cost and pricing data were considered acceptable as a basis for contract negotiation.	Negotiate a cost reimbursable or cost plus fixed fee contract.
BENEFIT PROGRAMS	
VA Regional Office Manila, PI	
Although controls exist to prevent abuses of the education benefits program, they are not effectively used. School approvals are not updated and current approval status was not shown in 8 of 16 approval folders reviewed. Conduct of compliance surveys and survey followup procedures require improvement. An $1,800 overpayment was identified by compliance survey; however, it was not established as an overpayment due to inadequate followup procedures. Of 3,900 enrollment certification cards mailed for the spring 1977-78 semester, 505 were not returned. Attendance has not been verified for 409 of these cases. Although management has initiated corrective action, increased supervision over education activities is necessary to preclude a recurrence of deficiencies.	Appoint an American Assistant Veterans Services Officer to increase supervision over the Education Services Unit. Send program officials from the Education and Rehabilitation Service to the Manila Regional Office to conduct training and provide technical assistance.

FINDINGS	RECOMMENDATIONS
VA Regional Office Manila, PI (Cont.)	
Controls to verify dependency evidence exist; however, special controls are needed since 64 percent of total payees are dependents and program abuse has occurred in this area.	Make use of the list of known claims fixers currently used only for Social Security benefit claims.
Three of six reexaminations showing erroneous payments involved dependency issues. The audit team reviewed a sample of 38 veterans who were receiving increased VA payment based on school attendance of their child dependent. Two were paid when the children were not enrolled and 20 enrollments were unverified.	Revise local procedures for verification of school child enrollments.
There are no written criteria to specify when verification of dependency evidence is required.	Establish specific criteria for verifying dependency documentation.
Supervision of field examiners requires improvement. Only three supervisory visits of field examiners have been conducted since 1974. A visit conducted in June 1977 detected travel voucher fraud. Verification of six prior field examinations conducted by two field examiners, who had resigned while under investigation, resulted in termination of six payment awards. A systematic analysis of operations is not performed in the field unit.	Implement a systematic analysis of operations program for the Field Section. Expand the scope and frequency of supervisory field visits.

FINDINGS	RECOMMENDATIONS
VA Regional Office Manila, PI (Cont.)	
Results of fee-basis medical examinations have been questioned by Manila Regional Office personnel. Social surveys have identified discrepancies in the results of fee-basis medical examinations. The VA has no listing of physicians performing fee-basis examinations or a system to verify the identity of a patient examined by fee-basis physicians.	Maintain a register of fee-basis physicians. Provide training to fee-basis physicians on VA procedures and requirements.
The Predischarge Education Program Conducted by the Ft. Steilacoom Community College, Tacoma, WA	
The college's accounting records did not accurately reflect revenues and costs for the Predischarge Education Program. Adjustments were necessary for unrecorded and improperly recorded costs and revenue. Total revenue for the period January 1973 through December 1976 was $3,095,730. Total costs for the same period were $2,587,024 creating a $508,706 surplus.	Pursue collection of the $508,706 reported surplus.
The Predischarge Education Program Conducted by the San Diego Community College District, San Diego, CA	
The financial statements provided by the college did not accurately reflect Predischarge Education Program costs incurred. Adjustments were necessary to eliminate costs not allocable to the program. Total revenue for the period February 1972 through January 1977 was $3,368,569. For the same period costs were $2,991,052 creating a surplus of $377,517.	Pursue collection of the $377,517 reported surplus.

ATTACHMENT 3

AUDIT REPORTS COMPLETED
SECTION A - INTERNAL

HEALTH CARE PROGRAMS

VA Medical Center Newington, CT
VA Medical Center Castle Point, NY
VA Medical Center Boise, ID
VA Medical Center Reno, NV
VA Medical Center Brooklyn, NY
VA Medical Center Poplar Bluff, MO
VA Medical Center Saginaw, MI
VA Medical Center Chillicothe, OH (Followup)
VA Medical Center Perry Point, MD
VA Medical Center Albany, NY
Management's Control Over the Utilization of Postgraduate and Inservice Training Program Funds, VA Central Office (Followup)
Pathology Service, VA Central Office
Manila Grant-In-Aid Program
Supply Fund Management Staff, VA Central Office
Pre-installation Review of Fee Basis Payment System
Homemember Payment System

BENEFIT PROGRAMS

VA Regional Office San Diego, CA
VA Regional Office Manila, PI
VA Regional Office Providence, RI
Reports Control, Compensation, Pension and Education and Miscellaneous Benefits Systems
Adjudication End Products

ADMINISTRATIVE AND MANAGEMENT PROGRAMS

Investigation Reports, VA Central Office
Systems Documentation - Definition and Approval
Operations - Data Transmission
Retirement Annuity Estimating System
Job Accounting System, Los Angeles Data Processing Center
Central Office Finance (Followup)

AUDIT REPORTS COMPLETED
SECTION B - EXTERNAL

HEALTH CARE PROGRAMS

University of Minnesota, Scarce Medical Contract - VAMC Minneapolis, MN
National Academy of Science, Evaluation of Rates FY 76
Texas Hospital Association, Development of a Resources Measurement and Cost Containment System
Stanford University, School of Medicine, Scarce Medical Contract - VAMC Palo Alto, CA
Louisiana State University, Medical Center Contracts and Grants
Texas Research Foundation, College Station, TX, Review of Federal Grants and Contract Administration 9/1/72 to 8/31/76
National Academy of Science, Final Audit
University of South Carolina, Audit of Costs Incurred under VA Contracts and Grants
School of Engineering, University of Pittsburgh, Refine and Expand the VA Energy Program Proposal
American Institute for Research, Proposed Overhead Rates for FY Ended 6/30/76
University of Wisconsin, Scarce Medical Contract - VAMC Madison, WI
Telesensory Systems, Inc., Development of an Advanced Optical Character Recognition Speech - Output Accessory to the Optacon Reading Aid for the Blind
Costs Incurred Under Federal Grants, Washington University, St. Louis, MO
Texas A&M University, System Review of Federal Grant and Contract Administration 9/1/72 - 8/31/76
University of Arkansas, Scarce Medical Contract - VAMC Little Rock, AR
Duke University, Final Audit
University of Nebraska, Scarce Medical Contract - VAMC Omaha, NE
University of Florida, Scarce Medical Contract - VAMC Gainesville, FL
University of Oklahoma, Scarce Medical Contract - VAMC Oklahoma City, OK
University of Minnesota, Final Audit
Virginia Polytechnic Institute and State University, Manpower Grant
University of California, Los Angeles, Final Audit
The Medical Service Group, Syracuse, NY, Scarce Medical Contract - VAMC Syracuse, NY
Duke University, Final Audit

HEALTH CARE PROGRAMS

Wright State University, Dayton, OH, Manpower Grant, 35-0099
Tufts New England Medical Center, Scarce Medical Contract - VAMC Boston, MA
University of Maryland, Final Audit
Southern Illinois University, Carbondale, IL, Manpower Grant, 13-0089
University of Iowa, Scarce Medical Contract - VAMC Iowa City, IA
Vanderbilt University, Scarce Medical Contract - VAMC Nashville, TN
University of Texas, Scarce Medical Contract - VAMC San Antonio, TX
University of Michigan, Scarce Medical Contract - VAMC Ann Arbor, MI
Science Program Group, Inc., Motion Pictures "The Prize Winners"
University of Missouri, Scarce Medical Contract - VAMC Columbia, MO
University of Pennsylvania, Scarce Medical Contracts - VAMC Philadelphia, PA (Individual contracts audited resulting in four reports).
Communications by Design, Proposed Increase

BENEFIT PROGRAMS

University of Wisconsin, Milwaukee, Interim Audit of Reporting Fees Paid Under PL 90-77
State Approving Agency - Vermont, Department of Education
State Approving Agency - Vermont, Department of Labor and Industry
State Approving Agency - Arizona
The Predischarge Education Program Conducted by the Ft. Steilacoom Community College, Tacoma, WA
The Predischarge Education Program Conducted by the San Diego Community College District, San Diego, CA

ADMINISTRATIVE AND MANAGEMENT PROGRAMS

Sherlock, Smith and Adams Architect - VAMC Birmingham, AL
Globe Engineering Co. Architect - VAMC Hines, IL
Malcolm Grear Designers, Inc., Development of Unified Graphics Communication System for the VA
WBDC Inc. Architect - VAMC Battle Creek, MI and VAMC Saginaw, MI
Reynolds, Smith, and Hills - VAMC Gainesville, FL
Pearson, Humphries, Jones Architect - VAMC Tuskegee, AL
Hewitt and Royer Architect - VAMC Knoxville, IA; VAMC Grand Island, NE; VAMC Poplar Bluff, MO
NBBJ Architect - VAMC Seattle, WA
Beardsley and Beardsley Architect - VAMC Canandaigua, NY
Brinderson Corp., Solar Heating - VAMC San Diego, CA

ADMINISTRATIVE AND MANAGEMENT PROGRAMS

Mitre Corp., Pricing Proposal FY 79 and 80
Potomac Research Inc., Proposal for Modification of Contract
Dubose Assoc., Minges Assoc., C.R. Blanchard, Jr. Architect, Joint Venture - VAMC Newington, CT
The Austin Co, Architect - VAMC Hines, IL
BCHW Architect, Joint Venture Modernization of VAMC North Little Rock, AR
Tutor - Saliba Co., Change Order #29, Air Conditioning Contract, VAMC Sepulveda, CA
Coath and Goss Inc., Central Office Proceed Order #2, Data Processing Center - VAMC Hines, IL, Construct Storage Addition
Glen L. White, Computer Services System Design
Reynolds, Smith and Hills - VAMC Gainesville, FL
RTKL, CS&D, and Henry Adams Inc. Architect - VAMC Baltimore, MD
Shoenwald, Harris, Harwood Architect - VAMC Fresno, CA
BCHW Architect - VAMC Little Rock, AR
Silling Assoc. Architect - VAMC Huntington, WV
Allen Y. Lew and W. E. Patnaude, Inc. Architect - VAMC Fresno, CA
Rand Information System, Contract Modification

CHAPTER IV

INVESTIGATIVE RESULTS

During the past six months, investigative activities have been primarily directed to two of the five previously described objectives, as follows:

	Staff Assigned	Percentage
Special initiatives for fraud, waste and mismanagement	17.5	51
Reactive investigations	16.5	49

SPECIAL INITIATIVES FOR FRAUD, WASTE AND MISMANAGEMENT

The two projects falling in this category were previously described in the Executive Summary. They are:

Investigation of Fraud in the Loan Guaranty Program
Investigation of the Extent of Use of Fraudulent Military Discharge Certificates to Obtain VA Benefits

REACTIVE INVESTIGATIONS

Twenty investigations were completed in reaction to allegations of serious administrative or criminal irregularities. The most significant of the criminal cases was the theft of $77,000 in government funds, from an imprest fund, utilizing fraudulent and forged receiving documents and other means to systematically embezzle these funds mostly over a three year period. The case was investigated, referred to the U. S. Attorney's Office and the individual was indicted and pled guilty to the theft of $39,000. At least $20,000 has been recovered so far.

As the result of reactive investigations during this six month period, three cases were referred to the Department of Justice. There was one indictment and a plea of guilty as previously described. Prosecution on a second case was declined. Action on the third case is pending further investigation by the Office of Inspector General and the FBI.

The majority of cases involved non-criminal but, nonetheless, serious allegations of misconduct or other irregularities. A major case of this nature involved the planned expansion of the Outpatient Reporting and Statistical Activity System. As discussed in the Executive Summary of this report, the investigation found that the system was not working satisfactorily and, as a result of the investigation, was discontinued avoiding an expenditure of $431,000.

Most allegations of a non-criminal nature are referred to the departments and staff offices of VA for development and disposition, with feedback on such disposition to the Office of Inspector General so we can be assured that adequate actions are taken. As an exception, the Office of Inspector General retains responsibility for investigation of the most serious or sensitive cases. This exception does represent a significant part of our reactive case load. In the past six month period non-criminal cases investigated by the Office of Inspector General have involved such matters as:

1. Allegations that a medical center construction project involved deviations from construction standards to the point that integrity of the structure and the safety of patients would be threatened. Extensive investigation, aided by construction engineers borrowed from another Federal agency, was necessary to resolve over 50 alleged deviations. It was found that the allegations were invalid or the major problems had been corrected, but this was not independently determinable without the investigative effort.

2. Allegations of patient abuse or unauthorized treatment by medical professionals.

3. Nepotism allegations against a personnel officer.

4. Diversion of funds to unauthorized, but not personally benefiting, projects by senior field managers.

5. Violation of proper drug handling procedures.

6. Personal misconduct of VA medical personnel in violation of VA regulations.

7. Allegations of improper procurement of equipment.

REFERRALS TO THE DEPARTMENT OF JUSTICE AND STATE LAW ENFORCEMENT AUTHORITIES

The following table shows referrals to the Department of Justice during the six month period and actions taken during this period on some of these and also prior period referrals. These referrals include those developed as a result of Office of Inspector General investigations, but the statistics are dominated by instances of apparent fraud, theft or other crimes detected by VA field installations and referred through VA District Counsels to local U.S. Attorney and FBI offices.

	Program	Referrals	Declinations	Prosecutions	Convictions	Dollars Recovered
Fraud	Education	91	66	12	16	$103,383
	Loan Guarantee	127	49	2	5	14,485
	Compensation & Pension	54	33	2	3	40,022
	Insurance	5				
	Medical	37	31	2	2	
	Contract		1			
Theft		19	10	4	1	
All Other		31	21		1	15,474
	Totals	364	211	22	28	$ 173,364

NOTE: Other than the "referral" column, the actions shown and dollars recovered include the results this period of prior period referrals.

In addition, 15 cases were referred to state law enforcement agencies. Three convictions resulted.

Program fraud was the most common. Of the 364 referrals, 233 resulted from apparent beneficiary fraud and 12 involved apparent employee program fraud, and there were 69 other program fraud cases involving institutions and individuals, mostly suppliers of services to veterans.

CHAPTER V

OTHER ACTIVITIES

VULNERABILITY ASSESSMENT

In August 1978 our proposal to establish a Risk Analysis Staff was approved by the Administrator. The original purpose of this staff was to assess the vulnerability to fraud, waste and mismanagement of all major programs, functions and activities of the VA. Subsequently, in November 1978, the Office of Management and Budget required agencies subject to the Inspector General Act to carry out such assessments (with drafts due in 45 days and finalized assessments due after the new Inspectors General are confirmed).

Our Risk Analysis Staff developed the assessment methodology which provided for the following three point format: (1) identify vulnerabilities; (2) identify key existing controls; and (3) assess the adequacy of the controls in relation to the vulnerabilities.

The initial vulnerability assessments developed by departments and staff offices of VA were reviewed by the Office of Inspector General. Suggestions were made as to which additional vulnerabilities should be considered by the departments or staff offices. We are currently refining the vulnerability assessments for Veterans Administration, which cover 96 analyses and identify 562 vulnerabilities.

Our overview statement in the VA vulnerability assessments makes the following points:

- VA programs, activities and functions have four sources of vulnerability to fraud and abuse -- beneficiaries, third party suppliers such as educational institutions, contractors/grantees, and employees.

- Benefit programs total $13.2 billion and represent 65 percent of VA budget. Major vulnerabilities include: (1) potential for using fraudulent documents to initially establish program eligibility, i.e., fraudulent military discharge certificates (reviews are currently being conducted by the Office of Inspector General); (2) false statements to obtain loan guaranty benefits or maintain education and other benefits (Office of Inspector General investigations have been directed to this problem; audits are also being addressed to contractual suppliers and the adequacy of compliance reviews of educational institutions); (3) overpayments and loans which are not being repaid

(increased collection efforts have been made with 30,000 cases totalling $34 million referred to Department of Justice for collection); and (4) errors in benefit payments (a DVB study report showed total dollar errors of 8 percent with underpayments exceeding overpayments).

- Medical programs total $5.7 billion and represent 30 percent of the VA budget. In addition to vulnerabilities similar to benefit programs, others are: (1) false certification of financial need for non-service connected care (a recent OM&S study showed that one of four applicants for non-service connected care had medical insurance, and of those with insurance, about 8 percent indicated they were able to defray the cost of medical care); (2) quality of care -- ongoing patient care audits, periodic VA and JCAH reviews, and other steps are taken to oversight the quality of patient care; and (3) other major potential vulnerability in the medical program stems from significant contractual activities for supplies, maintenance, construction, equipment and medical services, and from underutilization of facilities and equipment (several reviews in process by the Office of Inspector General are targeted at selected vulnerabilities).

- VA is the largest independent Federal agency employing over 215,000 people, and therefore potentially vulnerable to significant manpower utilization problems. The Office of Manpower Programs has recently been established to provide Agency-wide direction and assistance in strengthening manpower programs. A second employee-related vulnerability is misclassification. However, the incident of misclassification in VA is significantly lower than the national average.

- ADP systems and operations are quite sensitive. More extensive reviews and oversight will occur as the result of the recently issued Transmittal Memorandum No. 1 to OMB Circular A-71.

The continued development and extension of vulnerability assessments will provide an increasingly sound basis for selecting future audit and investigative initiatives. A planned extension includes a determination of the vulnerability to VA which may be created by systems of other agencies (e.g., Department of Defense controls over discharge

certificates which become input for VA benefits). We also intend to compare the vulnerabilities of VA programs to like programs of other agencies (e.g., HUD loan guaranty) to determine whether they have found cost beneficial control solutions which might be useful to VA.

REVIEW OF NEW LEGISLATION AND REGULATIONS

We have established arrangements for the required review of new regulations and legislation, in coordination with VA officials implementing the President's initiatives on improved regulations. We receive "Notices of Intent" sent to the Administrator when new regulations or changes are proposed. This enables us to make suggestions early during the development of the regulations. We also review the final regulations, during the concurrence process in VA, for areas which affect the economy and efficiency, and the prevention and detection of fraud and abuse in the related programs and operations. We also receive for review copies of all proposed legislation affecting VA programs and operations.

We started our reviews of new legislation and regulations in January 1979. As of March 31, 1979, we had reviewed 32 bills and six proposed regulations. Thus far we have made suggestions on two bills and three regulations, as follows:

H.R. 338 continues medicaid eligibility for certain individuals by disregarding certain involuntary increase in income such as increased income levels for VA beneficiaries. While we did not object to this legislation, we did recall the long standing problem of potential overpayments to beneficiaries as a result of duplication between VA and Medicaid. We reinforced the GAO recommendation that VA and DHEW should develop compatible payment systems which would allow for computer matches or any cost beneficial alternative that would preclude duplicate payments.

We coordinated with DHEW on the Administration's draft bill, "Privacy of Medical Information Act." We were concerned as to whether this bill would inhibit audit and investigative access to health care provider medical records. DHEW's General Counsel's interpretation of the draft included unlimited access to all health care provider medical records, both government benefit recipients as well as non-government individuals, necessary for the conduct of the investigation. This information was provided to VA's General Counsel for appropriate consideration should the access issue subsequently arise in connection with Inspector General investigations.

VA Regulation 14263 incorporated existing rules and policies on flight training courses into one regulation. While we support VA efforts seeking legislation to terminate flight schools as an education source eligible for VA benefits, we encourage interim control measures such as additional criteria and reasonableness tests which would assure that training approved was for the attainment of recognized vocations in aviation.

It is expected that our current audit of flight schools will develop some more specific recommendations to tighten up surveillance of these schools.

VA Regulations 14501 and 14504 concerning the Education Loan Program have been amended to provide that eligible veterans must attend a relatively high cost educational institution in order to qualify for an education loan.

Certain eligibility requirements are detailed in the regulations along with authority for the Regional Offices to waive some of the requirements. There is little or no waiver criteria in this regulation providing guidance for the Regional Offices; however, there is adequate criteria in another VA regulation. We therefore suggested that at least a reference be made to the other regulation which contains the criteria to avoid any misinterpretation.

REVIEW OF EXISTING LEGISLATION AND REGULATIONS

As appropriate, the review of existing legislation and regulations occurs during the normal course of an audit or investigation when the underlying causes for fraud, waste or mismanagement are traceable to these sources. Such analyses, during the last six months, led us to conclude that the following legislative proposals by VA are essential to reduce fraud and abuse.

> Legislative proposals to eliminate certain types of educational institutions, including flight schools, as qualifying to provide education to veterans. Preliminary results of audits in process show widespread avocational use of flight schools, and serious irregularities by some of the schools involved.
>
> Proposals to allow redisclosure of address information in VA and IRS records to permit aggressive debt collection efforts on overpayments and defaults. Our analysis showed that at least $93 million of existing accounts receivable cannot be pursued beyond the demand letter stage because of existing barriers to redisclosure. There is a closely related VA proposal, not requiring legislative action, to have the Internal Revenue Service use existing authority to offset debts due to VA against tax refunds due the debtor. If this proposal is adopted, and we believe it should be, current education accounts receivable of $391 million could be significantly reduced.

EMPLOYEE HOTLINE

A hotline for employees to report serious incidents of fraud, waste or mismanagement was established February 15. A letter from the Administrator advised all 215,000 VA employees of procedures for reaching

the Inspector General's hotline by telephone or correspondence, and the provisions for protecting their identity in accord with Section 7 of the Inspector General Act. Two Office of Inspector General employees staff the hotline telephone during duty hours and recording equipment operates on these dedicated telephone numbers at all other hours. About 70 percent of the complaints are initially received over the dedicated telephones; the remaining initial contacts are by letter.

Almost all telephone callers are willing to follow up their call with a letter explaining the situation in more detail. Even though over 70 percent of the complainants were willing to give us their names, only a little more than half of them had previously reported these complaints "through channels."

As of March 30, 1979, there were 232 "hotline" contacts from 120 VA facilities. Of the 232 complaints, 188 were related to VA medical centers, 20 related to 5 regional offices, 5 from Central Office, 3 from national cemeteries, and 3 from data processing centers. (The remaining complaints did not relate to a specific location.)

VA employee hotline contacts fall in the following categories:

	Number*
Potentially Criminal	
Pay	6
Theft of government property	18
Misuse of funds	8
Beneficiary abuse	5
Employee Misconduct	
Leave abuse	11
Employee misconduct	32
Personnel	47
Employee abuse	11
Management	
Security	6
Patient abuse	13
Poor facilities	8
Wasteful practices	41
Poor management	3
Other	
Employee grievance	55
Miscellaneous	18

* Includes 32 complaints in two categories
Includes 3 complaints in three categories
Includes 4 complaints in four categories

Over twenty percent or forty-seven of the hotline complaints are considered to be of a serious nature (i.e., probably requiring audit or investigation). These are:

Employee misconduct	16
Theft of government property	13
Wasteful practices	10
Patient abuse	5
Employee abuse	3

The serious allegations on employee misconduct covered a variety of subjects. Three stations were accused of improprieties in personnel practices -- one was substantiated which involved the improper hiring of an assistant (an unauthorized position). The other two allegations are under review. Physicians at two stations were accused of being paid although not on duty. In another instance, the station director was accused of receiving kickbacks from suppliers, and purchasing furniture for personal use. Some of the other allegations concerned a nurse who was required to alter nursing notes, and two physicians who were receiving hospital care by contending that they could not afford to pay.

Allegations of employee theft included such things as drugs, syringes, TVs, furniture, carpeting and media supplies. Most of these allegations appeared to be theft for personal use, rather than resale.

Some of the wasteful practices allegations included unnecessary purchases of new furniture and equipment to "use up" the allocation so it would not be reduced in subsequent periods.

The initial disposition of these 232 complaints has been:

Being considered for investigation or investigated	29
Being considered for audit or audited	32
Referred to appropriate department or staff office for inquiry and necessary corrective action	39
Closed, i.e., handled or referred during phone call	56
Holding for further information *	76
Total	232

* Subsequent to March 31, the added information has been obtained in 40 instances; referral or dispositon of these cases has been made.

SERIOUS OR FLAGRANT PROBLEMS

Section 5(d) of the Act provides:

> "Each Inspector General shall report immediately to the head of the establishment involved whenever the Inspector General becomes aware of particularly serious or flagrant problems, abuses, or deficiencies relating to the administration of programs and operations of such establishment. The head of the establishment shall transmit any such report to the appropriate committees or subcommittees of Congress within seven calendar days, together with a report by the head of the establishment containing any comments such head deems appropriate."

We have established the following criteria for judging instances in which this section of the Act applies:

1. A high level official of the Veterans Administration is involved in a serious irregularity.
2. VA management officials are failing to timely address or continue to ignore a particularly egregious problem of fraud or waste.
3. Fraud or waste is material in relation to the scope and funding of VA programs.

Applying these criteria, there has been no situation identified by the Office of Inspector General in the last six months that was reportable under this section of the Act.

REFUSALS OR DELAYS IN FURNISHING REQUESTED INFORMATION OR ASSISTANCE

Section 6(b)(2) of the Act provides:

> "Whenever information or assistance requested under subsection (a)(1) or (a)(3) is, in the judgment of an Inspector General, unreasonably refused or not provided, the Inspector General shall report the circumstances to the head of the establishment involved without delay."

No reportable situation of this nature occurred in the past six months.