



Department of Veterans Affairs

Office of Inspector General

September 2010 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General Testifies on Veterans Health Administration Contracting and Procurement Practices

Assistant Inspector General for Audits and Evaluations Belinda Finn testified before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives, on Veterans Health Administration (VHA) contracting and procurement practices. Ms. Finn's testimony followed up on a December 2009 hearing regarding deficiencies in VHA's acquisition of health care goods and services, which in fiscal year (FY) 2009 totaled \$9.05 billion in expenditures. Office of Inspector General (OIG) work continues to identify systemic weaknesses that were previously identified in December, including compliance issues with Federal Acquisition Regulations and VA Acquisition Regulations, and incomplete and unreliable data in acquisition support information systems. OIG noted improvements with the use of an automated acquisition information system in VHA procurements utilizing American Recovery and Reinvestment Act of 2009 (ARRA) funds. Ms. Finn was accompanied by Maureen Regan, Counselor to the Inspector General.

ADMINISTRATIVE INVESTIGATION

Investigation Substantiates Prohibited Personnel Practices, Abuse of Authority, Misuse of Position, and False Statements in Office of Human Resources and Administration

An administrative investigation substantiated that an Office of Human Resources and Administration senior official engaged in prohibited personnel practices, abused his authority, misused his position to appoint two subordinates, and that he made false statements. Further, one of the subordinates misused her official time; another misrepresented her income for a higher than minimum rate of pay and made false statements; a Human Resources Specialist and a former Management Analyst engaged in prohibited personnel practices; and a former Personnel Officer failed to follow policy in setting the higher than minimum rate of pay. [\[Click here to access redacted report.\]](#)

OIG REPORTS

Program Weaknesses Result in \$111 Million in Improper Post-9/11 GI Bill Emergency Payments

OIG reviewed a hotline allegation that inadequate controls during the Veterans Benefits Administration's (VBA's) emergency payment initiative resulted in payments to ineligible recipients. The review substantiated that VA inappropriately provided 37,700 emergency payments totaling approximately \$111 million to ineligible recipients. VA rushed to plan and execute the initiative in order to prevent further hardship to students affected by significant delays in implementing the Post-9/11 GI Bill. VA lacked a contingency plan for emergency payments, did not clearly communicate eligibility rules, and lacked adequate controls to determine eligibility for emergency payments. As such, the emergency payment initiative resulted in increased administrative burdens

and an estimated loss of about \$87 million in unrecoverable debts. OIG recommended that the Acting Under Secretary for Benefits develop a contingency plan for future advance payments that includes clear communication on service member eligibility and controls to check for eligibility. [\[Click here to access report.\]](#)

OI&T's Deployment of Post 9/11 GI Bill Long Term Solution Has Been Partially Effective

OIG also evaluated the effectiveness of OI&T's plan for developing a Long Term Solution (LTS) for Post 9/11 GI Bill implementation. OI&T's plan for LTS deployment has been partially effective; however, OI&T could improve the effectiveness of future LTS releases by conducting periodic independent reviews and instituting cost controls to help address system development and implementation issues. OIG recommended that OI&T develop and implement processes and controls to help ensure that future LTS releases achieve performance and cost objectives as well as scheduling timelines. OI&T concurred with the findings and recommendations and outlined plans to complete all corrective actions by August 2011. [\[Click here to access report.\]](#)

Inadequate Controls Could Double Cost of FLITE Strategic Asset Management Pilot Project

OIG audited the Financial and Logistics Integrated Technology Enterprises (FLITE) program to assess the quality of oversight of the Strategic Asset Management (SAM) pilot project. Program managers did not effectively control project cost, schedule, performance, or ensure timely deliverables. As a result, VA is considering extending the SAM pilot project from 12 to 29 months, and potentially more than doubling the original contract cost of \$8 million. OIG recommended the Assistant Secretary for Information and Technology (OI&T) and the Executive Director, Office of Acquisition, Logistics, and Construction establish stronger program management controls as well as mitigate risks related to the successful accomplishment of the SAM project. Department leadership recently increased its scrutiny of FLITE management and placed additional project contracts on hold. Unless improvements are made, the outlook for the SAM pilot project remains tenuous. [\[Click here to access report.\]](#)

In a related review, OIG reviewed allegations regarding management of the SAM pilot project. OIG substantiated that FLITE program managers needed to improve their overall management of the SAM pilot project and partially substantiated that FLITE program managers did not ensure certain elements, normally considered necessary for a successful software development effort, were included in the FLITE program. The review did not substantiate that the SAM Project Manager pressured VA personnel to complete the contractor's deliverables. OIG made additional recommendations to the Assistant Secretary for OI&T aimed at strengthening management controls. [\[Click here to access report.\]](#)

Implementation of Homeland Security Presidential Directive 12 Over 2 Years Behind Deadline

OIG evaluated VA's progress in implementing a reliable and effective system of Personal Identity Verification (PIV), in compliance with Homeland Security Presidential

Directive 12 (HSPD-12), to improve the security of its facilities and to protect sensitive information stored in VA networks. Overall, VA has made little progress in meeting compliance with HSPD-12, and is almost 2 years behind the Government-wide October 2008 deadline. As of June 2010, VA had only issued approximately 9 percent of the necessary credentials to its workforce, including contractors, and some were issued without the required background investigations. VA's lack of progress occurred because it did not make it a priority to implement HSPD-12 or have an effective management structure in place to direct this Department-wide effort adequately. The PIV system does not meet all critical mission requirements, and controls needed to track and provide accountability over program costs are weak. The Assistant Secretary for Operations, Security, and Preparedness concurred with OIG's findings and recommendations and provided target dates to complete planned actions. [\[Click here to access report.\]](#)

VHA Needs to Strengthen ARRA Contract Review Processes and Monitoring

An OIG review evaluated VHA's regulatory compliance for awarding ARRA funds for non-recurring maintenance at VA Medical Centers (VAMCs). Although VHA's ARRA awards generally met competition objectives and requirements, OIG determined that contract review processes needed strengthening to ensure contracting officers properly evaluated prospective contractors and completed required contractor responsibility determinations before they awarded contracts and orders. In addition, 13 awards lacked required ARRA clauses that are intended to ensure the efficient and effective use of funds. OIG made five recommendations for VA to develop a comprehensive policy on contractor responsibility determinations and to strengthen its contract monitoring. [\[Click here to access report.\]](#)

National Cemetery Administration Needs to Improve Management Processes Over ARRA Funds

OIG conducted a review to determine if the National Cemetery Administration (NCA) implemented effective policies and procedures to ensure accountability and transparency for \$50 million it received from ARRA. NCA needs to improve management processes to guarantee efficient administration of funds in line with ARRA accountability and transparency objectives. OIG recommended the Acting Under Secretary for Memorial Affairs develop a formal process to document the prioritization and selection of future work requirements, ensure complete procurement information is recorded in the Electronic Contract Management System, and establish performance measurements that facilitate the monitoring and management of ARRA-related project outcomes. [\[Click here to access report.\]](#)

OIG Determines Wisconsin Patient's Care Appropriate Despite Allegations

At the request of the VA Secretary and Representative David R. Obey, the OIG performed a review to determine the validity of allegations regarding multiple care deficiencies at the Tomah VAMC and William S. Middleton Memorial Veterans Hospital in Tomah and Madison, WI, respectively. The complainant alleged that a patient died as a direct result of mismanagement of his antiarrhythmic cardiac medications and that the patient was denied benefits for exposure to Agent Orange while stationed in

Thailand during the Vietnam War. OIG did not substantiate most of the complainant's specific allegations and determined that there was disparity between the complainant's perception of the patient's care and the actual care that was documented in the patient's medical records. OIG made no recommendations. [\[Click here to access report.\]](#)

Alaskan Patient Referrals and Transfers to the Lower 48 States Appropriate

At the request of Senator Lisa Murkowski, OIG conducted a review of patient referrals and transfers from the VA Healthcare System in Anchorage, AK, to VA specialty care providers in the lower 48 states. Factors related to Alaska's location and geography pose challenges to providing a full range of health care services. In FY 2009, the system referred 4 percent of patients to the lower 48 states for specialty care either not available or with limited availability in Alaska such as spinal cord injury, neurosurgery, and neurology. The system complied with existing laws and regulations related to providing health care to Alaskan VA enrollees and the transfer of these patients appears to be a reasonable use of resources. OIG made no recommendations. [\[Click here to access report.\]](#)

Healthcare Inspection Confirms Delay in Cancer Diagnosis at Iowa City VAMC

The purpose of OIG's review was to determine the validity of allegations regarding a delay in cancer diagnosis and treatment and quality of care issues at the Iowa City, IA, VAMC. OIG substantiated that 52 days elapsed from the time the patient's initial computed tomography scan showed an abnormality to the biopsy indicating pancreatic cancer. OIG also substantiated that the patient was misinformed regarding non-VA care and reimbursement for travel. OIG recommended that the Veterans Integrated Service Network (VISN) and VAMC Directors monitor reporting of abnormal tests and make provisions for staff to refer patients to the appropriate administrative support offices when there are questions related to eligibility and travel pay. [\[Click here to access report.\]](#)

Patient's Allegations Not Substantiated Against Portland, Oregon, VAMC

OIG conducted a healthcare inspection at the Portland, OR, VAMC to determine the validity of allegations that a woman Veteran received inappropriate treatment. OIG confirmed that the patient was placed in a room with a shared bathroom; however, the adjacent room was empty. Although OIG could neither confirm nor refute that unit employees were insensitive to the patient's disability, facility managers agreed to conduct sensitivity awareness training. OIG made no recommendations. [\[Click here to access report.\]](#)

VHA Research and Development Expense Reporting Needs Improvement

OIG conducted a healthcare inspection to review allegations concerning whether VA Research and Development (R&D) expenses were being over-reported by VAMCs to gain increased reimbursement funding. The review was initiated after an Administrative Investigation Board found inappropriate reporting of R&D projects that increased the Veterans Equitable Resource Allocation (VERA) funding for R&D expenses at the VA Maryland Health Care System by \$15,500,000. The scope of the review was limited due to underlying R&D data integrity and validation issues. OIG recommended that the

Under Secretary for Health establish: (1) a process that validates the Enterprise Project Management Information System and Research and Development Information System data with the VISN chief financial officers prior to submission to the Allocation Resource Center, and (2) an R&D management and tracking system to help facilities meet Congressional and other reporting requirements. Additionally, historical records should be maintained so that the Office of Research and Development has the ability to support and explain any data variances between supporting data and the data reported in the VERA Table 8 allocation. [\[Click here to access report.\]](#)

Community Based Outpatient Clinics Reviewed in VISNs 1, 2, 4, and 5

OIG reviewed eight Community Based Outpatient Clinics (CBOCs) to assess whether they are operated in a manner that provides Veterans with consistent, safe, high-quality health care. Facilities reviewed included Pittsfield and Greenfield, MA, in VISN 1; Dunkirk and Niagara Falls, NY, in VISN 2; Hermitage (Marzano) and Foxburg (Clarion County), PA, in VISN 4; and Cumberland, MD and Harrisonburg, VA, in VISN 5. The review covered five areas: quality of care measures, credentialing and privileging, environment of care and emergency management, suicide safety plans, and CBOC contracts. OIG noted several opportunities for improvement and made 16 recommendations for improvement. [\[Click here to access report.\]](#)

Benefits Inspection Division Visits Mississippi and New Jersey Regional Offices

OIG conducted an onsite inspection at the Jackson, MI, VA Regional Office (VARO) to review disability compensation claims processing and Veterans Service Center operations. VARO staff correctly processed traumatic brain injury (TBI), herbicide exposure disability, and post-traumatic stress disorder (PTSD) claims. Staff also correctly established dates of claims in the electronic record, recorded Notices of Disagreement (NODs) for appealed claims in the Veterans Appeals Control and Locator System, completed all Systematic Analysis of Operations (SAOs), and corrected errors identified by VBA's Systematic Technical Accuracy Review (STAR) program as required. VARO management needs to improve the control and accuracy of claims processing for temporary 100 percent disability evaluations, date stamping incoming mail, and processing competency determinations. [\[Click here to access report.\]](#)

OIG conducted a similar review at the Newark, NJ, VARO. The Newark VARO correctly processed herbicide exposure and PTSD disability claims. Management ensured staff followed VBA policy to establish correct dates of claims in the electronic record. Further, staff was generally compliant in correcting errors identified by STAR. VARO management needs to strengthen controls for temporary 100 percent evaluations and TBI claims processing, recording NODs for appealed claims, conducting SAOs, processing incoming mail upon receipt, and final competency determination processing. OIG made seven recommendations to improve operations. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

Fourteen Defendants Sentenced for Fraud

Fourteen defendants, previously indicted on charges of conspiracy to defraud the United States, bribery of a public official, theft of Government funds, and money laundering stemming from an investigation by OIG and the Federal Bureau of Investigation, have been sentenced. The defendants included a former VARO employee, a former Disabled American Veterans (DAV) service officer, a former Marine F-18 pilot, the mother of the DAV service officer, and other Veterans. Sentences in this case ranged from probation to 68 months' incarceration, with most defendants receiving a sentence of between 12 to 30 months' incarceration. In November 2008, the defendants were indicted for filing fraudulent claims with VA. The investigation revealed that the former VA employee and former DAV employee recruited friends, family members, and other acquaintances to submit fraudulent VA disability claims. All fraudulent claims were supported with counterfeit or altered medical documentation from either VA or private physicians as proof of the disability. The former VA employee and the former DAV employee received kickbacks from the Veterans receiving large retroactive checks. Most of the Veterans were rated 100 percent disabled and were deemed "permanent and total," which could have resulted in no future review of their claim. The majority of Veterans received monthly payments in excess of \$2,700. The loss to VA is approximately \$2 million.

Veteran Who Fraudulently Obtained Purple Heart Pleads Guilty to Theft of VA Funds

A Veteran, who was also a VA employee, pled guilty to the theft of Government funds and the unlawful wearing of a service medal after an OIG investigation revealed he filed fraudulent documents with the U.S. Air Force and VA claiming to have been wounded in Vietnam. Based upon the fraudulent claims and counterfeit documents, the U.S. Air Force awarded the Veteran a Purple Heart. The Veteran then used the Purple Heart and a self-inflicted gunshot wound, received 20 years after his military service, to obtain compensation benefits from VA. The loss to VA is approximately \$180,000.

Veteran Who Submitted False Statements of Combat Activities Charged with Theft from VA

A Veteran was charged with theft after an OIG investigation revealed that the Veteran provided false information to a VARO and a VAMC in support of his claim for VA disability compensation benefits. Between 2003 and 2006 the defendant submitted VA forms, along with pictures, and made false statements attesting to his claims that he participated in combat activities while serving in the first Gulf War. The claims included hand-to-hand combat in the trenches, seeing fellow soldiers die, seeing dead bodies inside burned-out tanks, and being "hit" in a chemical attack. The investigation also revealed that the VARO relied on those statements when basing its decision to award service connection for PTSD. The loss to VA is over \$173,000.

Veteran's Widow Sentenced for Theft of VA Funds

The widow of a Veteran was sentenced to 18 months' incarceration, 3 years' probation, 80 hours' community service, and ordered to pay VA \$207,892 in restitution after pleading

guilty to theft of Government funds. An OIG investigation determined that, between August 1990 and December 2008, the defendant fraudulently received VA Dependency and Indemnity Compensation benefits by failing to report her remarriage.

Son of Deceased Beneficiary Sentenced for Theft of VA Funds

The son of a deceased VA beneficiary was sentenced to 24 months' incarceration, 36 months' probation, a \$5,000 fine, and ordered to pay \$92,596 in restitution after pleading guilty to the theft of Government funds. In 2001, the defendant, who was a loan officer at a bank, assisted the Veteran in opening a joint bank account at the defendant's bank. In March 2004, the beneficiary died in a foreign country and the son was notified of the death by the U.S. Department of State. The defendant concealed the death from VA and then subsequently used VA benefits for his personal benefit. The investigation revealed that the defendant used his position at the bank to facilitate the scheme to defraud VA.

Veteran's Brother Sentenced for Identity Theft

The brother of a deceased Veteran was sentenced to 18 months' incarceration and ordered to pay \$173,000 in restitution after pleading guilty to wire fraud. An OIG and VA Police investigation determined that the defendant obtained VA medical and pension benefits using his brother's identity.

Postal Service Employees Plead Guilty to Theft of VA Pharmaceuticals

A former U.S. Postal Service (USPS) employee pled guilty to mail theft after an OIG and U.S. Postal Inspection Service investigation, which included a sting operation, revealed that the defendant stole packages of VA pharmaceuticals from the mail. Stolen VA narcotics were found in the defendant's vehicle at the time of his arrest. He subsequently admitted to stealing VA narcotics during the past year. A second USPS employee pled guilty to theft by mail, after an OIG and USPS OIG investigation determined that between December 2009 and April 2010 he diverted 12 shipments of VA prescribed narcotics from the mail. Finally, a former USPS clerk, who is a service-connected Veteran, was sentenced to 2 years' probation and 100 hours' community service after pleading guilty to the destruction of U.S. mail. An OIG and USPS OIG investigation revealed that the defendant stole 8 VA controlled substance shipments, containing approximately 1,200 tablets of oxycodone, methadone, and hydrocodone between September 2009 and January 2010.

Veteran Sentenced for Mortgage Fraud

A Veteran was sentenced to 6 months' incarceration, 10 years' probation, and a \$10,000 fine after pleading guilty to making false statements to obtain property or credit over \$200,000. As part of his plea agreement, the defendant agreed to testify against a mortgage broker who is also a target of the investigation. As a result of this investigation, the mortgage broker was indicted for engaging in organized criminal activity.

Veteran's Daughter and Son-In-Law Arrested for Exploitation

The daughter and son-in-law of an incompetent Veteran, who were acting as primary caregivers, were arrested for exploitation of the disabled/elderly, obtaining property by false pretenses greater than \$100,000, and conspiracy to obtain property by false pretenses. Just prior to this arrest, the son-in-law and his brother were arrested for breaking into and entering the Veteran's residence, and then stealing and pawning the Veteran's property. An OIG, Social Security Administration (SSA) OIG, local law enforcement, and social services investigation revealed that the defendants stole \$213,662 from the Veteran and physically and mentally abused him for several years. The Veteran receives funds from VA, SSA, and the Defense Finance and Accounting Service, as well as a monthly inheritance from his deceased mother's estate. Based on the investigation, the Veteran was assigned a fiduciary and moved to a safe residential environment.

Fugitive Veteran Arrested at Jackson, MS, VAMC

A Veteran was arrested at the Jackson, MS, VAMC by OIG, assisted by local police, pursuant to felony warrants. The Veteran initially conveyed threats to blow up the Jackson, MS, VARO. The threats were vague in nature; however, during the course of the investigation, it was determined that the Veteran had outstanding felony warrants in both Mississippi and Alabama for selling and possessing cocaine. The Veteran's criminal history spanned over 20 years and included prior arrests for assault, burglaries, bank robbery, drug offenses, and sexual battery. The Veteran is currently being held without bond pending extradition.

(original signed by:)

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