



## FOREWORD

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

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

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

*WILLIAM T. MERRIMAN  
Deputy Inspector General*

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## EXECUTIVE OVERVIEW

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This semiannual report highlights the activities and accomplishments of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) for the 6-month period ended September 30, 1997. During this reporting period, 81 audit, review, and inspection reports were issued; 2 settlement agreements were completed; and 115 investigations were closed. These initiatives identified actual and potential recoveries of \$30.9 million and made operational recommendations which could result in better use of an estimated \$126.5 million. In addition, as a deterrent to fraud, waste, and mismanagement, our investigations and other reviews resulted in 62 indictments, 36 convictions, and 127 administrative actions against third parties, VA employees, and benefit recipients.

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

### PROCUREMENT PROGRAMS

#### Contractor Overcharges

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

#### Reviews of FSS Proposals

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

#### Procurement Fraud

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

### MEDICAL CARE PROGRAMS

#### Resource Utilization

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

Fee Basis Program

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

Quality of Health Care

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

Patient Care Inspections

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

## **BENEFIT PROGRAMS**

Delivery of Benefits and Services

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

Program Fraud

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

## FINANCIAL MANAGEMENT

Consolidated Financial Statements

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

Income Verification

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

## INFORMATION RESOURCES MANAGEMENT

Telephone Access Systems

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

Security Controls Over Benefits Payments

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

## **EMPLOYEE INTEGRITY**

### **Specialized Investigations**

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

### **Employee Misconduct**

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

## **FOLLOWUP ON OIG REPORTS**

### **Unresolved Reports**

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

# SUMMARY OF OIG OPERATIONS

Current 6 Months  
4/1/97 - 9/30/97  
FY 1997  
10/1/96 - 9/30/97  
(Dollars in Millions)

## OIG Reviews Completed and Resolution Action

Reports Issued.....	81	181
Settlement Agreements.....	2	4
Value of Reports/Agreements		
Questioned Costs.....	\$28.0	\$35.2
Unsupported Costs.....	1.5	5.8
Recommended Better Use of Funds.....	<u>120.7</u>	<u>197.7</u>
<b>Total</b> .....	\$150.2	\$238.7
 Reports Resolved (issued this and prior periods).....	 34	 79
Value of Resolved Reports/Agreements		
Disallowed Costs.....	\$27.4	\$37.5
Funds to Be Put to Better Use.....	<u>58.1</u>	<u>123.8</u>
<b>Total</b> .....	\$85.5	\$161.3
 Unresolved Reports		
Over 6 Months as of 9/30/97:		
Internal Audit.....	0	N/A
External Contract.....	21	
Less than 6 Months as of 9/30/97:		
Internal Audit.....	0	
External Contract.....	<u>33</u>	
<b>Total</b> .....	54	
 Value of Unresolved Reports:		
Questioned Costs.....	\$ 4.5	N/A
Unsupported Costs.....	1.5	
Recommended Better Use of Funds.....	<u>101.3</u>	
<b>Total</b> .....	\$107.3	

## Investigation Activities

Investigative Cases		
Opened.....	88	229
Closed.....	115	245
Pending.....	333	N/A
 Impact of Investigations		
Indictments.....	62	107
Convictions.....	36	110
Probation (in years).....	127	313
Prison Sentences (in years).....	33	131
Fines, Penalties, Restitutions, and Civil Judgments.....	\$2.2	\$3.7
Investigative Recoveries and Savings.....	\$5.0	\$13.9
Administrative Sanctions.....	98	178

**Current 6 Months**  
**4/1/97 - 9/30/97**

**FY 1997**  
**10/1/96 - 9/30/97**

**Audit Activities**

Reports Issued		
Internal Audits .....	13	32
Other Reviews .....	<u>9</u>	<u>16</u>
<b>Total .....</b>	<b>22</b>	<b>48</b>
Audit Workload		
Carry-Over Projects Completed .....	18	34
Planned Projects Initiated .....	12	25
New Projects Received.....	<u>11</u>	<u>16</u>
<b>Total .....</b>	<b>41</b>	<b>75</b>

**Contract Review Activities**

Reports Issued/Settlement Agreements		
Contract Reviews by OIG Staff		
FSS Contracts.....	28	37
PL 102-585 Reviews .....	1	4
Other .....	3	5
Contract Reviews by Other Agencies .....	<u>11</u>	<u>46</u>
<b>Total .....</b>	<b>43</b>	<b>92</b>

**Hotline and Special Inquiry Activities**

Hotline Cases		
Opened.....	376	733
Closed .....	313	624
Percent of Founded Allegations.....	24%	23%
Impact of Hotline Activities		
Administrative Sanctions .....	29	57
Special Inquiries Completed		
Reports Issued.....	8	28
Administrative Closures .....	<u>12</u>	<u>25</u>
<b>Total .....</b>	<b>20</b>	<b>53</b>
Special Inquiries Workload		
Carry-Over Projects .....	25	41
New Projects Received.....	<u>36</u>	<u>56</u>
<b>Total .....</b>	<b>61</b>	<b>97</b>

**Healthcare Inspection Activities**

Projects Completed		
Inspection Reports Issued.....	10	17
QA/Patient Care Reviews.....	30	52
Clinical Consultations/Technical Support. ....	<u>69</u>	<u>130</u>
<b>Total .....</b>	<b>109</b>	<b>199</b>
Projects Pending		
QA/Patient Care Reviews.....	51	N/A
MI Case Evaluations.....	0	
Clinical Consultations/Technical Support.....	<u>26</u>	
<b>Total .....</b>	<b>77</b>	