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SEMI-ANNUAL REPORT OF THE INSPECTOR GENERAL

(October 1, 1979 to March 31, 1980)

A REPORT

PREPARED BY THE

VETERANS' ADMINISTRATION

(Pursuant to Section 5(a) of Public Law 95–452)

SUBMITTED TO THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

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LETTER OF TRANSMITTAL

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

June 4, 1980

Honorable Alan F. Cranston
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In accordance with the provisions of section 5(b) of the Inspector General Act of 1978 (Pub. L. No. 95-452, 92 Stat. 1101), I am herewith transmitting the Semi-Annual Report of the Veterans Administration's Inspector General for the period of time from October 1, 1979, through March 31, 1980.

I am pleased to report that the relationship between the Office of the Inspector General and the various departments of the Agency and this office continues to be a sound and productive one. The Office of the Inspector General has been instrumental in improving the economy and efficiency of our operations through identification of problems and development of solutions.

When the last Semi-Annual Report of the Inspector General was published in September 1979, I wrote to senior Agency officials and directed their continuing priority attention to the major problem areas identified in the report for which corrective action had not yet been completed. Their efforts, in concert with the efforts of the Inspector General, have resulted in significant improvements in our ability to minimize fraud, waste, and mismanagement.

A major accomplishment has been to increase the use of the automatic data processing (ADP) systems to detect instances of error or potential fraud in overpayments of benefits, and to enhance the collection of accounts receivable. We anticipate that the use of TARGET, one of the automated systems now undergoing phased implementation, will significantly reduce overpayments in education benefits by shortening the average processing time by four days. Untimely processing of changes of training status has been responsible for about 22 percent of the overpayments.

By using a computer program developed by the auditors of the Office of the Inspector General to match education benefit records by social security number and other characteristics, some 26,200 pairs of records containing the same social security number were identified. Identification of such duplication resulted in 95 cases involving current payments being referred to the Department of Veterans Benefits where payments were either suspended or terminated in order to avoid further overpayments. Other matching programs between the Veterans Administration and various Federal agencies and mail retrieval procedures recently developed with the Postal Service promise to increase our ability to deter fraud and error in the administration of benefit programs.

As a result of the current Semi-Annual Report of the Inspector General, a recent review of year-end procurements by the Office of Management and Budget, and related congressional oversight hearings which raised a number of questions regarding procurement practices in the VA, I have requested the Inspector General to intensify his reviews of VA procurement activities. Specific problems in ADP procurements are being addressed in several related efforts:

a. I assigned responsibility for implementing recommendations of the Inspector General, received in early May, to improve the procedures and controls for procuring ADP equipment and services.

b. I assigned a task force, headed by the Assistant Deputy Administrator for Administration and Logistics, to investigate the specific case-by-case questions identified by OMB in their review of ADP contracts.

A combination of inflationary pressures and a ceiling on travel costs--both for employees and beneficiaries--creates some serious problems for both this fiscal year and next in meeting legitimate program administration and beneficiary needs. Both the current and prior Semi-Annual Reports of the Inspector General identify some specific weaknesses at a few medical centers. I have asked the Inspector General

to take on a more broadly based review of travel costs to see if there are opportunities to reduce travel costs by eliminating losses resulting from fraud, waste, or abuse.

Prior to the statutory creation of the Office of Inspector General, I was persuaded that such an Office would be an asset to the Agency and would significantly contribute to the public interest of minimizing fraud, waste, and mismanagement in the operation of Government agencies. I believe the anticipated benefit has become a reality, and I will continue to offer my strong support to the Office.

Sincerely,

MAX CLELAND
Administrator

Enclosure (1)

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CHAPTER I

OVERVIEW

During the past six months, we have given particular emphasis, in concert with VA's top management, to identifying solutions to problems which are both practical and effective in minimizing fraud, waste and mismanagement. Major areas addressed included longstanding problems, and creative solutions are needed that do not entail significant resource investments which are unavailable.

When our prior semi-annual report was published, the Administrator wrote to senior Agency officials and directed their continuing priority attention to the major problems identified in that report for which corrective action had not yet been completed. The ensuing efforts resulted in some completed actions, others which are progressing, and the pursuit of fresh initiatives. Without the support and initiatives of VA's top management, the improvements made would not have occurred.

The following paragraphs include a summary of major findings, conclusions and corrective actions stemming from activities of our office. The paragraphs also include major initiatives of VA's top management related to these issues.

BENEFITS PROGRAMS

Compensation, pension, education and related benefits comprise approximately two-thirds of the Agency's budget or almost $13.4 billion for FY 1980. Our recent activities were concentrated primarily in the education and loan guaranty program areas. As stated in the previous report, we have not found widespread fraud in these programs. However, several factors, primarily error, abuse and lack of effective authorities, continue to create some multimillion dollar losses. Because of the scope and magnitude of benefit programs, such losses can be significant even when the underlying cause occurs infrequently or at a moderate rate.

Education Programs. We have continued to examine education programs to detect abuses and losses and to determine underlying causes. The education accounts receivable balance remains a major problem although the balances have declined from $483.9 million in FY 1977 to $405.8 million at March 31, 1980. These accounts receivable result from the overpayment of educational benefits, most often caused by changes in training status of veterans which are not known or acted on promptly by the Department of Veterans Benefits. Benefit adjustments are manually made one or two months after the change in status, giving rise to overpayments (averaging about $800 each).

a. Causes for Overpayment. Based on a sample of centralized accounts receivable records, we determined that overpayments are due to: (i) untimely processing of changes in training status by regional offices (22 percent); (ii) retroactive terminations required by the prohibition of payment for courses not counted to satisfy graduation requirements (20 percent); and, (iii) delays in changes in training status by veterans and educational institutions (58 percent). We determined that 3.4 percent of the overpayments were due, all or in part, to advanced or prepayments. This is a significant improvement since GAO reported in March 1976 that 21 percent of overpayments were attributable to advanced or prepayments. Prepayments were abolished by the 94th Congress.

During the past year, audits at 6 of 16 regional offices disclosed that systematic analyses of error trends of adjudication benefit claims were not being properly performed. Five audits identified problems with the quality of administrative decisions which affected overpayments. Regional Office Directors concurred in audit recommendations.

An automated system, called TARGET, is undergoing phased implementation. This system should reduce overpayments by shortening by 4 days the current average processing time of 10-19 days. Additional reductions in overpayments can be achieved by establishing processing timeliness criteria and goals, closely monitoring check interception, improving identification of school reporting errors and improving systematic quality control reviews. We are still analyzing the problem of delays and inaccurate reporting by veterans and educational institutions to determine if some practical solution can be found.

Using a computer program developed by our auditors to match education benefit records by social security number and other characteristics, we identified approximately 26,200 pairs of records containing the same social security number. Ninety-five cases involving active awards were referred to the Department of Veterans Benefits where suspense and termination actions were taken to avoid further overpayments. Based on a sample of the remaining cases, the audit team estimated that 1,100 beneficiaries were overpaid $1.5 million.

The Department's initial analysis of the problem indicates that most of the duplication occurred because VA's automated beneficiary locator system could not locate the existing file number and automatically established another file number. Twenty percent of the duplicate cases were attributable to errors by regional office employees. The Department has agreed to investigate these cases, and establish accounts receivable or stop payments as appropriate, and to identify indications of fraud for possible referral to Justice. Also, the Department, with technical assistance from our auditors, is currently developing information requirements and manual procedures to preclude duplicate benefits. Periodic computer matches will be used. Automated system changes are also being considered.

Compliance surveys are conducted by VA regional offices at all schools where veterans are receiving education benefits to verify and assure the propriety of payments. The Compliance Survey Program serves to reduce overpayments caused by a school's failure to report dropouts and reductions in training time, among other things.

We reported the need for improving compliance survey activity in our last semi-annual report. Improvements were observed at nine regional offices where audits of educational overpayments were made. However, our audits have continued to disclose that further improvement is needed. At two regional offices, we judged the quality of surveys to be poor based on review of survey workpapers and our own onsite audits at educational institutions. For instance, the survey reports did not disclose many of the deficiencies found by us. At three offices we found that surveys were not in compliance with published policies, failed to meet schedules, lacked followup action on reported deficiencies, and failed to conduct followup surveys or expand the scope of surveys at problem schools.

The primary causes of the compliance survey deficiencies were: understaffing, lack of training, and ineffective supervisory and quality control reviews. The regional office directors were receptive to our recommendations and are initiating corrective actions. The Department of Veterans Benefits published a comprehensive training guide for compliance survey specialists in February 1979. We should see improvement in the compliance survey program with the increasing use of this guide.

b. Effectiveness of Collection Action. During the past six months we evaluated the collection programs of regional offices and the Centralized Accounts Receivable System (CARS). CARS is an automated system that is intended to facilitate the processing of a large number of accounts receivable. Automated features of the system include computer generated letters and forms, locator and credit report requests, account adjustments and terminations, and reports. The computer system monitors the accounts receivable in every category and takes action based on preprogrammed events. CARS processes about 85 percent of the Agency's compensation, pension, education and loan guaranty accounts receivable collections.

Our audit of CARS showed that VA has taken some measures to improve the resolution of accounts receivable. However, we found that: the effectiveness of telephonic contact with debtors needs to be better determined; identification and collection of VA and other Federal employee accounts receivable could be more aggressively pursued; and collection techniques for terminated accounts receivable could be improved. These and other recommendations are currently being considered by department and staff offices within the Agency.

Five of seven audits of regional offices in the last six months identified a lack of prompt and aggressive collection action on accounts which are decentralized for collection action. Four deficiencies were identified: (i) excess time between contacts with debtors; (ii) insufficient monthly payments or offsets against other benefits based on the debtor's ability to pay; (iii) failure to refer cases timely to GAO; and (iv) lack of required contacts, especially personal contacts.

Initiatives to Reduce Overpayments and Improve Collections. In our last report we noted that the General Counsel was going to perform a one-year test to evaluate the cost effectiveness of pursuing collection by instituting civil actions against small debtors. Since then, selected "under $600" accounts for which collection action had previously (and unsuccessfully) been pursued in accordance with Government collection procedures, were referred to six of eleven test regions. The results of the first 12 weeks of activity are promising. Of the 371 workable cases pursued after initial screening, a favorable disposition rate of 72 percent was achieved and over $100,000 will be collected in the 270 cases.

The Department of Veterans Benefits is continuing its policy of refusing to grant loan guaranty benefits to veterans with delinquent educational debts to the VA, and pursuant to Section 1810(b) of Chapter 37, Title 38, U.S. Code are determined not to be good credit risks.

Home Loan Applications - Education Overpayments
May 1979 through February 1980

Status of Indebtedness	Number	Amount ($ Millions)
Paid in full	13,060	$4.9
Repayment plan established	3,014	2.0
Plan to reenter school within 45 days	280	.2

Initial cash received as full or partial settlement amounted to $5.4 million. There are additional potential collections totalling about $1.6 million. In accordance with their policy, the department denied loan guarantees to 6,498 individuals, who collectively owe the VA about $4 million, because they would not settle their debts.

The Department of Veterans Benefits has completed a study and is considering a series of actions that include improved communication with beneficiaries through: use of public media, periodic check stuffers, and revised award letters; procedural and regulatory changes; improved collection procedures; and a one-year test, using

selected regional offices, to determine the feasibility of decentralizing accounts receivable responsibility back to the regional offices. This also includes obtaining personal contact with debtors while using the computer capabilities of CARS.

The Department of Veterans Benefits has adopted mail intercept procedures. The Postal Service will, if requested, stop delivery of a benefit check when VA learns of changes in eligibility too late to stop preparation and mailing of a benefit check, but prior to delivery of the check. These procedures, adopted at our suggestion, have been found thus far to be 50-75 percent effective and should reduce overpayments by more than $30 million per year.

VA is continuing to refer cases to the Department of Justice. As of March 31, 1980, the VA has referred over 72,000 cases for collection. These cases, each in excess of $600, represent a total liability of $83 million. To date, $8 million has been collected.

In October 1979 the VA entered into an interagency agreement with the Internal Revenue Service to obtain current address information. Through February 1980, approximately 194,000 accounts have been referred for IRS locator service, 5,782 accounts (total value of $5,625,754) have established repayment plans and 1,433 have been paid in full. The Agency recovered almost $1.5 million through the end of February.

A new computer application is being developed which will periodically match CARS records with VA employee pay records. When a match is found, a letter will be sent giving the employee 30 days to resolve the indebtedness. If the employee does not resolve the debt, the facility director where the employee works will be notified. Funds may be deducted from the employee's salary, or retirement account, if the employee leaves VA employment before the debt is liquidated. The system is scheduled for implementation in the fall of 1980. We are also developing a matching project to identify employees in other Federal agencies who are in debt to the VA and to pursue collection from their employees through government channels.

VA has a legislative initiative pending to permit redisclosure of address and other information on debtors and, when appropriate, to disclose to consumer reporting agencies VA's poor collection experience with veterans who have refused all debt collection efforts.

We believe that effective implementation of our recommendations and aggressive pursuit of the other initiatives described will make a marked impact on the collection of education and other accounts receivable. However, many of these processes are slow, and some are expensive. None appear to hold the promise of VA's proposal, which has been pending OMB clearance since September 1978, to offset debts against tax refunds. Based on subsequent GAO studies,

a very large reduction in VA accounts receivable (the potential appears to be 50 percent) could be obtained by this means. Recent information from OMB's debt collection project, being conducted under the sponsorship of the President's Management Improvement Council, indicates that this proposal is being considered, but that moving forward with a test at this time is risky and a decision should be deferred until August 1980 when the OMB study is completed. The basic risk identified by the OMB project concerns the reliability of government accounts receivable records.

Loan Guaranty Program. The Loan Guaranty Program provides housing credit assistance to eligible veterans and service personnel through guarantees of loans made by private lenders and through direct loans in capital-short areas. An estimated $16.1 billion in FY 1979 home loan guarantees have been made for 366,000 beneficiaries.

Because of increased number of loans closed and guaranteed, the program continues to be an increasing source of potentially uncollectible debts resulting from loan defaults. As of December 31, 1979, loan guaranty indebtedness had risen to over $138.7 million. During the first quarter of FY 1980 almost $7.5 million in new indebtedness was established; slightly over $3.8 million in indebtedness was disposed of by collection and offset against other benefits ($1.6 million), waiver and compromise ($1 million), or termination of collection activity ($1.2 million). We are providing substantial audit coverage to areas that have a direct effect on reducing or preventing loan guaranty indebtedness. We also plan to continue monitoring the actions being taken or planned by the Department to reduce accounts receivable resulting from loan defaults.

Checking for delinquent education indebtedness at the time of loan guaranty application (discussed earlier) has not only reduced education indebtedness, but has also resulted in more accurate credit information for loan guaranty approvals.

As discussed in our prior report, the extent of detected program fraud and abuse is greater in this program than in any other VA program. Even so, the proportion of known cases is quite small in relation to total program activities. As a result of proactive investigations, we completed and turned over to Department of Justice the results of multiple investigations involving seven lenders. In addition, program officials identified 157 individual cases which were referred through VA District Counsels to the Department of Justice. We are participating with the Office of Inspector General, Department of Housing and Urban Development, in a joint audit/investigation of loan guaranty programs in Puerto Rico.

The Department of Veterans Benefits has implemented procedures we recommended to better identify suspect lending institutions and realty brokers who may be engaged in fraud to falsify credit, employment and other information. We are following up at the regional offices to see how well these procedures are being implemented.

About 18 months ago, the Department of Veterans Benefits doubled (from 5 to 10 percent) the required number of post audit reviews of lenders' prior approval home loan submissions. The main purpose of these reviews is to identify possible high incidences of inappropriate, faulty, or illegal practices by individual lenders. Upon identification, loan processing sections are required to intensify surveillance of suspect lenders and to refer the most serious cases for investigation.

We are presently performing an agencywide audit of selected aspects of the Loan Guaranty Program. Based on the findings to date, only 80 percent of the required post audit reviews are being performed. Six of seven regional offices audited so far have not reviewed the required ten percent of the prior approval home loan submissions. At five of seven regional offices, verifications of employment and bank deposits were not always obtained from or completely filled out by lenders and employers.

The post audit review process can be improved by assuring that: all required reviews are performed; procedures for verifying employment and asset information are uniform throughout the Agency; and, that followup action is initiated where indicated.

In 3 of 12 regional offices, we found that panels of fee appraisers, management brokers, and compliance inspectors were not representative of the population mix in their area. The Chief Benefits Director instructed regional office management to review the makeup of these panels to ensure that there are qualified minority participants and, if necessary, to increase the number of minority and female participants so the panels can be representative of the community.

Eight of the twelve regional offices had problems with fee-basis appraisers and compliance inspections, usually involving poor quality of inspections and an inadequate number of field reviews by VA staff. At one office, 36 percent of the work performed by 10 fee appraisers was inadequate and required additional work. Also, for 9 properties that had no reported inspection discrepancies, our review found 13 instances of non-compliance with property standards and 8 instances of unauthorized deviations from the original specifications. At another office, about two-thirds of all construction complaints were on properties inspected by three particular fee-basis inspectors. Training, counseling and, if necessary, disciplinary action were recommended. At a third office, field compliance reviews performed by VA staff had endorsed the appraisers' valuations. However, a comparison of certificates of reasonable value at the time of foreclosure with those completed at the time of sale showed substantial differences in 4 of 15 cases.

At two offices we found that Loan Guaranty Division personnel were not conducting the required number of field reviews of fee appraisals and compliance inspections. At three other stations we found such problems as unrealistic construction valuations

by VA staff appraisers and a lack of controls to assure that total fees paid to appraisers were within average monthly limitations.

Insurance Programs. The VA life insurance program consists of eight types of insurance which provides coverage exceeding $105 billion to about 8 million policyholders. The computer support for insurance activities is provided by obsolete equipment, subject to narrowing sources of maintenance expertise, and lack of replacement parts. In October 1978 a contract in excess of $1.1 million was awarded for the conversion of 195 insurance computer programs. This was to allow automated processing on newly installed TARGET Regional Data Processing Center equipment.

A preliminary audit of the conversion found that the contractor failed to meet established milestones. Based on the information available, we questioned the contractor's ability to deliver the desired end product within the stipulated time limits. The judgment at that time by responsible Agency officials was that the contractor was making progress and the contract should continue. Subsequently, because of the continued inability to deliver a usable product, the contractor was held in default on February 11, 1980.

The problems which led to the awarding of the conversion contract remain. To solve these, the Agency is trying to acquire a different computer on which the system can be run in emulation as an interim measure. A preliminary study of insurance system redesign is also under way. We will continue to monitor this effort.

Compensation and Pension Programs. In FY 1979, $10.3 billion was paid to approximately 4.7 million beneficiaries in these programs. As reported in our last semi-annual report, a VA study of the Pension Program, issued in October 1978, showed a high incidence of errors (10.3 percent overpayments and 15.9 percent underpayments), but a relatively low dollar impact. The gross dollar error was 8 percent with net underpayments exceeding net overpayments. To minimize these errors, the Department of Veterans Benefits has developed an ongoing sampling instrument to verify the accuracy of beneficiary reporting and VA payments. During January and February 1980, the Department pretested the program at the regional offices. We monitored the test at three regional offices and found satisfactory implementaion. Currently, the Department is compiling the results of the test program. Subequently, we will provide further analysis. The annual process of sampling will extend from April to November of each year. A limited verification program will be completed in FY 1980 with the full program becoming operative in FY 1981.

As reported in our last semi-annual report, one of our audits matched active Compensation and Pension System master records by social security number. The Department identified a total of 321 beneficiaries who had more than one record and were receiving more than one benefit check. The primary causes were errors in

reporting by beneficiaries, in claims processing by adjudicators, and in computer inputs. Since then, additional cases have been found. The Department of Veterans Benefits took prompt action to prevent further overpayments in these cases and established over $1.4 million in overpayments. Operational improvements include requirements for two signature approval of adjudication determinations, certain controls which will be available from full TARGET implementation, and periodic computer matches.

MEDICAL PROGRAMS

The VA operates the largest centrally-directed health care system in the nation. The system includes 172 medical centers, 224 outpatient clinics and 16 domiciliaries. There are one or more VA medical centers in each of the contiguous states, in the District of Columbia, and the Commonwealth of Puerto Rico. In Alaska and Hawaii, the VA operates outpatient facilities and provides hospitalization and extended care under contract with non-VA health care facilities. Of the Agency's FY 1980 budget, $5.8 billion or 28 percent is allocated for the Department of Medicine and Surgery (DM&S). The Department's 190,000 employees represent 89 percent of the Agency's FY 1980 budgeted staffing.

Specialized Medical Programs. In FY 1978, there were 1,196 specialized medical units including 165 intensive care units with 2,293 beds. In our last report we noted that 18 of 34 medical centers audited in FY 1979 had one or more underutilized specialized medical programs. For the first half of FY 1980, 4 of the 17 facilities audited revealed similar underutilization problems. Followup on our prior findings, where sufficient time had elapsed to measure progress, found improved utilization in 14 programs although 6 remained at an unacceptable level.

One of the recognized options for improving substandard utilization is sharing. An October 1979 audit survey report showed that barriers to sharing included legally established priorities for VA health care which provide that (i) non-veterans and non-Federal patients have lowest priority for care, and (ii) only those specialized resources operating below maximum effective capacity can be shared; reimbursement and fund distribution methods; and program officials' reluctance, in some cases, to fully support or encourage sharing. The survey concluded that these barriers should be investigated by site visits to medical centers and discussions with VA medical center and local hospital (private and Federal) managers. We are performing additional reviews to determine whether sharing options are aggressively pursued and to assess use of three specialized medical programs: electron microscopy, hemodialysis and cardiac catheterization.

Procurement and Monitoring of Pacemakers. In FY 1978 the VA purchased 3,000 pacemakers for about $6 million. In response to allegations of serious irregularities in the procurement and

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monitoring of pacemakers, we undertook several investigations and an audit. Investigations of pacemaker procurement and monitoring services revealed that three VA physicians at two VA medical centers were involved in apparent conflicts of interest in performing evaluations of pacemakers for manufacturers. The audit of VA Central Office and eight medical centers identified the need for improved procurement and inventory controls, competitive bid purchases, credits for return of used pacemakers, and standardized monitoring and other services for pacemaker patients. DM&S has issued policies to correct program shortcomings.

Patient Abuse. To ensure that beneficiaries receive the best possible care, the Agency has the policy that under no circumstances will patient abuse or mistreatment by any employee of a VA health care facility be tolerated. Adherence to this policy was determined during audits at 16 medical centers. The final conclusion of this audit was that patient abuse was not a major problem at the medical centers reviewed. However, the most significant weakness noted was the failure of over half the facilities reviewed to incorporate VA's policy into their own local policies, and to adequately disseminate these policies to all employees. Complaints received through such mediums as the employee hotline or complaint mail will continue to be pursued. For example, during this reporting period, audit and investigative activities of allegations resulted in correction of weaknesses in addressing patient abuse incidents at a medical facility.

Medication Handling. In FY 1979, about $225 million was spent for drugs. Medication handling involves the receipt, storage, distribution, control, accountability and administration of drugs. Controlled substances are drugs which have a potential for psychological or physical dependency with harmful side effects if abused. The distribution, recordkeeping and security of these drugs are explicitly regulated to minimize intentional or unintentional diversion. During our medical center audits, we reviewed medication handling with emphasis on physical security requirements for the prevention of controlled substance loss.

Thirty-four medical center audit reports showed the need to improve medication handling in one or more of the following respects: drug inventory and storage practices needed improvement (7 medical centers); physical security of the pharmacy (13 medical centers); security for and accountability of controlled substances (23 medical centers); and inventory control of controlled substances (9 medical centers). In addition, at 4 medical centers, controlled substances, shown on inventory records as having been administered to patients, were not recorded in patients' records. Pharmacists were not monitoring drug usage on wards as required and inspectors were not randomly comparing entries on the Controlled Administration Records with the applicable patients' medical records.

At four medical centers, outdated drugs were found on the wards; some drugs had been outdated for over one year. At one

medical center ten patients were administered outdated controlled substances. We plan to continue our review of medication handling during our cyclical medical center audits.

We performed a vulnerability assessment of medication handling. Based on information available in FY 1978, the estimated dollar loss for drugs which may be stolen, dispensed without appropriate records, destroyed without correcting records, or otherwise lost is $18 million. This consists of $17.4 million which occurs in hospital inpatient medication distribution systems, and $.6 million in station warehouse inventories. An additional cost of $4.7 million from filling prescriptions on a fee-for-service basis could be substantially reduced through identification and elimination of program abuses, such as paying excessive drug charges, prescribing excess quantities of medications and participation by ineligible veterans. Further, losses due to duplicate prescriptions, improperly obtained by beneficiaries, constitute a multimillion dollar problem; however, existing information is too limited to develop a reasonably reliable systemwide estimate of the loss. A cost/benefits study is currently being conducted by the VA to obtain this information. An inventory accountability system, that could account for all drugs or drugs involved in major dollar losses as they flow through the system, does not exist. Department and staff office responses to our vulnerability assessment delineated steps that would resolve issues; however, the pace and degree of improvements to the inpatient medication distribution systems remain unresolved. The solution requires extensive manpower, computer systems, and other resources.

Patient Medical Records. Emphasis on patient record reviews has continued in our audits of VA medical centers. The following are those deficiencies of sufficient frequency to be of concern.

a. At 21 VA medical centers, failure to fully document patient consent for surgery or anesthesia, to participate in research, or to use investigational drugs was found.

b. Since the chargeout system was ineffective, medical records could not be easily located at 8 medical centers.

c. A problem with timely completion of medical records was reported at 19 VA medical centers.

Continued emphasis on medical records is needed. A summary of audit findings on quality controls for patient care, to include medical records, is being prepared and will be provided to the Chief Medical Director.

Non-Service-Connected Outpatient Treatment. DM&S policy restricts outpatient care to no longer than 12 months after inpatient discharge unless it is medically determined that a longer period

is required. Three medical center audits disclosed that patients were not systematically evaluated to determine their medical need for continued outpatient care. At one medical center, there was no documented evidence to insure that non-service-connected veterans were evaluated for their need for continuous treatment. Also, in 101 cases sampled at the other 2 centers, 32 patients had been in an active outpatient status from 1 to 9 years without documented evidence to support the need for continued medical care.

Beneficiary Travel. As a result of our recommendations, the Department of Medicine and Surgery and the Controller are preparing improved procedural requirements governing beneficiary travel payments. Corrective actions have been initiated locally in response to a similar situation revealed by an audit issued during the last semi-annual reporting period. These actions show positive steps by local management to appropriately control program costs. At another medical center it was noted that Medical Administration Service had been successful in reducing reimbursements for beneficiary travel expenses even though outpatient visits, ambulatory care visits, and the privately owned vehicle mileage rate had all increased.

Although our coverage of beneficiary travel was less intense during this current semi-annual reporting period, findings reported indicate management attention is still needed. At one medical center and its associated outpatient clinic, accountability and control over $340,000 in public transportation tokens was unsatisfactory. The audit uncovered no major discrepancies in the $208,000 worth of tokens on hand at the medical center. However, the associated outpatient clinic was unable to account for $37,500 of its $132,000 worth of tokens. Records and reports were inaccurate, and fiscal audits were either in error or so superficial that they were unreliable.

Billing and Collections. The Controller has taken collection initiatives including the issuance of a statistical report on the status of selected medical receivables which includes ineligible and emergency hospitalizations. Our audits are still identifying deficiencies in followup actions and debts, billings and collections for medical care cost recovery, and on miscellaneous overpayments. Six of our audit reports identified problems such as untimely followup and lack of followup. Five of our reports identified problems with medical care cost recovery. For example, medical centers were not billing ineligible veterans, not billing insurance carriers, or not billing Medicare for medical services provided. Our reports also identified overpayments to affiliated medical schools for residents whose services were not provided. The VA has proposed legislation to facilitate recovery of costs from insurance carriers, employers and other sources from which the veteran may be entitled to complete or partial reimbursement for medical expenses. This legislation was introduced in the 96th Congress as S.759 and H.R.3475.

Silver Recovery. In 1978, the VA recovered $4.2 million in silver. All VA medical centers have equipment to recover silver from x-ray processing solutions. VA had an efficiency recovery rate of 79 percent in 1977 and was cited by GAO as, "among the most efficient agencies in the recovery of silver from film and photographic material." We have completed two audits of this well-run program. Opportunities to further improve silver recovery do exist, however, and the Department of Medicine and Surgery was responsive to our proposals. The three most significant proposals were: (i) extending the "batch" collection system, currently in use at some medical centers, to all medical centers (this increases yield 9 percent and could mean 28,000 more ounces per year); (ii) collecting spent silver fixer solutions from all low-volume processors; and, (iii) improving physical security for recovered silver. The Chief Medical Director has agreed with all recommendations and has issued clarifying instructions to all medical centers.

Other Trends. We elaborated on the preceding topics due to significance, frequency or Congressional interest. Additionally, our trend analysis produced three topics which, while of less import, are worth mentioning. These topics are patients' valuables, fire/safety program in community contract nursing homes, and emergency preparedness planning. Eleven medical center audits showed the need for increased protection of patients' valuables; 4 centers failed to take action to return valuables to patients upon discharge. Of 260 patients' valuables records reviewed at 5 medical centers, 82 percent of the records were neither signed by the patients nor their representatives and 46 percent of the records were not co-signed by VA employees. The fire/safety program for community contract nursing homes was reviewed during 11 audits. At two medical centers, precontract inspection teams did not include physicians as required. At 2 medical centers, the quality of fire/safety inspections needed improvement. Four medical centers need to improve procedures for insuring that cited fire/safety deficiencies are corrected. During this reporting period, we tested emergency preparedness planning at 33 medical centers. We found that the emergency preparedness plans at 5 medical centers were not current and plans were not complete at 12 medical centers. Local management has agreed to take corrective action on recommendations addressing these three topics.

MEMORIAL AFFAIRS PROGRAMS

Audits of 25 national cemeteries found all but one to be well maintained. Unused or underused equipment was found at eight of the 20 VA-maintained cemeteries, and consisted of 27 items with a total valuation of $17,600. In each instance, cemetery directors agreed to excess the equipment.

OTHER PROGRAMS AND FUNCTIONS

We have continued to assess major functional activities within the Agency. Signficant departmental initiatives have been

directed to time and attendance accountability. Continued administrative emphasis is needed in the areas of Agency cashier and equipment inventory.

Time and Attendance. Personnel costs approximated $4 billion in FY 1979, including $38.1 million in overtime. During FY 1979, overtime increased over FY 1978 costs by 20.5 percent as compared to a 25.8 percent increase between FY 1977 and FY 1978. As a result of our audit of overtime, part-time, and time and attendance records and other audits identifying payroll discrepancies, the Controller issued supplemental information to the heads of departments, staff offices, and field stations. This information was provided in a September 5, 1979 newsletter to all VA facilities. It addressed overtime authorizations, salary limitations, reductions and calculations of overtime, and quarterly audits of timekeepers, emphasizing that the audits serve as valuable training mechanisms. The Controller suggested rescheduling work shifts to reduce overtime. Such an adjustment of routine work schedules to overlapping time periods permits transfer of keys, narcotics counts, and the like, thus avoiding use of 1/4-hour regularly scheduled overtime at midnight. Two audits were conducted after publication of the Controller's newsletter, and improved controls were found at both facilities.

As a followup to these audit report findings, investigations of alleged work-hour abuse by part-time physicians, other information from the Controller, the Department of Medicine and Surgery, and allegations from the employee Hotline, we performed a special analysis of the time accounting for 3977 part-time physicians. The basic problems identified were that existing timekeeping procedures are (i) unrealistic in light of the need for part-time physicians to deviate from scheduled tours of duty (ii) unrealistic because timekeepers often do not know of changes from scheduled tours, and (iii) vulnerable to fraud and abuse.

New procedures adopted in June 1979 have not alleviated the timekeeping accountability problems even though the prescheduled tours of duty have been made more flexible. Only 15 facilities have implemented these procedures placing only 330 part-time physicians under the adjustable work hour provisions. The most critical comments received from the various facilities not using these procedures indicated that the daily sign-in/sign-out requirement was unacceptable to the physicians as being unprofessional.

Therefore, we proposed a modification which would keep the flexibility of the adjustable work hours; would meet the definition of "part-time" through prescheduled "core" hours necessary for leave and benefit calculations; and, would provide direct accountability to the part-time physicians for actual hours worked or leave taken. Presently, this proposed modification has been submitted to GAO for review. Unless there are objections from GAO, this new procedure should be implemented in the near future.

Laboratory Examinations. The Office of Investigations continues to operate a technical laboratory for the examination of official documents, handwriting, handprinting, typewriting, inks, papers, films and various other questioned material. The laboratory renders expert opinions concerning the authenticity of the various materials submitted. In addition to providing technical support for the Office of Investigations, cases are submitted directly to the laboratory from all VA activities. During the reporting period, the laboratory completed 153 cases. Identification of fraudulent documents in 55 cases contributed to the denial of claims, prevention of improper payments, recovery actions and identification of VA employees involved in irregularities.

Procurement. The VA spent $1.9 billion for construction, and to acquire services, equipment and supplies in FY 1979. While our reviews to date are insufficient to provide a comprehensive overview, several patterns have emerged for some categories of contracts. One, which is discussed elsewhere in this report, is pacemakers. Others are:

a. ADP Contracts. Major system design and conversion contracts have not specified documentation requirements. In addition, conversion contracts have not tied progress payments to contract deliverables, resulting in a significant expense for one contract which utlimately had to be terminated for non-performance. Mini-computers, software and consulting procurements acquired to meet medical center needs in FY 1978 and 1979 have raised a number of questions regarding adequacy of planning and the propriety of procurement actions. These have been partially addressed in investigative and audit work completed to date, and the FY 1979 procurements have also been subject to critical reviews by the Office of Management and Budget and Congressional oversight hearings.

b. Equipment Maintenance Contracts. A multi-site audit of the practices used in contracting for maintenance services by 6 medical centers showed that improvements were needed at five of the centers to assure greater competition. Of the five facilities lacking competition, four had what were essentially automatic renewals of previous years' agreements with the same contractors. Negotiated contracts lacked statements to justify negotiation instead of competitive bidding. Four facilities had maintenance agreements which could have been consolidated because the contracts were for servicing similar equipment by the same vendor. Consolidation could result in potential cost savings through blanket contracts for similar equipment. The maintenance contract audit findings are similar to those our cyclical audits have often found at other medical centers. However, not all medical centers fail to seek out competition. Many audits show proper contract administration with sufficient competitive bids routinely sought.

c. Sole Source Procurements. An audit of VA Central Office and five medical centers' sole source procurements showed that contracting officers were often relying on program officials'

assertions rather than independently establishing that there was only one source, and frequently the sole source justifications were insufficiently documented.

d. Other. Other types of problems existed relating to the audit support for procurement activities.

(1) Technical Reports. Of the 80 contract audits completed between October 1, 1979, and March 31, 1980, 66 reports were qualified due to the absence of a technical report. According to Section 1-3.809(b)(6) of the Federal Procurement Regulations (FPR) such reports should be furnished at the earliest possible date to enable the auditor to include the financial effect of technical findings in the audit report. The regulation further provides, "In the event the technical analyses are not available in time to be reflected in the audit report, the audit report shall so state." In those cases noted above where technical reports were not received, the effectiveness of the audits was diminished since the auditors had to express qualified opinions.

(2) Cost or Pricing Data. The FPR Section 1-3.807-3(a) states that it is the contracting officer's responsibility to require that the contractor submit written cost or pricing data. However, in the 80 completed contract audit reports for architect/engineer, construction and supply contracts and scarce medical contracts, there were 14 cases of inadequate cost and pricing data. As a result, there was a significant amount of unsupported costs, for which no audit opinion could be expressed.

Most of the foregoing deficiencies are the type which make procurement programs vulnerable to kickbacks and other personal benefits. We have not had the investigative resources to undertake proactive investigation efforts in such situations, but expect that resources recently added to address these issues soon. However, several specific cases have been investigated where audit, the employee hotline or other sources have identified specific situations where there were indications of such illegal activities.

Equipment Inventory. The value of VA's non-expendable property totalled $1.2 billion at the end of FY 1979. Continued coverage of this area in 20 of 27 facility audits indicated that equipment inventory controls and utilization require greater management attention. Improvements are required in accounting for equipment through annual certification of consolidated memorandum receipts inventories. Audit results also indicate a need to improve procedures for identifying and turning in excess and underutilized equipment. In several instances, equipment could not be accounted for due to loss, theft, or poor recordkeeping (e.g., items turned in but not deleted from records). At one regional office, the consolidated memorandum receipt had not been certified since 1976. At a medical center, equipment was identified as government property with easily removable foil tags and four pieces of equipment valued

at $47,823 were not tagged. Excess equipment was found at most facilities audited. For example, excess casket lowerers were found at six cemeteries.

Under the direction of the Inspector General, General Services Administration, we participated with 17 other Executive Branch agencies in an audit of property management. For the National Capital area, we selectively reviewed VA's office furniture transactions during FY 1979 and physically inventoried VA-owned office furniture. We found that subsequent to the discontinuance of formal accountability of office furniture on June 30, 1972, there has been a loss of control over the acquisition, use, and disposition of furniture. Also, there was a failure to use alternatives to new furniture purchases. Furthermore, we found a lack of control over restricting executive furniture to grades GS-15 and above and those employees in direct support of them. VA is developing instructions which will require all managers to undertake an effort in the near future to inventory all property, identify all excesses and redistribute to locations experiencing shortages, and surplus unneeded property.

CHAPTER II

IMPLEMENTATION OF THE INSPECTOR GENERAL ACT IN THE VETERANS ADMINISTRATION

ORGANIZATION

The most significant developments to date in FY 1980 have been the reorganization of the Offices of Audit and Investigations. The Office of Audit reorganized the Central Office level on October 21, 1979. The primary objective of this reorganization was to streamline staff and line relationships by shifting most of the audit activity in Central Office to the field offices - leaving the Central Office elements to function almost exclusively in a staff capacity. Another important accomplishment was restructuring the Central Office elements along functional and programmatic lines. This reorganization enabled a shift of 21 positions from Central Office to the field.

In FY 1980, the Office of Investigations was authorized an increase in staff from 46 to 72. Early in the fiscal year, the office established five field offices enabling the Inspector General's office to function more efficiently by having resident investigators in geographic areas. Three offices are co-located with Field Offices of Audit in Atlanta, Chicago and Los Angeles. An office has been established in New York City. The Washington Field Office has a sub office in San Juan, Puerto Rico. The Central Office organization has added a separate unit, to be staffed with 7 professionals to work primarily on proactive investigations.

STAFFING

The staff on board as of March 31 was as follows:

Professional Staff	
IG	2
Risk Analysis	6
Audit	237
Investigation	49
Subtotal	294
Clerical Staff	50
Total	344

The professional staff of the Office of Audit is multi-disciplinary, consisting of 48 percent management analysts, 31 percent accountants, 14 percent computer specialists and 7 percent

audit specialists. The professional staff of the Office of Investigations consists primarily of investigators who have had extensive prior criminal or administrative investigative experience with military, Federal, state or municipal agencies. They have had additional training and experience in such diverse fields as law, accounting, document analysis, procurement fraud, contract fraud, and other areas of white collar crime. Recently, we have hired investigators with extensive experience in VA programs.

RESOURCE APPLICATION

Five key objectives of our office were established about 18 months ago. A description of these objectives and the professional resources applied to each objective are:

	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.	4.0	2
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.	12.4	7
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.	23.3	13

*All references to staff assigned represent the average number of professional staff dedicated to these activities during the six-month period.

	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.	107.3	62
Objective 5: Reactive Investigations To investigate complaints of serious administrative and criminal irregularities and to assure that corrective actions are taken.	26.6	16

We are concerned with the reductions, over the past six months, in the amount of resources and the percentage of our efforts applied to Objective 3. A comparison with the previous six-month period shows that the reductions have exceeded 50 percent. We are taking actions to reverse this trend.

The reductions occurred because, in the face of declining resources and added workload, we attempted to obtain a three-year cycle on medical center audits (Objective 4). Such a cycle is consistent with the purpose for which resources were added in FY 1978.

Prior to FY 1978, individual medical centers were audited very infrequently. These centers, 172 in all, are quite large. On the average, a medical center represents a $30 million annual business to provide patient care; allied health services such as dietetics, pharmacy, social work and chaplaincy; research; education; and administrative services such as building management maintenance and security, supply, fiscal, medical administration and personnel services. Because of the nature of the business they are in, medical center managers necessarily receive rather extensive delegations of authority and have a good deal of discretion in carrying out their operations. The average expenditure of 275 audit staff days once every three years to audit each medical center is a minimal level of oversight warranted, particularly in light of the types of problems found and reported in Chapters I and III of this report.

In FY 1978, audit resources were increased from 102 to 295 to establish a three-year cycle for all VA activities. However, we found it necessary to slip this frequency to 5 years for other than medical centers, in order to accommodate Objectives 2 and 3. The

decision to continue to try to obtain a three-year cycle for medical centers was ours. It was consistent with interests expressed by the Congress and the Administrator.

A subsequent decline in audit resources (21 positions) added workload (e.g., OMB Circular A-71 requirements for computer security audits), and slippages in filling vacancies created a serious shortfall in audit capability during this latest six-month period. We do not expect any improvement in this situation during the remainder of FY 1980 nor in FY 1981, except that the hiring lapse situation should improve when the freeze is lifted. Therefore, we have decided to reduce the frequency of cyclical audits of medical centers to five years. This will free 14 additional staff to work on Objective 3 projects.

We also expect more investigative resources to be applied to Objective 3. A portion of the recently added resources will be released for this purpose as soon as their temporary assignments to assist in overcoming an existing backlog of reactive investigative cases is complete.

In addition to the resources allocated to the foregoing objectives, staff resources were 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	3.0
Employee hotline	1.5

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

CHAPTER III

AUDIT RESULTS

During the past six months, audit activities have been directed to three of the five previously described objectives, as follows:

	Staff Assigned	Percentage
Preinstallation reviews	12.4	9
Special Initiatives for fraud, waste and mismanagement	17.9	13
Cyclical audits	107.3	78

PREINSTALLATION REVIEWS

The Office of Audit has completed five preinstallation reviews during the period. Preinstallation review efforts have continued on the TARGET System, replacement medical center construction projects, and Health Care Information Systems.

TARGET System. The preinstallation review of the TARGET System, which began in August 1978, continued throughout this reporting period. TARGET is an on-line computer system which will replace existing VA compensation, pension and education automated systems. It is presently being installed at 57 of VA's 58 regional offices. When completed in FY 1983 the TARGET System will allow almost instantaneous access to beneficiary records. The redesigned system provides real-time capabilities to substantially improve response time for handling claims and status inquiries, while reducing personnel requirements. The total development and installation costs for TARGET, including hardware and software packages, are expected to approximate $81.5 million. Continuing annual operating costs for TARGET will be about $13.5 million. Our oversight during this report period focused on reviewing TARGET System privacy and security controls at VA's Data Processing Centers and its Central and Regional Offices. Evaluation was also made of the Agency's risk analysis efforts regarding the extent to which individual privacy of records is being protected in the TARGET System.

The audits made of the TARGET System resulted in recommendations to (i) enhance, standardize and follow privacy procedures, (ii) develop and implement a TARGET security program for Data Processing Centers, (iii) perform security audits at Data Processing Centers, and (iv) improve methodology for control and safeguard of claim folders. The appropriate department and staff offices agreed with the recommendations.

The TARGET System risk analysis effort is not complete because the Risk Analysis Oversight Committee has not exercised the coordination and control function for which it was originally established. The following risk analysis functions were recommended: (i) complete the report on the Agency's TARGET System risk analysis which discusses all risks and countermeasures; (ii) establish a schedule for implementation of countermeasures approved by the department; (iii) develop plans and timetables for future risk analysis; (iv) revise guidelines for future risk analysis; and (v) ensure that these guidelines are consistently and uniformly applied. Actions have been initiated to implement these recommendations.

Emphasis for future TARGET audits will continue to focus on pre- and postinstallation reviews of major phases of new development for user initiated actions and TARGET Central System redesign. The preinstallation reviews are planned to cover functional specifications, implementation plans and schedules for system controls and test plans.

The postinstallation reviews will analyze and test the effectiveness of manual and ADP controls, compare output to specifications, determine user satisfaction with output and procedures, and ascertain the completeness and utility of the documentation.

Field work for our first audit of TARGET Documentation is scheduled to be completed during the third quarter of FY 1980. This audit, which will be done annually, should insure that (i) initial documentation meets required standards; and (ii) documentation is updated when the system is changed.

Construction Activity Audit

During this reporting period the implementation of our strategy for surveillance of replacement medical center construction projects has continued. These surveys are designed to assess projects on a cyclical basis as they reach critical stages of the construction activities. A survey has recently been completed and a draft report, Construction Clearance/Approval Steps, has been issued for comments to the Department of Medicine and Surgery and the Office of Construction.

An audit of the process of identifying and selecting major and minor construction projects was completed on February 25, 1980. The results of this audit are discussed on page 3-10.

Based on overall audit priorities, we will continue to assess these audit plans for the remainder of FY 1980 and for FY 1981 to address other areas such as cost overruns, architect engineer contracting, resident engineer functions, and nonrecurring maintenance and repair activities.

Health Care Information Systems (HCIS)

A preinstallation audit of the Department of Medicine and Surgery Affiliation Assessment Project has been completed and a draft report submitted to the Department for comments. This project was initiated in early 1977 to create a descriptive, analytic computer based model which would provide composite profiles of the nature and intensity of teaching affiliations between VA facilities and health profession educational institutions. The computer model is intended to be used to develop a more flexible management instrument for the maintenance, alteration, and initiation of affiliations. The resultant data is expected to be used for predicting the impact of increasing the number of students; comparing the resources necessary to educate similar numbers of students at different affiliation sites; comparing the cost of affiliations; and for determining the effect on patient care which may result from new or changed modes of patient care delivery.

During the report period we made a review of allegations concerning FY 1979 year-end purchases of computer related equipment and services by the Department of Medicine and Surgery for minicomputer support, acquired as an interim solution pending implementation of a health care information system in the late 1980's and early 1990's. Our review showed that acquisitions were based on hurried decisions and some lacked the disciplined planning, coordination and thoroughness appropriate for procurements of this magnitude. Significant costs for site preparation, file conversion and peripheral hardware were not fully addressed, nor were decision makers alerted to the funding required in future fiscal years. Also, cost/benefit studies were unreliable. The Office of Management and Budget and the General Accounting Office are also reviewing ADP procurement and future HCIS development. It is expected that the results of these reviews may significantly impact on future development of HCIS. Once we have determined the impact of these reviews we will re-evaluate our strategy which addresses current and planned HCIS activities.

SPECIAL INITIATIVES FOR FRAUD, WASTE AND MISMANAGEMENT

Seventeen reports completed during the last six months and other continuing audit activity identified cost avoidance and collection recommendations totaling $2.2 million. The first four audit subjects below cover areas included in the last semi-annual report which required continued audit attention during the current period. Following these are summaries of other reports completed within the past six months, which contain major findings as a result of special initiatives.

PREP Audits. In the last semi-annual report, we stated that 12 Predischarge Education Program (PREP) audits had been completed and we found that the schools and consultants had received $6.6 million of surplus funding which should be returned to the

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Government. One of these audits of a school, indicated no surplus funds. The remaining 11, for two consultants and nine schools, were referred to the Controller for collection action.

PREP programs at the eight schools and one consultant indicated below had reported surpluses as shown. The recommendation in each case was to pursue collection of the reported surplus and collection letters were sent to all nine. One of the schools, Olympic College, requested and received information concerning compromise procedures; the Controller has deferred action in this case pending receipt of a compromise proposal from the college. The other schools and the consultant have refused to pay, and the Controller, with guidance from the General Counsel, is planning to take two of these to the Justice Department for resolution. Further action against the other six will be deferred until completion of action in the two test cases.

Institution	Reported Surplus
Barstow College, Barstow, CA	$ 229,217
American Preparatory Institute, Killeen, TX	1,134,717
Ft. Steilacoom Community College, Tacoma, WA	508,706
San Diego Community College District, San Diego, CA	377,517
St. Louis High School, Honolulu, HI	2,119,868
Olympic College, Bremerton, WA	1,033,520
Gavilan College, Gilroy, CA	898,689
Modulearn Inc., San Juan Capistrano, CA	(1,487,073)*
Newport News Public Schools, Newport News, VA	37,896
TOTAL	$ 6,340,130

* Surplus reported for the consultant, Modulearn, Inc., is a summation of portions of the surpluses reported for three schools who used Modulearn's services. The General Counsel recommended taking collection action against the four, individually, for surplus amounts which might involve joint liability, pending determination of respective liability. The amount for Modulearn includes the following amounts from the schools indicated: $154,780 from Barstow College; $807,303 from St. Louis High School; and $524,990 from Gavilan College. While these collection actions resulted in double billing, actual collections will be sought from each auditee in accordance with its determined share of liability.

We have received legal determinations for one of the two PREP audits not yet finalized, and the draft report will be issued to the school for comments within the next 30 days. The other audit is awaiting additional data from the school's attorneys and accountant.

Based on desk audits of financial statements from 104 other schools which participated in PREP, we have initiated two separate actions:

a. We referred 11 schools with surpluses exceeding $25,000 each to the Controller for collection action. The Controller's proposed collection letter is being reviewed by the General Counsel. Total surplus funds at these schools amount to $1.3 million.

b. We completed arrangements with the Defense Contract Audit Agency and the Health, Education and Welfare Audit Agency to verify revenue and cost data for 11 of 12 schools with reported questionable costs in excess of $25,000 each. Arrangements have not been completed for auditing the remaining school. Total questionable costs reported by these schools are $2.3 million.

Patient Abuse. A summary report covering 16 VA medical centers concluded that the VA medical system is not experiencing a severe patient abuse problem (41 sustained cases nationwide in FY 1978 and the first three quarters of FY 1979). However, the Department of Medicine and Surgery needs to strengthen facilities' implementation of VA's strong patient abuse policy in several areas. Since implementation of VA's patient abuse policy is the responsibility of the individual health care facilities, the most significant weaknesses noted were the failure of over half of the facilities reviewed to incorporate VA's policy in their local policies and to adequately disseminate VA's patient abuse policies to all employees. Although insufficient employee training or understanding of patient behavior is the major cause of patient abuse incidents, the majority of the medical centers reviewed had not established formal training programs to assure that their employees are able to effectively deal with patient crisis situations. It is important that measures be taken to address program weaknesses because, if not corrected, they have the potential of increasing the number of patient abuse cases in the future.

The Chief Medical Director agreed with the summary report recommendations and has directed that immediate action be taken by medical center directors to correct these weaknesses.

A separate special audit of the anti-abuse program at VA Medical Center, Waco, Texas, identified more specific local weaknesses. All were related to failures on the part of center management to reinforce, support, investigate, and enforce the program.

a. Employees feared reprisal actions (from management, union, and peers) if they reported possible abuse instances, and were frustrated about reporting due to a feeling of hopelessness about any change or improvement taking place as a result of such reports. Reviews of patient medical records and on-site interviews revealed that some instances were not reported while others were

reported as accidental injuries or as resulting from patient altercations with one another. Management's failures to support employees; identify and investigate reported injury instances; and implement protective and corrective changes contributed to this situation.

b. Followup and trending studies were not conducted for patient incident reports and results of investigations to identify problem areas.

c. Disciplinary actions taken in 9 of the 10 sustained patient abuse investigations during the past two years resulted in the "minimum" recommended punishment or less. Three of these involved the same employee. Disciplinary actions have not reflected the VA's strong anti-abuse policy or served as deterrents to repeated abuses.

d. Registered nurse supervision needed to be increased to reduce the likelihood of patient abuse incidents.

The audit team recommended corrective actions and the center director concurred and has initiated specific activities aimed at correcting the identified shortcomings.

Maintenance Contracting. Audits for all six of the VA medical centers included in this project have been completed. Only two of the centers had satisfactory operations and all six exhibited at least some need for improvement. Areas requiring attention at one or more of the centers included needs-justification, back-up documentation, competitive bidding, certification of vendor performance, and compliance with VA procurement regulations. The most significant reasons behind these shortcomings are lack of training and inadequate supervisory oversight. Specific improvement actions have been recommended and the center directors are implementing needed changes.

A summary report covering the six audits is currently being coordinated with the Department of Medicine and Surgery prior to finalization and release.

VA Contract Administration and Procurement. Of the two contract administration audits mentioned in the last semi-annual report, one involving the extent of competition in procurement was completed. This audit, conducted at VA Central Office and five VA medical centers, cited the following significant problems:

a. Lack of sufficient documentation to support a sole source procurement determination in 56 of the 79 contracts reviewed.

b. Failure of procurement personnel to determine conclusively that procurement could be obtained only from one source. Contrary to VA directives, procurement personnel accepted program officials' determinations that only one firm could fill the

requirement, rather than making independent determinations. Corrective measures designed to assure proper procurement methods were recommended.

The other audit, concerning the disposition of claims submitted to contracting officers, was temporarily suspended due to higher priorities.

Fraud Inquiries. Three audits were completed involving either the investigation of possible fraud or the determination if fraud or the potential for fraud existed.

The first of these was a review of ADP procurement actions triggered by an anonymous letter to the Director, OMB. Allegations in the letter challenged the honesty and judgment of officials involved in a series of procurement actions involving more than $15 million. The review found no indications of fraud or personal gain motivation in any of the actions. Some procedural deficiencies were noted due to hurried, end-of-fiscal-year decisions, and less-than-normal planning discipline. The review team will be submitting a separate report of recommendations for clarifying and strengthening ADP guidelines based on its reviews of ADP procurements in FY 1978 and 1979.

The second was a coordinated audit and investigation of pacemaker procurement and monitoring procedures. The audit portion of this project conducted at VA Central Office and eight medical centers, did not identify any fraud or other criminal activities beyond those which had previously been brought to our attention by outside contractors. However, the audit concluded that the program is vulnerable because controls are inadequate for requisition, receipt, stocking and disposition of pacemakers. Major findings included lack of standard criteria for selection and procurement resulting in widely varying costs; inadequate inventory control and security; failure to claim credit for removed pacemakers or to recycle or reuse them, if that is an acceptable practice; failure to establish procedures or systems for protecting patients affected by pacemaker recall; and the lack of specific policy governing responsibility for monitoring pacemaker patients resulting in inconsistent monitoring. Specific comments highlighting some of these findings were:

a. VA Medical Center, Denver, Colorado, received competitive bids which were up to $800 or 40 percent lower, per unit, than prices paid by other medical centers.

b. Inventory levels ranged from one to 15 units with five units as the average. Individual medical centers had up to seven different brands and ten different models in their inventories.

c. Methods and procedures for communicating recall information and identifying the patients affected were inadequate.

The audit team presented specific recommendations to improve the management and control of the pacemaker procurement program and the Chief Medical Director agreed with them. Certain procedural and legal considerations, particularly involving recycling of pacemakers and VA's legal liabilities, are undergoing appropriate review. Audit recommendations include potential immediate savings of more than $800,000.

The third, an audit of VA Medical Center, Providence, Rhode Island, involved evaluating the adequacy of controls for preventing fraud and unauthorized expenditures of funds, and assessing the efficiency and effectiveness of operations in Fiscal and Supply Services. No major deficiencies were found in Fiscal Service although the need to implement some mandatory controls was noted. Supply Service, on the other hand, needed significant improvement. Although fraud was not identified, warehouse stock records had been falsified to cover stock loss caused by errors; an off-station warehouse was not secure; procurement and contract administration deficiencies were found; and insufficient training of personnel had resulted in lack of knowledge of regulations and inadequate performance of service functions. The center director concurred with all audit team recommendations and corrective actions are either underway or already completed.

Special Inquiries. Reports of two special inquiries were completed during the period, one requested by a Member of Congress and the other by the Administrator.

The Congressional request concerned allegations made by a number of individuals about practices and procedures at the William S. Middleton Memorial Veterans' Hospital, Madison, Wisconsin. A significant number of the complaints involved grievances or similar concerns which were in various stages of adjudication and were not considered by the review team, since any such consideration might adversely affect these procedures. One allegation that adverse information maintained in a "secret" file was forwarded to another employer was substantiated. While no malicious intent was detected, this information should not have been released without the individual's approval as provided for in the Privacy Act. The team also reviewed the incidence of unfair labor practice charges and found that five had been filed by the local union (AFGE) in the preceding six months. Two of these had been dropped by the union before adjudication, two were mutually settled after adjudication, and one is still in adjudication. None of the four completed cases resulted in a sustained unfair labor practice. No substantial reason was found for the sudden increase in charges, except for perceived increases in responsibilities for employees due to activation of a new building which may have caused increased employee resentment. No changes in management or union policy or procedures have occurred.

Another special inquiry was conducted at VA Medical Center, Fort Wayne, Indiana at the Administrator's request. Numerous complaints from patients and their families, townspeople, and employees had reached a Fort Wayne/Allen County veterans service officer and the center's employment practices had been criticized in a local TV news documentary. In 273 interviews, the audit team elicited 74 compliments and 417 complaints. The county veterans service officer provided 122 written comments about the center. While the vast majority of these complaints had no basis in fact, the number received and the wide distribution of complainants revealed a significant failure on the part of center management to keep the center employees and the community informed. Lack of information -- for employees, about events and policies affecting them; for patients and their families, about extent and prognosis of patient condition; and for the community, about center plans and activities -- contributed to deterioration of employee morale, increased doubts and distrust of patient treatment programs, and questions about the center and its role in the community. The audit team recommended that the center institute intensive human and community relations programs to counter the adverse effects of the previous lack of communication. In addition to several minor findings, the inquiry team's physician consultants identified nine cases of questionable medical care. In three of the cases, attending physicians apparently overlooked significant symptoms or laboratory results and, in four others, failed to use consultations and diagnostic studies when indicated. In this area the team requested that a central office professional standards board review the actions of the physicians involved and take necessary corrective actions. The Chief Medical Director concurred in all recommendations and will provide progress reports on implementation status of corrective measures.

Maintenance and Construction Contracts. An audit at VA Medical Center, Washington, DC, revealed that maintenance service, construction, and architectural/engineering contracts were not being handled in accordance with VA directives. Major shortcomings included failures to: obtain adequate cost and pricing data prior to contract negotiation; prepare and/or retain records of negotiations; solicit adequate competition in the bidding process; allow adequate bid time for vendors; request pre-award audits; follow Small Business Administration procedures; and handle cost and price analyses in accordance with VA directives or Federal Procurement Regulations. In addition to recommendations designed to correct these shortcomings, training was recommended for contract administration personnel, and, in the case of two contracts where profits as a percentage of cost exceeded 68 percent, renegotiation of the contracts was suggested. The center director concurred with all recommendations and is taking corrective action. Team recommendations resulted in actual savings of about $51,000.

Identification and Selection of Major and Minor Construction Projects. This audit evaluated the policies, procedures and methods used by the Department of Medicine and Surgery to identify and select major and minor construction projects for inclusion in VA's FY 1980 construction budget request. Of the $390.3 million requested by VA for FY 1980 construction, the Department's share accounted for $352.6 million or 90 percent.

The Department has a sophisticated system for identifying construction needs, obtaining project justification, and establishing construction priorities; however, neither the Engineering Service nor the Construction Review Board retained documentation of their procedures. This prevented the audit team from verifying priority determinations and determining if the highest priority projects were selected.

Of the 48 major and minor projects reviewed, only one lacked adequate documentation for need and justification. Two significant findings were reported in the audit: a $7 million project to expand a spinal cord injury unit was approved for the FY 1980 budget but not supported by workload or demographic analyses; and conservative cost estimates for some minor construction projects to correct electrical deficiencies caused funds to be exhausted prior to completion so that special funding action was required for their completion. The audit team recommended that the $7 million expansion project be suspended until appropriate analyses are completed and the need established, and that cost estimations be sufficiently developed so that additional funding is not required. The Department concurred and is taking corrective actions.

Timekeeping Practices at VA Medical Center, Durham, North Carolina. An audit of timekeeping practices in Surgical, Dental, Psychiatry, Medical, and Anesthesiology Services revealed that most of the services were following proper procedures and maintaining adequate controls. In the Medical and Surgical Services, however, improvements were needed in the maintenance of and control over subsidiary time records and time and attendance reporting for part-time physicians.

The auditors found that: some part-time physicians were signing in-and-out when they reported for work and leaving before the sign-out time; subsidiary records were not used in the Medical Service even though the timekeeper was in no position to monitor physicians' time; and, during one pay period, five part-time physicians had been paid about $1,100 for 51 hours which they had not worked. The audit team's recommendations, including the need for formal training of timekeepers, were accepted by the center director and corrective actions are underway.

Misuse of Funds at VA Medical Center, Providence, Rhode Island. This audit confirmed that a research position had been established and filled in 1977 without the availability of research funds, and that this research activity had been supported with medical care funds amounting to nearly $40,000 at the time of the audit. A laboratory was constructed and equipment purchased for use by this research employee with medical care funds, but the laboratory and the equipment were underutilized.

The audit team recommended disciplinary, collection, and corrective actions, and the Chief Medical Director concurred and will initiate appropriate actions.

Report of Survey: Potential Barriers to Sharing Underutilized Equipment and Other Resources. An October 29, 1979, survey report on the barriers to sharing concluded that, although some real barriers do exist that inhibit sharing, there are more artificial barriers that really preclude the most efficient and effective utilization of resources. Barriers identified in the report included legally established priorities for VA health care which provide that (i) non-veterans and non-Federal patients have lowest priority for care, and (ii) only those specialized resources operating below maximum effective capacity can be shared; reimbursement and fund distribution methods; and program officials' reluctance, in some cases, to fully support or encourage sharing. The survey concluded that these barriers should be investigated by site visits to medical centers and discussions with VA medical center and local hospital (private and Federal) managers. For this reason, we are instructing our auditors to give emphasis to determining whether sharing options are being aggressively pursued when appropriate.

Property Management, National Capital Region. An audit to determine the extent of compliance with property management regulations by VA capital region activities was conducted as part of an interagency audit under the direction of the GSA Inspector General.

The audit concluded that, although adequate Federal and VA regulations exist for efficient property management, significant failures in the exercise of controls over and implementation of this program have occurred. Resultant problems and shortcomings include incomplete or inadequate justification for purchases; failure to consider repair or rehabilitation before ordering new furniture; failure to redistribute excess items where need exists; failure to obtain Central Office approval where required; lack of documentation and managerial oversight; and lack of inventory controls.

The audit team made specific recommendations to correct these situations and the Directors of all supply activities and the audited entities have agreed to implement needed improvements.

CYCLICAL AUDITS

During this six month period cyclical audits completed resulted in 52 internal audit reports. Internal audits were completed on 27 medical centers and 5 regional offices. Two of these audits were combined audits of medical and regional office centers with single reports issued. Nine cemeteries and a national cemetery area office were also audited. Audits of 12 other program entities were completed, including 5 health care programs, 2 benefit programs, and 5 functional and support activities. Estimated savings for the 52 audits, primarily in the nature of cost avoidance, totalled $7.6 million.

The 108 completed external audits of contractors, grantees and other external organizations participating in VA programs represented costs audited of $61.5 million. Recommended cost adjustments of $3.9 million were made and $7.5 million in unsupported costs were identified. The contracting officers must resolve these either by getting contractors to obtain adequate documentation to support the costs or by refusing the contract proposals. Twenty-eight of the 108 completed audits were resolved or closed during the period resulting in savings of about $3,000. Additional savings approximating $102,000 were realized on 35 audits completed in prior reporting periods and resolved during this six month period.

Our analysis of cyclical audit findings for completed internal and external audits will be considered in planning future audits and in modifying cyclical audit guides. Guidelines issued during this period included modifications to the present guides on compliance surveys and cemeteries, and guidelines for auditing the installation security of computerized data processing activities and automated data processing application systems.

FOLLOWUP SYSTEM ON AUDIT REPORTS FROM THE OFFICE OF INSPECTOR GENERAL

The six month period ending March 31, 1980, is the first full semi-annual reporting period during which the VA system for monitoring resolution of audit findings and recommendations and collecting funds disallowed by audit has been in operation. The system was established on June 21, 1979, in VA Policy Manual MP-1, Part II, Chapter 23, to implement the provisions for following up on audit recommendations contained in Office of Management and Budget (OMB) Circular No. A-73 (Revised) and the Inspector General Act of 1978.

In December 1979, OMB Circular No. A-73 was again revised to make specific aspects of a followup system mandatory for the audit of Federal operations and programs. We are in the process of revising our followup system policy which will require:

- A maximum of six months to determine agency action on each audit recommendation, including those involving other than "funds recovery".

- Specific procedures for resolving major disagreements between audit and program offices.

- That the semi-annual report to the Agency head specifically include: (i) the number of reports or findings resolved during the period, (ii) collections or offsets made, and (iii) demands for payments made.

- Periodic evaluations of the Agency's followup system.

- That VA coordinate its corrective actions with that of other affected organizations.

In September 1979, we established an audit recommendation tracking system within the Office of Audit which tracks and monitors the status of corrective actions by responsible VA program officials. VA department and staff offices have designated individuals who are responsible for tracking and monitoring actions taken or planned and for submitting quarterly reports to the Inspector General on the status of each recommendation until resolved. A summary of audit recommendations on which corrective action has not been completed is shown in Appendix 3.

VA AUDIT UNIVERSE

The VA audit universe is a compilation of programs and operations subject to audit by the Office of Audit. Established in accordance with the provisions of OMB Circular A-73 (Revised), Audit of Federal Operations and Programs, the audit universe serves as a basis for workload definition, audit planning, and determination of audit priorities. We have identified various organizational, program, and functional entities and grouped them according to the VA's major activities: medical care, financial assistance and benefits programs, cemetery services, and administration and management activities with VA-wide applications. Presently, 1,619 entities are identified. We are continually updating the audit universe to reflect additions, deletions, or other changes to existing VA organizational, program, or functional entities.

To identify the programs, functions, and organizations in the VA which are most deserving of audit attention, we are developing a quantitative measurement system for prioritizing the universe entities. This system, called Systematic Calculations of Priorities and Efforts (SCOPE), will allow for periodic review and updating of audit priorities as required by OMB. SCOPE will facilitate the audit planning process using the factors required by OMB Circular A-73, including dollar value, newness or change, management needs, sensitivity, other Federal involvement, and previous audit experience. In addition, we have included factors for Congressional interest, hot line calls, and vulnerabilities. Each factor is weighted based on its relative importance. We anticipate having this system refined and computerized by the end of FY 1980. We are also developing preliminary plans to expand this system to measure audit efforts against universe priorities. The results will be most beneficial for developing audit plans and measuring audit effectiveness.

We have been attempting to audit the medical centers on a three year cycle and the rest of the universe on a five year cycle. Although comprising only about 10 percent of the 1,619 audit universe entities, the VA's 172 medical centers are the major component of our cyclical audit coverage in terms of required staff days per year. An average of 275 staff days has been set aside for each medical center audit, although this will vary depending on the scope defined for each. Our experience in attempting to maintain a three year audit cycle for medical facilities has detracted greatly from the need to conduct program and functional audits. As a result, we find it necessary to put all VA field facilities, including medical centers, on a five year audit cycle, and increase the number of program and functional audits.

The VA audit universe summary is shown on the following page.

AUDIT UNIVERSE SUMMARY

Type of Entity	NUMBER OF ENTITIES				
	Health Care	Benefits	National Cemetery	Administration & Management	Total
Field Facilities	207	75	108	76	466
Other Field Activities	26	1			27
State Approving Agencies, State Homes, Grantees and Other	200	229			429
Contractors*	89			71	160
Intermediate Level Management Activities	39	3	3		45
Central Office Level Management Activities	197	103	14	178	492
TOTAL	758	411	125	325	1619

* Contractors include architect-engineering firms, construction companies and providers of supplies and services. The number of entities is the estimated number of annually negotiated contracts over $100,000 awarded to these contractors.

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 provided to veterans or which puts 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

- Significant 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.

Following are significant audit findings and recommendations reported in completed audits during this six month period and not included in other sections of this chapter.

BENEFIT PROGRAMS

FINDINGS	RECOMMENDATIONS
VA Regional Office Chicago, IL	
The required number of compliance surveys of education institutions are not performed. Some institutions have never been surveyed. Also, an annual survey schedule was not developed.	Develop an annual schedule and monitor completion.
A review of 11 on-the-job training establishments revealed 23 veteran trainees were paid benefits of $73,398 in violation of VA wage/employment qualification requirements.	Establish the overpayments.
Possible Multiple Compensation and Pension (C&P) Benefit Payments	
The computer matching process identified 608 C&P beneficiaries who had multiple master records on file. Using the lesser of the monthly benefit payment amounts from each of the identified cases, the monthly overpayment amount is estimated to be $44,000.	That the Department of Veterans Benefits investigate these cases to: (i) identify and stop overpayments, (ii) determine why multiple records were established for the same payee, and, (iii) implement controls to prevent recurrences. (Subsequent to our audit, the Department found additional cases and established overpayments of $1.4 million).

FINDINGS	RECOMMENDATIONS
Audit of the State Approving Agency (SAA), California Department of Industrial Relations, San Francisco, CA	
Contract costs authorized for FY 1977 and 1978 totaled $1,041,929. The audit disclosed overpayments of salary costs, administrative expense allowance, and travel expenses amounting to $228,546. Unallowable costs of $41,778 on similar items as above were claimed in the fourth quarter of FY 1978.	Recoup the overpayment of $228,546 and reduce the reimbursement of the FY 1978 fourth quarter claim by $41,778 of unallowable costs. Strengthen controls to insure compliance of contract terms by the SAA.
Audit of the State Approving Agency (SAA), California Department of Education, Sacramento, CA	
Contract costs reimbursed by the VA on SAA contracts for FY 1977 and 1978 were about $1,600,000. The audit disclosed overpayments of $328,128 resulting from an inadequate allocation plan for sharing joint costs.	Recover the overpayments of $328,128. Develop time records that show actual time spent on SAA work and State work by professional staff providing services to both functions. Allocate joint costs based on these time records.

HEALTH CARE PROGRAMS

VA Medical Center, Indianapolis, IN	
The medical center does not need a separate renal laboratory and it should be closed. The planned movement of the renal laboratory to the new addition at the West Tenth Street Division will not be required. One time savings are estimated at $73,690.	Close the renal laboratory and transfer work load, staffing, and equipment to Laboratory Service.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Indianapolis, IN (Con't.)	
The cardiac catheterization laboratory is significantly under-utilized.	Determine if utilization of the laboratory could be improved by establishing sharing agreements for catheterizations with local medical facilities.
VA Medical Center, Palo Alto, CA	
Documentation and timely completion of active medical records need improvement. Consent forms were not being properly completed. Problem lists were missing or blank in 14 of 82 records checked. Of 477 progress notes checked, 142 were incomplete or in error.	Require proper completion of medical records through continuous training and critical review.
The centralized scheduling system is not fully implemented. Clinic profiles, clinic closings, and schedule changes are accomplished without the expressed approval of the Chief of Staff for Professional Service or the Associate Chief of Staff for Ambulatory Care.	Implement the centralized scheduling system and establish controls over clinic schedules.
Controls over outside professional activities of full-time VA physicians are inadequate.	Provide direction to ensure approval and reporting of outside professional activities.
Controls over time and attendance of physicians within major professional services are inadequate.	Strengthen controls through maintaining a current designation of timekeepers and alternates, properly annotating physician timecards to reflect outside activities and conducting Agency required quarterly audits.

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FINDINGS	RECOMMENDATIONS
VA Medical Center, Lexington, KY	
The medical center's five-year facility plan is not accurate and contains unjustified items Space requirements are overstated by 16,296 square feet in the facility improvement project, representing approximately $3.5 million in planned construction costs. Also, elimination of duplicate Laboratory resources planned would save over $596,000. Cancellation of an unneeded project to renovate space in the operating room suite would save an estimated $20,000.	Recalculate need for space changes in the facility improvement project. Cancel the project to renovate the operating room space.
Our review of 83 medical records of outpatients showed that approximately 50 percent of the outpatient nonservice-connected patients and 32 percent of the ambulatory care patients should not be on the outpatient rolls and are not entitled to further medical care.	Outpatient nonservice-connected and ambulatory care patients not entitled to further medical care in accordance with VA requirements should be removed from the program.
Our sample of 10 percent of Supply Service's approximately 1,150 inventory line items disclosed that 43 percent of the sampled items were overstocked based on requirements analysis reports. Economic order quantity guidelines were not used in ordering and maintaining the inventory. We estimate total overstockage of $163,860.	Improve supply inventory management by purchasing in economic order quantities when stock levels are reduced to reorder levels.

FINDINGS	RECOMMENDATIONS
VA Medical Center, St. Cloud, MN	
The Medical Media Production Service should be closed. Staff (at an annual cost of $121,636) and equipment (currently valued at $137,937) are underutilized. The service's closed circuit television system is "on the air" about 28 percent of available time.	Close the service and eliminate all service positions except one. Declare the closed circuit television system and the television production equipment excess to the medical center's needs. Evaluate the need for the remaining audiovisual equipment and excess if indicated. As indicated in Appendix 3, the Department is now analyzing audiovisual activities at all stations as a prelude to a nationwide decision.
VA Medical Center, Baltimore, MD	
An electron microscope which costs $195,515 is underutilized. There are unused attachments costing approximately $35,000 which can be excessed immediately.	That the electron microscope be excessed prior to the move to the new VAMC Baltimore facility and that unused attachments be excessed now.
The special diagnostic and treatment unit needs to be formally evaluated for its appropriateness, effectiveness, and resource utilization. Annual costs of the unit are approximately $300,000.	That the unit's four inpatient beds be redesignated and that a program review be made, to include VA Central Office determination, for its continuation.
VA Medical and Regional Office Center, Wilmington, DE	
The Wilmington Cardiac Catheterization Laboratory is underutilized.	Close the Cardiac Catheterization Laboratory at Wilmington.

FINDINGS	RECOMMENDATIONS
VA Medical and Regional Office Center, Wilmington, DE (Con't.)	
The 20 bed Respiratory Care Center is not a segregated unit and is being used for both respiratory and non-respiratory patients.	Redesignate the 20 bed Respiratory Care Center as non-respiratory or undesignated.
The overall occupancy of the the facility of 73.3 percent for calendar year 1978 and 79.0 percent for the first three months of calendar year 1979 indicates the 20 beds at the Respiratory Care Center could easily be absorbed by the remainder of the facility's 316 beds.	That upon the redesignation of the respiratory beds the overall bed capacity of the facility be reduced by a like number of beds.
VA Medical Center, Knoxville, IA	
VA Central Office has not been notified that a Respiratory Care Center and a General Intensive Care Unit authorized in 1976 have not been activated. Equipment with a depreciated value of $5,504 should be excessed.	Notify VA Central Office that these programs were not activated and are not needed. Excess unneeded equipment.
VA Medical Center, Topeka, KS	
All beds are not being effectively used by the medical center. Respiratory patients require 4 more than the assigned 20 beds of Ward 13A, while the remaining 13 general medical beds of Ward 13A are not needed at all.	Increase the size of the respiratory unit from 20 to 24 beds, and close 13 general medical beds in Medical Service.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Hampton, VA	
Conditions previously reported in the 1974 Internal Audit Service Report, 1978 General Accounting Office Survey, VA Central Office Supply Service Technical Visit, VA Central Office Personnel Management Review, Systematic External Review Program and internal memorandums have not been corrected.	That aggressive action be taken to correct previously noted deficiencies.
The accuracy rate of warehouse stock inventories is unsatisfactory. We found the existence of unmarked "overflow" areas, inventory splitting where part of stock is in one location and part in another, lack of a locator system, unsatisfactory labeling and items in wrong locations. Also, periodic spot checks of warehouse stock are not being accomplished.	Improve accuracy rates of warehouse inventories by: (i) conducting periodic spot checks; (ii) rearranging stock to eliminate "overflow" areas and inventory splitting; (iii) relabeling all stock so the stock number, nomenclature, and unit of issues are easily read; (iv) implementing an effective locator system; and, (v) providing additional training for Storage and Distribution staff.
Uneconomical buying of some stock items resulted in excessive warehouse inventory. There were 1,015 line items valued over $275,000 in the warehouse on November 30, 1979. Of 167 line items sampled, we found that 36 items (22 percent) were overstocked by $13,610. This projects to 223 line items overstocked in the total inventory, and represents significant funds tied up in excess stock.	Improve inventory management by: (i) ordering line items at the most economical order quantity; (ii) not ordering items prior to the established reorder point; and, (iii) discouraging user services from requesting inappropriate quantities of stock.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Hampton, VA (Con't.)	
Inventories of nonexpendable equipment on Consolidated Memorandum Receipts assigned to Supply Service have not been taken or maintained as required by VA regulation.	Improve timeliness of nonexpendable equipment inventories by: (i) establishing separate Consolidated Memorandum Receipts for Personnel Service, Fiscal Service, Psychiatry Service, Medical Intensive Care Unit, Surgical Intensive Care Unit, and Outpatient/Ambulatory Care; and, (ii) having responsible officials in these areas conduct annual inventories.
Accountability for some nonexpendable equipment is inadequate. VA regulations require Supply Service assign and affix a maintenance tag to personal property to be included in the preventive maintenance program. We found 151 nonexpendable equipment items valued at over $251,000 that did not have preventive maintenance tags. A review of selected Consolidated Memorandum Receipts revealed additional equipment not properly identified with a tag, serial number, and/or an adequate description (such as brand or model number). Also, we identified 147 pieces of equipment valued over $43,000 on three receipts assigned to Supply Service without a tag number or serial number.	That accountability for nonexpendable equipment be improved by: (i) timely affixation of preventive maintenance numbers; (ii) assurance that all nonexpendable equipment already in use at the medical center is properly identified on the Consolidated Memorandum Receipts with a preventive maintenance number, serial number, and/or some other identifiable description; and, (iii) inclusion of the location for non-mobile equipment on the receipt whenever possible.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Hampton, VA (Con't.)	
Inadequate methods for recovery of silver resulted in the loss of over 330 ounces in the past year. Used photographic (hypo) solution, from which silver is recovered, was being poured down the drain in Dental, Surgical and Nuclear Medicine Services.	That an effective centralized silver recovery program be established at the medical center to increase the volume of silver recovered.
VA Medical Center, Wadsworth, Los Angeles, CA	
The outpatient pharmacy had signature cards for only 211 of the 587 physicians and dentists who were authorized to write prescriptions. A review of 49 prescriptions filled on August 9, 1979, showed that 37 were written by individuals whose signatures were not on file.	Maintain a complete and current file of signature cards to verify signatures on prescriptions and fill only properly authorized prescriptions.
Unauthorized persons have access to patient records stored at the Central Medical Records Unit. During a recent period, 269 of 8,268 records which should have been available at the storage area could not be found.	Lock doors to the medical records storage area and place a barrier between the storage area and another medical center activity sharing the same room.
Four new high pressure washers costing $4,200 for Building Management Service and a new central Electrocardiogram Computer System costing $136,000 for Cardiology Service were received in March 1977 and October 1978 respectively, but had not been installed because of delays in locating adequate space.	Designate and thoroughly evaluate the space for the installation of equipment before equipment is ordered.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Dublin, GA	
Corrections of program deficiencies noted in prior Joint Commission on the Accreditation of Hospitals (JCAH) (May 1978) and Systematic External Review Program (February 1977) reports and in Pharmacy Service Systematic Internal Reviews have not been completed. The deficiencies noted were: the lack of an automatic replenishment system, pharmacy involvement in the intravenous (IV) admixture program, a unit dose program, and patient profile review activity. Pharmacy Service's reviews also noted the lack of patient consultations.	Perform patient profile reviews and patient consultations as required; and, provide additional staffing support to the Pharmacy Service to remedy noted program deficiencies in the IV admixture, automatic replenishment and unit dose programs.
VA Medical Center, Manchester, NH	
Long standing managerial and administrative deficiencies have existed in the Alcohol Dependence Treatment Program, yet management plans to enlarge the program to include an inpatient unit.	That management take immediate action to resolve deficiencies in the program before enlarging it.
VA Medical and Regional Office Center, Fort William H. Harrison, MT	
An excessive number of medication errors have been made by nursing personnel.	Provide continuing training in medication administration to nursing staff members and take appropriate disciplinary action towards staff members who continually make medication errors.

FINDINGS	RECOMMENDATIONS
VA Medical and Regional Office Center, Fort William H. Harrison, MT (Con't.)	
Narcotics shown on ward records as having been administered to patients were not always recorded in patients' medical records. Also, required monthly inspections of narcotics were not conducted during 3 of 12 months reviewed, and inspections conducted did not include comparisons of entries on medical records and controlled substance accountability forms.	Establish controls to ensure that medications administered to patients are recorded in patients' medical records, and that narcotics inspections are conducted monthly and are complete.
Medical records were not always properly completed. On consent forms, the operation or procedure performed was not always defined in layman's terms, the "exception to" blocks were not always completed and the time and date consent was obtained were not always shown. Blood transfusion forms also were not properly completed.	Ensure proper completion of medical records by clearly defining the responsibility for completion of medical record forms and by including known problem areas in medical record reviews.
VA Medical Center, Iowa City, IA	
Accounts receivable totalling $143,793 from FY 1976, 1977, and 1978 have not been collected or resolved.	Collect or resolve outstanding accounts receivable from FY 1976, 1977, and 1978.
A fire/safety specialist is not participating in scheduled reinspections of intermediate care contract nursing homes.	Conduct appropriate reinspections of all contract nursing homes.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Boston, MA	
Electron microscope usage could be improved by adjusting work schedule and not replacing the older of the two microscopes when it is due for replacement.	Do not replace the older of the two electron microscopes when it becomes due for replacement.
VA Medical Center, Denver, CO	
Three of the 13 required monthly pharmacy narcotic inspections were not conducted. No back-up inspectors were appointed.	Pharmacy narcotic inspections should be conducted monthly, and the system for designating inspectors should be improved to include provisions for a back-up inspector.
Two of the 12 required monthly ward and clinic narcotics inspections were not conducted. Six of the 10 inspections conducted identified a total of 170 clerical errors.	Ward and clinic narcotic inspections should be conducted monthly. Procedures should be implemented to reduce discrepancies and clerical errors.
Nursing staff were not properly documenting inter-ward transfer of controlled substances. Controlled substances were transferred without Pharmacy Service being notified.	Controls over inter-ward transfers of controlled substances should be reviewed and strengthened.
Pharmacy Service was not consistently conducting monthly ward and clinic inspections of drug storage areas as required.	Pharmacy Service should conduct ward and clinic drug storage area inspections monthly and correct noted deficiencies.
Outdated drugs were found on the wards by the audit team.	Outdated drugs should be removed from the ward and clinic drug storage areas.
Ten patients were administered an outdated controlled substance.	Nursing staff should routinely check their ward or clinic areas for outdated drugs and return them to the pharmacy.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Portland, OR	
Five construction contracts totalling $599,526 exceeded the Government estimates by 58 to 215 percent. Medical center personnel attributed the differences to inaccurate cost estimates, but had not re-evaluated the accuracy of the estimates prior to awarding the contracts.	Estimate construction project costs more accurately and reevaluate estimates when significantly different bids are received.
The tours of duty for 9 of 12 full-time physicians engaged in outside activities for remuneration were not recorded on time and attendance records. Also, one physician certified his own time record, another physician used a facsimile stamp to certify time records and two time records were processed without being certified.	Post to time records irregular tours of duty for full-time physicians engaged in outside activities and discontinue the use of facsimile stamps for certifying time records before processing for payment.
VA Medical Center, Asheville, NC	
Outdated drugs were found in the cardiac catheterization laboratory and one medical ward. In addition, we could not verify that 27 drugs were current because no expiration date was on the drug containers.	That management ensure: a. all drugs are current; and b. all drug containers are dated.
Cardiac catheterization workload was inaccurately reported in FY 1979. Procedures other than cardiac catheterizations were reported as cardiac catheterizations. As a result, actual workload was 63 percent of reported workload in FY 1979 (524 cardiac catheterizations were reported while only 333 were performed).	That management ensure cardiac catheterization laboratory workload is accurately reported.

FINDINGS	RECOMMENDATIONS
VA Medical Center, Vancouver, WA	
The pharmacist was not monitoring the usage of drugs as required.	Monitor the usage of controlled substances by setting usage levels (standards) to identify variances from normal usage and requiring investigation whenever significant variances from the set usage level occur.
VA Medical Center, Fresno, CA	
Controlled substances and narcotics in patient care areas were not adequately secured under double lock. Patient medical records and unissued patient hospital clothing were accessible to unauthorized persons. Large losses of patient hospital clothing are being experienced.	Secure narcotics and other controlled substances under double lock and patient medical records and unissued patient hospital clothing from access by unauthorized persons.
Usage of some narcotics and other controlled substances could not be verified in patient records.	Provide nursing personnel with guidance on the importance of accounting for all controlled substances. Investigate the cause(s) of the unaccounted for dosage units of Dalmane and take appropriate action to account for such units in the future. Randomly verify narcotic usage to patient records during monthly narcotic inspections. Establish pharmacy procedures for monitoring usage of controlled substances in patient care areas.

FINDINGS	RECOMMENDATIONS
ADP Installation Audit of VA Medical Center, Long Beach, CA	
Requests for ADP equipment are processed by Supply Service without being reviewed and approved by medical center management.	Strengthen liaison relations between the Systems Manager and Supply Service.
Requestors are not informed of the status of their ADP equipment requests.	Committee communications procedures should be strengthened.
Supply Service is not accurately inventorying all ADP equipment.	The Equipment Inventory Listing be updated. Supply Service be provided with technical assistance to ensure an accurate inventory.

FUNCTIONAL AND SUPPORT ACTIVITIES

Review of Land Management Service	
Environmental Impact Statements required by the National Environmental Policy Act have not been used as "decision making tools" as intended by law.	No recommendation by Office of Audit. Issue addressed by Administrator's Environmental Task Force.
As a result of weaknesses in the processing of Environmental Impact Statements, construction projects at 4 cemeteries and 5 medical centers were delayed and construction costs have or will increase.	Develop procedures which provide for establishing project priorities, quantifying workloads, establishing target dates, and publishing progress reports.

FINDINGS	RECOMMENDATIONS
Review of Land Management Service (Con't.)	
Because protracted negotiations must take place with GSA before a leasing action is completed, delays on VA's part resulted in increased costs. For example, remodeling costs for the proposed Boston Outpatient Clinic relocation increased by more than $1 million between 1974 and 1977. Delays of various other projects resulted, in part, from VA's rejection of GSA lease proposals, departmental differences, inadequate processing and followup procedures, and the Agency's policy of collocating outpatient clinics with field offices.	Require applicable VA Departments to provide full justification for their rejection of General Services Administration proposals. Develop lease project schedules to include expected and actual dates of completion of lease steps. Reconsider the requirement to collocate outpatient clinics and field facilities when establishing new facilities.
Audit of Technical Assistance at the Philadelphia Data Processing Center (DPC)	
Technical Assistance Staff needs to develop password security procedures for the Honeywell Insurance System.	Develop procedures for assigning, changing, restricting and protecting passwords for the Honeywell Insurance System.
The DPC has not developed guidance for identifying sensitive data needing safeguarding as required by OMB Circular A-71, Security of Federal Automated Information Systems.	Develop procedural guidance for identifying sensitive data needing safeguarding.
The DPC has not obtained required exceptions and waivers from the Office of Data Management and Telecommunications before programming in languages other than COBOL.	Comply with waiver provisions of the Federal Information Processing Standards Publication when programming in languages other than COBOL.

FINDINGS	RECOMMENDATIONS
Audit of Technical Assistance at the Philadelphia Data Processing Center (DPC) (Con't.)	
System software security procedures are needed to preclude unauthorized access to the IBM 360/40 System's vital and sensitive files, and to preclude personnel from dumping libraries and proprietary software.	Develop procedures restricting access to vital and sensitive files, and require authorization before executing jobs on the IBM 360/40 System.
Under the Insurance System, PRIVITY, a Honeywell total system access feature for changing master files, was not properly controlled. Also, records were not maintained of unauthorized PRIVITY job attempts.	Identify jobs requiring PRIVITY and place this authorization under the exclusive control of the Chief, Technical Assistance Staff.
The Office of Data Management and Telecommunications has not established a policy for coordinating operating system changes affecting the Philadelphia region Honeywell system with the Hines DPC. The Philadelphia and Hines DPCs also need procedures for identifying, installing and testing required changes to the Honeywell operating system.	Develop procedures for coordination and resolving Honeywell operating system deficiencies between the Hines and Philadelphia DPCs. The procedures should include methods for installing and testing Honeywell operating system changes.

FINDINGS	RECOMMENDATIONS
Review of Claim for Equitable Adjustment Relative to Alleged Government Caused Delay for Boiler Plant Replacement Contract at VA Medical Center, Manchester, NH	
The claim was in the amount of $764,058 for the alleged government caused delay. The audit disclosed questionable costs totalling $629,351 relating to subcontracts, direct labor, site overhead, other direct costs, general and administrative overhead, bond expense and interest on money.	Reduce the claim amount by costs questioned of $629,351.
Evaluation of Equitable Adjustment Claim Under VA Contract at VA Medical Center, Perry Point, MD	
The contractor's claim was for $422,081 for a change in contract specifications and added work. The audit revealed total questioned costs of $305,684 which represent direct costs and overhead costs.	Reduce the contractor's claim by the questioned costs of $305,684.
Evaluation of Architect-Engineer Contract for Preparation of Contract Drawings and Specifications, Construction Period Services and Site Visits Pertaining to Construction of 505 Bed Replacement Hospital at VA Medical Center, Little Rock, AR	
The contract proposal was in the amount of $3,306,649 for the subject phase. Seven different companies in various regions were involved and three separate DCAA offices performed audits. The results were complex and	Require the contractor to properly support cost and pricing data and consider reducing the contract amount by at least $492,016.

FINDINGS	RECOMMENDATIONS
Evaluation of Architect-Engineer Contract for Preparation of Contract Drawings and Specifications, Construction Period Services and Site Visits Pertaining to Construction of 505 Bed Replacement Hospital at VA Medical Center, Little Rock, AR (Con't.)	
inconclusive due to inconsistencies and incompleteness of cost and pricing data. Nevertheless, we determined potentially questionable costs of at least $492,016 for overstated labor and overhead.	
Review of Claim for Equitable Adjustment Relative to Alleged Government Caused Delay in Contract for Replacement of Air Conditioning System in Surgical Suite at VA Medical Center, Boston, MA	
The claim was in the amount of $191,671 for the alleged government caused delay. The audit disclosed questionable costs totalling $156,443 relating to direct costs of the general contractor, subcontractor claims, general contractor markup on subcontractor claims and general contractor overhead.	Reduce the claim amount by cost questioned of $156,443.
Evaluation of Proposal for Construction Consultant Services for a Replacement Medical Center at VA Medical Center, Portland, Oregon	
The contractor's proposal was for $470,302 to provide construction consultant services. The audit revealed total questioned costs of $237,203 which represent general and administrative expenses.	Require the contractor to develop an equitable general and administration (G&A) expense rate which would allocate G&A expense to all work of the company's division.

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SUMMARY OF AUDIT RECOMMENDATIONS ON WHICH CORRECTIVE ACTION HAS NOT BEEN COMPLETED

SECTION A - SIGNIFICANT RECOMMENDATIONS FROM THE PRIOR SEMI-ANNUAL REPORT ON WHICH CORRECTIVE ACTION HAS NOT BEEN COMPLETED

The Semi-Annual Report for the period April 1, 1979 - September 30, 1979, identified significant audit findings and recommendations for audits completed during that six month period. Of 150 recommendations made, 112 have been implemented. The status of implementation for the remaining recommendations is as follows:

HEALTH CARE PROGRAMS

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
Drug Dependence Clinical Support System	
Flag prescription files in pharmacy to identify those patients being maintained on methadone and have pharmacist notify the Drug Dependence Treatment Center physician whenever a contraindicated medication is prescribed.	Mental Health and Behavioral Sciences Service is working with Pharmacy Service to implement this recommendation. A June 1980 target date has been set for completion.
VA Medical Center, Philadelphia, PA	
Controls should be established and direction provided to ensure that service level operations are conducted in accordance with applicable laws and regulations.	Control breakdown has been identified at the service level and five key supervisory personnel have been replaced. VA Central Office consultants have assisted in the process of restoring control. Restoration of program functions to an effective level is expected within a six month period.

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
ADP Installation Audit, VA Medical Center, Lake City, FL	
Complete the justification for an uninterruptable power supply for the Center for Endoscopic Programs, if it is determined to be economically feasible, and submit through proper channels to Central Office.	Justification for power supply delayed pending VA Central Office approval of continued funding for the Endoscopic Program.
VA Medical Center, Saginaw, MI	
Close the respiratory intensive care unit, and modify the general purpose intensive care unit renovation plan to add four beds for respiratory care patients.	The Chief Medical Director has approved using the respiratory intensive care unit for a "step down medical unit" to provide care somewhere between that provided by a general medical ward and that of an intensive care unit. The intent of the recommendation was to either reduce or reallocate staffing. The Chief Medical Director reported utilization has improved but no changes in staffing have been reported.
Department of Medicine and Surgery Educational Television Resources	
Eliminate television production capabilities at all medical centers other than VAMC's St. Louis and Salt Lake City and reduce staffing and equipment levels accordingly.	The Department of Medicine and Surgery has frozen, but not eliminated, television resources at current levels through a comprehensive moratorium. Existing resource data is being

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
Department of Medicine and Surgery Educational Television Resources (Con't.)	
Eliminate holdings of educational and general purpose Closed Circuit Television Systems and Networks (CCTV) at all medical centers except at VAMC Temple, Texas; reduce staffing supporting CCTV activities accordingly.	analyzed to consider appropriate distribution of resources and to explore possibilities for the most effective organizational relationships between the two production centers and the Regional Medical Education Centers. Cost estimates are being developed for dismantling the general purpose CCTV systems and networks so that funds can be identified and actions taken when final determination has been reached regarding the extent of the phase down.
Automated Fee-Basis System	
Establish procedures for control of and accountability for the VA Outpatient Medical Treatment Information Card.	Redesign of the card to a numbered, accountable form is still pending. In the interim, outpatient clinics have been instructed to secure these cards in locked drawers.
Establish and implement procedures for reevaluation of the veteran's condition and the current treatment.	A computer program which will generate a listing of veterans due for reevaluation is targeted to be in operation by September 1980.
Develop and implement a standard billing form which would be signed by the veteran and physician and show type of treatment.	The Department of Medicine and Surgery has delayed developing a form pending receipt and evaluation of a standardized form presently being developed by HEW. The Department anticipates developing their own form if the HEW form is not received within 90 days.

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
Automated Fee-Basis System (Con't.)	
File fee-basis prescriptions by veteran name and periodically review files to determine if the program is being abused.	Revision of the Pharmacy Service manual, which will incorporate these changes, is still pending.
Edit physician speciality code against patient type to minimize the possibility of the veteran receiving treatment other than that authorized.	The edit has not been accomplished because the Department of Medicine and Surgery has determined it would generate a tremendous workload for each clinic of jurisdiction.
Develop and implement procedures for reporting an End of Validation Date for Fee-basis cards, request a listing by clinics of cards due to expire, and purge the Veteran Master File and prepare a list by clinic of records purged.	Computer programs are currently being developed which will provide end of validation data and automatically delete deceased veterans cards from the fee file. Instructions will be sent to the clinics of jurisdiction requesting that they take the appropriate "delete" actions upon receipt of the existing computer generated listing of inactive veterans.
VA Medical Center, Oklahoma City, OK	
That the inpatient drug treatment unit be either closed or used to near capacity; the planned project to correct fire and safety deficiencies in Building 3 be revised; and the administrative staff be moved from leased office space to space occupied by the drug treatment unit.	The inpatient drug treatment unit has been reduced from 25 to 20 beds with a reported increased utilization rate. We will continue to monitor the program.

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
VA Medical Center, Oklahoma City, OK (Con't.)	
That the plan to acquire electronic microscope equipment be cancelled.	Additional justification has been submitted to continue plans to acquire an electron microscope for FY 1983. A site visit by VA Central Office Pathology Service is anticipated to evaluate the request.

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
VA Regional Office, Des Moines, IA	
Conduct comprehensive compliance surveys of all colleges to identify extent of violations of compliance and approval requirements identified during audit; work closely with schools to resolve.	VA regulations in this area are conflicting. One manual reference supports the deficiencies identified during audit while another negates the deficiencies. The Chief Benefits Director has requested an advisory opinion from the General Counsel to resolve the conflict.
Predischarge Education Programs (PREP)	
Concordia PREP Program Partnership, Seattle, WA	
Actively pursue collection of the $210,331 reported surplus.	Collection action for both institutions is awaiting finalization of the audit of the affiliated school, Concordia College.
Bellarmine Preparatory School, Tacoma, WA	
Actively pursue collection of the $98,555 reported surplus.	

RECOMMENDATIONS	STATUS OF IMPLEMENTATION
Statement of Transactions, Centralized Accounting for Local Management (CALM) System	
Develop and implement an automated procedure to enable daily reconciliation of all CALM payments on the generated Voucher and Schedule of Payments.	Projected completion of the necessary automated program is April 1981.
Fix responsibility for reconciling differences; provide written procedures for reconciliation; and establish timetable for accomplishing reconciliations.	The Office of Controller is working with the Data Processing Center Austin, Texas, to determine the magnitude of the needed reconciliation.
Overtime, Part-Time, Time and Attendance	
Improve timekeeping methods by establishing specific timekeeping procedures for part-time physicians, and ensuring that these procedures are used throughout the department.	The Office of Controller has issued timekeeping procedures for part-time physicians and reiterated in its newsletter the need for quarterly audits and proper completion of overtime requests. Policy is being developed to have reconciliations accomplished and have alternates maintain time and attendance records.
Strengthen control of timekeeper activities by assuring quarterly independent audits are conducted of time and attendance records and that these audits include reconciliation of overtime authorized and worked.	The Department of Medicine and Surgery has developed a policy, presently being circulated to obtain necessary concurrences, which reinforces the Controller's policies and requires field facility directors to institute procedures that will improve the monitoring and control of overtime.
Improve control over the use of overtime by ensuring proper completion and submission of overtime request forms, and by requiring adequate justification and reporting of work accomplished to management.	
Improve control of overtime payments and compensatory time. Make independent reconciliations	

Overtime, Part-Time, Time and Attendance (Con't.)

of records comparing overtime authorized and worked to employees' time and attendance reports.

Improve time and attendance record controls by having alternates maintain timekeepers' time and attendance records.

SECTION B - SUMMARY OF OPEN AUDIT REPORTS

All open VA internal and external audit reports as of December 31, 1979, are shown below. Internal audit recommendations summarized have all been concurred in by responsible program officials and are in various stages of implementation. The 103 open external audit reports include the 11 Predischarge Education Program (PREP) audits described in Chapter 3 and 92 contract audits for which we are awaiting the Record of Price Negotiation.

INTERNAL AUDITS

Days Unresolved	Open Audit Reports	Open Recommendations
0-90	12	86
91-180	25	229
181-365	11	81
365+	8	32
TOTALS	56	428

EXTERNAL AUDITS

Days Unresolved	Open Audit Reports	Dollar Costs ($ millions) Questioned	Unsupported	Open Recommendations	Awaiting Record Of Price Negotiation
0-90	35	$ 2.9	$ 2.0		35
91-180	18	7.4	.8	9	9
181-365	27	1.8	4.5	2	25
365+	23	.8	1.0		23
TOTALS	103	$ 12.9	$ 8.3	11	92

AUDIT REPORTS COMPLETED
SECTION A - INTERNAL

HEALTH CARE PROGRAMS

VA Medical Center, Indianapolis, IN
VA Medical Center, Palo Alto, CA
VA Medical Center, Lexington, KY
VA Medical Center, St. Cloud, MN
VA Medical Center, Baltimore, MD
VA Medical Center, Knoxville, IA
VA Medical Center, Topeka, KS
VA Medical Center, Hampton, VA
VA Medical Center, Butler, PA
VA Medical Center, Los Angeles (Wadsworth), CA
VA Medical Center, Dublin, GA
VA Medical Center, Manchester, NH
VA Medical Center, Iowa City, IA
VA Medical Center, Boston, MA
VA Medical Center, Lyons, NJ
VA Medical Center, Coatesville, PA
VA Medical Center, Amarillo, TX
VA Medical Center, Denver, CO
VA Medical Center, Portland, OR
VA Medical Center, Asheville, NC
VA Medical Center, Vancouver, WA
VA Medical Center, Highland Drive, Pittsburgh, PA
VA Medical Center, Fresno, CA
William S. Middleton Memorial Veterans Hospital, Madison, WI
VA Medical and Regional Office Center, Wilmington, DE
(Audit of Medical Center)
VA Medical and Regional Office Center, Wichita, KS
(Audit of Medical Center)
VA Medical and Regional Office Center, Fort William H. Harrison, MT
(Audit of Medical Center)
VA Medical Center, Providence, RI (Investigative Action
Report)
VA Medical Center, Fort Wayne, IN (Special Purpose Audit)
William S. Middleton Memorial Veterans Hospital, Madison, WI
(Special Purpose Audit)
VA Medical Center, Providence, RI (Special Purpose Audit)
VA Medical Center, Lyons, NJ (Maintenance Contracts)
VA Medical Center, Boston, MA (Maintenance Contracts)
VA Medical Center, Manchester, NH (Maintenance Contracts)
VA Medical District No. 10, Birmingham, AL
VA Supply Depot, Bell, CA
Potential Barriers to Sharing Underutilized Equipment and
Other Resources (Survey)
VA Silver Recovery Program

HEALTH CARE PROGRAMS

Procurement and Monitoring of Pacemakers
Patient Abuse at 16 Medical Centers
Patient Anti-Abuse Program, VA Medical Center, Waco, TX
Timekeeping Practices, VA Medical Center, Durham, NC
Review of Anonymous Letter Addressing Possible Fraud in the Veterans Administration (Health Care Information Systems ADP Procurement)
Maintenance and Construction Contracts, VA Medical Center, Washington, DC
Contract Hospitals, Nursing Homes and Satellite Clinics, VA Medical Center, San Juan, PR
ADP Installation Audit of VA Medical Center, Long Beach, CA

BENEFIT PROGRAMS

VA Regional Office, Chicago, IL
VA Regional Office, Louisville, KY
VA Regional Office, Nashville, TN
VA Medical and Regional Office Center, Wilmington, DE (Audit of Regional Office)
VA Medical and Regional Office Center, Fort William H. Harrison, MT (Audit of Regional Office)
Possible Multiple Compensation and Pension Benefit Payments, VA Data Processing Center, Hines, IL
Insurance Program Management Division at Regional Office Insurance Center, Philadelphia, PA

MEMORIAL AFFAIRS PROGRAMS

VA National Cemetery, Crown Hill, IN
VA National Cemetery, Danville, IL
VA National Cemetery, Keokuk, IA
VA National Cemetery, Quincy, IL
VA National Cemetery, Rock Island, IL
VA National Cemetery, Jefferson City, MO
VA National Cemetery, Camp Butler, IL
VA National Cemetery, Marion, IN
VA National Cemetery, Alton, IL
National Cemetery Area Office, Philadelphia, PA

FUNCTIONAL AND SUPPORT ACTIVITIES

Replacement Medical Center Construction Projects (Survey)
Review of Land Management Service, Office of Construction
Analysis and Control Division at VA Data Processing Center, Philadelphia, PA
Job Accounting Software, VA Data Processing Center, Hines, IL

FUNCTIONAL AND SUPPORT ACTIVITIES

Technical Assistance at the Data Processing Center, Philadelphia, PA
TARGET System Privacy and Security at Regional Offices
Review of Privacy and Security Pertaining to TARGET within Central Office
Privacy/Security at VA Data Processing Centers Processing TARGET Applications or Transactions
Audit of VA's Process of Identifying and Selecting Major and Minor Construction Projects
Clearance Procedures for VA Employees, VA Data Processing Center, Austin, TX
Extent of Competition in Procurement
Property Management, National Capital Region

AUDIT REPORTS COMPLETED
SECTION B - EXTERNAL

HEALTH CARE PROGRAMS

Rhode Island Veterans Home, Bristol, RI, State Home Procedures
University of Colorado, Scarce Medical Contract, VAMC Denver, CO
State University of New York, Downstate Medical Center, Scarce Medical Contract, VAMC Brooklyn (Brooklyn Division), NY
St. Louis University, Scarce Medical Contract, VAMC St. Louis, MO
Blinded Veterans Association, FY 1980 Contract Proposal
University of Minnesota, Scarce Medical Contract, VAMC Minneapolis, MN
University of Arkansas for Medical Sciences, Scarce Medical Contract, VAMC North Little Rock, AR
Western Nebraska Veterans Home, Grand Island, Scottsbluff and Norfolk, NE, State Home Procedures
University of New Mexico, Scarce Medical Contract, VAMC Albuquerque, NM
Teledyne Inet, Uninterruptable Power System, VA DPC Philadelphia, PA
University of Connecticut, Scarce Medical Contract, VAMC Newington, CT
Medical College of Wisconsin, Scarce Medical Contract, VAMC Wood, WI
University of Kansas Medical Center, Kansas City, KS, Manpower Grant 16-0093
University of California, Los Angeles, CA, Manpower Grant 4-0177 (4 audits - FY's 1975-78)
Reynolds, Smith & Hill, Training and System Installation in the Hospital Energy Control System (171 VA facilities)
University of Nevada, Reno, NV, Followup Review of Administration of Federal Projects
Leland Stanford Jr. University, Scarce Medical Contract, VAMC Palo Alto, CA
University of Utah, Scarce Medical Contract, VAMC Salt Lake City, UT
Albany Medical College, Scarce Medical Contract, VAMC Albany, NY
Stearns Roger Architects, Ltd., Proposal for Boiler Plant Design, VAMC Miles City, MT
University of Wisconsin, Madison, WI, Manpower Grant 27-0406
University of Missouri, Scarce Medical Contract, Harry S. Truman Memorial Veterans Hospital, Columbia, MO
University of California, Followup Review of Equipment Screening Procedures
University of Pennsylvania, Scarce Medical Contract, VAMC Philadelphia, PA (3 audits - 3 individual contracts)
Frontier Science and Technology Research Foundation, Inc., Statistical Collaboration for the Veterans Administration Lung Cancer Studies
Tufts New England Medical Center, Scarce Medical Contract, VAMC Boston, MA

HEALTH CARE PROGRAMS

Diversified Computer Service, Inc., Optimization of Compensation and Education Programs
University of Wisconsin Medical School, Scarce Medical Contract, William S. Middleton Memorial Veterans' Hospital, Madison, WI
Stewart Consultants, Inc., Management Consulting and Systems Coordination Services
University of Louisville, Scarce Medical Contract, VAMC Louisville, KY
Duke University, Durham, NC, Provide for Educational Materials Support at New Education Building, VAMC Durham, NC
Potomac Research, Inc., Programming Services for Integration of Improved Pension Reform Legislation
Galler Associates, Inc., Automated Prescription Processing Labeling Editing & Storage (APPLES) System Translation Conversion & Enhancement
Research Triangle Institute, Report & Statement of Direct Costs (2 audits - FY's 1977 & 78)
Sutherland Learning Association, Inc., Research on Problems of Alcoholism
University of Michigan, Scarce Medical Contract, VAMC Ann Arbor, MI
University of Nebraska, Scarce Medical Contract, VAMC Omaha, NE
Watkins & Associates, Update Secondary Electrical System & Replace Fire Claim System, VAMC Lexington, KY
University of Florida, Scarce Medical Contract, VAMC Gainesville, FL
Creighton University School of Medicine, Omaha, NE, Exchange of Medical Information Grant
Mt. Sinai School of Medicine, New York City, NY, Manpower Grant 32-0090
Leland Stanford Jr. University, Research Service Contracts for Personal Information System for the Blind; Robotic Aids for the Severely Disabled; Program to Improve the Restoration of Functions Following the Division and Subsequent Repair of Peripheral Nerves in Man; VAMC Palo Alto, CA
University of Washington, Seattle, WA, Evaluation of Internal Controls for the Administrative Data Processing Center
Oregon State University, Corvallis, OR, Followup Review to the Review of Financial Management Systems
Yale University, Review of Material and Supply Charges (Stockroom Issues Only) to Federal Grants and Contracts
University of Washington, Seattle, WA, Audit of the Financial Management Systems Used to Distribute Personal Services Costs Among Institutional and Federal Programs
University of California, Berkeley, CA, Followup Review of Controls Over Recharge Center Billing Rates
University of California, Berkeley, CA, Audit of Costs Transferred to Federal Projects
Georgetown University, Washington, DC, Review of Direct Costs Incurred Under Federal Research and Training Grants and Contracts
University of California, Scarce Medical Contract, VAMC Long Beach, CA

HEALTH CARE PROGRAMS

University of California, Scarce Medical Contract, VAMC Sepulveda, CA
University of California, Scarce Medical Contract, VAMC Los Angeles (Wadsworth), CA
University of Oklahoma, Scarce Medical Contract, VAMC Oklahoma City, OK
Creighton University, Omaha, NE, Costs Incurred Under Federal Research and Training Grants and Contracts, FY's 76-78
Hampton Institute, Hampton, VA, Manpower Grant 46-0025
University of Miami, Miami, FL, Application of Refined and Novel Prosthetic and Orthotic Fittings Techniques for Difficult and Unusual Problems of the Lower Limb
Eastern Virginia Medical Authority, Norfolk, VA, Manpower Grant 46-0266
Emory University, Atlanta, GA, Manpower Grant 10-0018
Emory University, Atlanta, GA, Manpower Grant 10-0289
University of Texas, Scarce Medical Contract, Audie L. Murphy Memorial Veterans Hospital (San Antonio), TX
University of Cincinatti, Scarce Medical Contract, VAMC Cincinatti, OH
Seminole Fire Department, Fire Protection Service, VAMC Bay Pines, FL

BENEFIT PROGRAMS

State Approving Agency, California Department of Education, Sacramento, CA
State Approving Agency, California Department of Industrial Relations, Division of Apprenticeship Standards, San Francisco, CA
State Approving Agency, Department of Labor, Albany, NY

FUNCTIONAL AND SUPPORT ACTIVITIES

Pearson, Humphries, Jones and Associates, Inc., Safety and Fire Deficiencies, VAMC Tuscaloosa, AL
Wright - Rich Associates, Inc., Ambulatory Care Addition, VAMC Dallas, TX
Hillmuth, Obata & Kassabaum, Termination Claim for Predesign Study for Replacement Hospital, John L. McClellan Memorial Veterans' Hospital, Little Rock, AR
Kaplan/McLaughlin/Diaz, Remodel Buildings 2, 4, and 200, VAMC San Francisco, CA
Lewis-Eaton, Renovation of Building 2, VAMC Biloxi, MS
LML Corporation, Contract Termination Settlement Proposal, VAMC Coatesville, PA
Heat Extractor Corporation, 42 Heat Recovery Systems for Various Medical Centers
Daft - McCume - Walker, Inc., Phase I - Architectural and Engineering Services, Quantico National Cemetery, Quantico, VA

FUNCTIONAL AND SUPPORT ACTIVITIES

Harry C. Partridge, J. R. Sons, Inc., Replacement of Windows and Stucco for Two Buildings, VAMC Perry Point, MD
Heapy and Associates, Technical Evaluation of Master Plan, VAMC Dayton, OH
Donovan Construction, Equitable Adjustment Claim, VAMC Phoenix, AZ
Hellmuth, Obata & Kassabaum, Construction Period Services for Replacement Medical Center, John L. McClellan Memorial Veterans' Hospital, Little Rock, AR
Gloster & Gloster, Correct Fire and Safety Deficiencies, VAMC Northport, NY
Beardsley & Beardsley, Renovate Patients Building, VAMC Canandaigua, NY
Robert E. McKee, Inc., Construction Consultant Services for Replacement Medical Center, VAMC Portland, OR
NBBJ, Preliminary Drawings for Replacement Hospital, VAMC Seattle, WA
NBBJ, Working Drawings for Replacement Hospital, VAMC Seattle, WA
Williams & Tazewell and Perkins & Will, Design Solar Energy Alternate for Replacement Medical Center, VAMC Richmond, VA
Glankler & Broadwell, Clinical Improvements & Relocation of Support Function, VAMC Alexandria, LA
Katz Waisman Weber & Bertone Pineless, Fire and Safety Deficiencies, VAMC New York, NY
Wright & Kremers, Inc., Outpatient Clinic Expansion, VAMC Buffalo, NY
Stetson - Dale, Patient Support System, VAMC Albany, NY
Polote Builders, Inc., Proposal for Service Building and Site Work, Chattancoga National Cemetery, Chattancoga, TN
Charles Construction Co., Inc., Boiler Replacement, VAMC Manchester, NH
Bernard Johnson, Inc., Dead End Stairs, VAMC Waco, TX
W. S. Fidelity Guaranty Co., Replacement of Air Conditioning System in Surgical Suite, VAMC Boston, MA
RTKL Associates, Inc., Delay Claim, VAMC Baltimore, MD
Rochlin & Baran, AIA & Associates, Proposal for Renovation of Domiciliary Buildings, VAMC Los Angeles (Wadsworth), CA
Ingleside Contractors of Maryland, Inc., Delay Claim, VAMC Perry Point, MD
Skidmore Owings and Merrill and Zimmer Gunsel Frasca Partnership, Design Services for Replacement Hospital, VAMC Portland, OR
Elkhorn Construction Co., Default Termination, Modification of a Sewage Collection and Treatment Facility, VAMC Fort Lyon, CO
Environmental Planning and Design Partnership, Develop 20 Acres and Administration and Service Buildings - Phase I, Indiantown Gap National Cemetery, Annville, PA
A&S Air Conditioning, Equitable Adjustment Claim for Contract Delay, VAMC Sepulveda, CA
Smith, Miller & Associates, Inc., Proposal for Working Drawings for 3 Elevators, VAMC Wilkes-Barre, PA

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FUNCTIONAL AND SUPPORT ACTIVITIES

Ritchie Associates Inc. & Ellerbe Associates Inc., Modernization of Building I, VAMC West Roxbury, MA
The Ratcliff Architects, Surgical Addition, VAMC Palo Alto, CA
Grinnell Fire Protection Systems Co. Inc., Preliminary Sprinkler Drawings for Replacement Hospital Building No. 100, VAMC Bronx, NY

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	5.4	17
Reactive investigations	26.6	83

SPECIAL INITIATIVES FOR FRAUD, WASTE AND MISMANAGEMENT

Loan Guaranty. All temporary investigators from the loan guaranty task forces which had been investigating fraud in the loan guaranty program in five geographic areas during the past few years have been released. Several cases which were initially targeted by the temporary task forces were completed during this reporting period. Investigations of seven lenders involving forty-nine individual loan guaranty cases were completed, and work continues on a few remaining cases.

We indicated in our previous report that we and the HUD Inspector General agreed that a free exchange of information regarding irregularities in housing matters was essential for determining where major problem areas exist, especially in matters where irregularities were found on the parts of brokers and lenders dealing with both the VA and HUD. As the result of several meetings between VA and HUD Inspector General staffs, a joint VA/HUD audit and investigative effort has been initiated in San Juan, Puerto Rico. Findings thus far indicate that most of the irregularities involve "sales of entitlement" whereby a qualified veteran poses as the buyer of a property using his VA benefits. The veteran is paid in amounts of up to $500 by the broker or lender involved in the transaction, and after the loan is closed, the property is transferred to a non-veteran or abandoned. The scheme also involves the submission of false verifications of employment showing inflated earnings by the veteran, thereby allowing an otherwise ineligible veteran to qualify for the purchase of a property. Further details regarding this project are contained in Chapter VI.

Education. The Office of Investigation has been cooperating with the U. S. Army Investigation Command to obtain necessary information regarding VA benefits being paid to soldiers attending

an overseas branch of an American college which is suspected of serious irregularities. We are now exploring the possibility of conducting a special initiative investigation, possibly in concert with U. S. Army Investigators, to determine if there are similar fraudulent practices being conducted by this college at military installations in the United States. Further information regarding this school is contained in Chapter VI.

REACTIVE INVESTIGATIONS

Twenty-six investigations involving allegations of serious administrative or criminal irregularities were completed during the past six months. Twelve of the investigations were predicated upon complaints received from VA employees and officials, six of which were received on our "Hotline". Four of the investigations were referred by the Office of Audit, three by Members of Congress, and two by other government agencies. Of the remaining four cases, two resulted from anonymous complaints and two were requested by the VA's Board of Veterans Appeals.

Investigations into pacemaker procurement and monitoring services revealed that three VA physicians at two VA Medical Centers were involved in apparent conflicts of interest in performing evaluations of pacemakers for manufacturers. The physicians were paid by the manufacturers for these evaluations without the VA's knowledge. They also improperly released information concerning the VA patients involved to the manufacturers in violation of the Privacy Act, and in some instances improperly used VA patients for research. An investigation into the activities of another VA physician revealed he was using VA time, vehicles, secretarial help, franked mailing privileges and reproduction equipment in pursuit of non-VA activities. A fourth investigation, which also involved a physician, revealed he had improperly obtained a sizable amount of drugs from a VA Medical Center pharmacy and from other outside sources for his own use. The doctor also admitted accepting gifts from a former VA patient, obtaining unauthorized medical care for himself and his dependents, and authorizing sick leave for a VA Medical Center Director without conducting an examination or having evidence of the Director's alleged illness.

Two former contracting officers at a VA Medical Center were found to have shown favoritism and were involved in conflict of interest in the awarding of contracts. An Engineering Service Chief at another VA Medical Center failed to follow proper contracting procedures in the awarding of contracts totaling over $430,000. Other investigations involved a Medical Center Director and Engineering Service Chief who circumvented VA regulations in building renovation projects; improper handling of research funds by a VA physician; and allegations of patient abuse and negligent care at a VA Medical Center.

A few investigations involved irregularities in Department of Veterans Benefits activities. One significant investigation involved conflicts of interest on the parts of two VA loan specialists at a VA Regional Office who used their positions to surreptitiously gain title to two VA portfolio properties and who used unethical means in selling one of the properties and in attempting to sell the other. Another investigation involved allegations that personnel at a state college suggested to a veteran's wife that educational assistance benefits could be avoided if she attended classes in his stead. Allegations in this case were not sustained.

Other investigations involved various services, including the Office of Construction and the Department of Memorial Affairs. A Cemetery Director utilized VA material, equipment, and personnel for his own personal use, and an Office of Construction official used questionable judgment in contracting activities.

Thirty-three investigations are currently in process, two of which, a patient abuse matter at VAMC Waco, Texas, and an investigation of law enforcement capabilities and activities at VAMC Palo Alto, California, have had considerable Congressional interest and press coverage. Reports regarding these two investigations are being prepared. Eighteen additional investigations involving serious irregularities at VA facilities and in VA programs are awaiting assignment.

LABORATORY EXAMINATIONS

The Office of Investigation continues to operate a technical laboratory for the examination of official documents, handwriting, handprinting, typewriting, inks, papers, films and various other questioned material. The laboratory renders expert opinions concerning the authenticity of the various materials submitted. In addition to providing technical support for the Office of Investigation, cases are submitted directly to the laboratory from all VA activities and involve all major benefit programs administered by the VA: education, loan guaranty, insurance, compensation and pension. The purpose of these submissions is for the laboratory to detect any evidence of fraud in claims for VA benefits.

During the reporting period, the laboratory completed 153 laboratory cases consisting of 1,448 technical examinations. Seventy-one of these cases involved contested insurance claims amounting to approximately $700,000 in insurance coverage. Sixteen of these cases were identified as being fraudulent, and the laboratory findings helped to prevent improper or duplicate insurance payments and litigation costs that otherwise would have been encountered. Thirty-two cases involved home loans to veterans of which twenty-two were found to contain one or more fraudulent loan documents. The VA loan liability ranged from $12,500 to $25,000 in these cases. As a result of the laboratory examinations, the Loan Guaranty Service terminated their loan liability

in four cases amounting to a total of $70,000, recouped $24,948 plus 7 percent interest in four other cases, and saved approximately $16,000 in acquisition, management and resale costs. In ten cases involving medical records, x-rays or other documents submitted by claimants for benefits, the laboratory found seven cases in which fraudulent material was submitted in support of claims. The laboratory examinations were instrumental in preventing improper payments ranging from about $1,600 to $2,400 per year in each of these cases. Among the remaining cases, there were ten in which the laboratory found evidence of fraudulent documentation in hospitalization claims, education claims, and in investigations involving employee irregularities. The findings in these cases resulted in the prevention of improper benefit payments and/or the identification of VA employees involved in irregularities.

REFERRALS TO THE DEPARTMENT OF JUSTICE AND STATE LAW ENFORCEMENT AUTHORITIES

The table on the following page shows referrals to the Department of Justice and state law enforcement authorities during the six-month period, and action 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 the 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	67	53	15	11	$ 34,192
	Loan Guaranty	158	111	1	5	323,950
	Compensation & Pension	52	42	3	5	14,579
	Insurance	2				
	Medical	51	42	2	1	2,820
	Contract	2	2			
Theft		10	4	4	4	64,667
All Other		33	12	17	5	120
		375	266	42	31	$440,328

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

CHAPTER V

VULNERABILITY ASSESSMENTS.

The Risk Analysis Staff, established to assess vulnerabilities to fraud, waste and mismanagement of Agency programs, functions and activities, performed analyses affecting the medical programs, and followed up on previous assessments in the benefit programs.

DRUG LOSSES AND ACCOUNTABILITY

Risk Analysis completed an assessment of drug losses and accountability. Based upon DM&S draft vulnerability assessments, drug programs are most vulnerable to dollar loss. In FY 1979, $225 million was spent on these programs.

Based on available information from FY 1978, the estimated dollar loss for drugs which may be stolen, dispensed without appropriate records, destroyed without correcting records, or otherwise lost is $18 million. This consists of $17.4 million which occurs in hospital inpatient medication distribution systems, and $.6 million in station warehouse inventories. An additional cost of $4.7 million from filling prescriptions on a fee-for-service basis could be substantially reduced through identification and elimination of program abuses, such as paying excessive drug charges, prescribing excess quantities of medications and participation by ineligible veterans. DM&S concurred with a 1975 GAO recommendation to reduce inpatient drug losses by implementing the unit dose medication distribution system; however, by FY 1978, only 13 percent of VA pharmacy issues were unit dose dispensed. DM&S policy requires that every effort be made to utilize VA pharmacies for prescription services. Yet, for the past eight years, the percent of fee-basis medical prescriptions dispensed by VA pharmacies has, essentially, remained the same. Options and recommendations proposed in this report could significantly reduce drug dollar loss.

Losses due to duplicate prescriptions constitute a multi-million dollar problem; however, existing information is too limited to develop a reasonably reliable systemwide estimate of the loss. To prevent issuance of duplicate prescriptions, in March 1976, Management Engineering Service recommended that the APPLES computer system be expanded nationwide. Since that recommendation, APPLES has only been expanded to Medical District 26 (7 of 202 sites). DM&S currently plans to install a more comprehensive pharmacy system during FY 1980 which would include the capability for preventing issuance of duplicate prescriptions.

An inventory accountability system, that could account for all drugs or drugs involved in major dollar losses as they flow through the system, does not exist. FY 1978 losses of

posted drug stock amounted to $.6 million; however, the magnitude of drug dollar loss for other than posted stock can only be estimated and only when sufficient information exists for such an estimate. Because of this limitation, no estimates were attempted for the following areas of known drug loss:

a. unposted drugs,

b. outdated drugs not reimbursed by manufacturers,

c. drugs in long supply that cannot be used by other stations,

d. drugs in VA pharmacies lost from such causes as pilferage, theft, robbery, and prescription fraud, as well as drug issues to ineligible beneficiaries and employees, and

e. drug losses on wards which utilize unit dose. An inventory accountability system is needed to account for all or high dollar loss drugs as they flow through the system.

Department and Staff offices comments delineated steps that would be taken to (i) prevent issuance of duplicate prescriptions, (ii) reduce costs of the Fee-Basis Pharmacy Program, and (iii) establish a more comprehensive inventory accountability system. In late February 1980, the Inspector General briefed the Administrator and other top Agency officials on report findings and comments. The Administrator asked DM&S to study the feasibility of a modified unit dose system VA-wide and to provide him with a progress report in 90 days. In concert with this effort, DM&S is preparing Congressionally requested cost estimates for complete unit dose conversion in one year. Thus, the pace and degree of unit dose implementation remain unresolved issues as of this reporting.

TIME ACCOUNTING OF PART-TIME PHYSICIANS

A special study was performed to ascertain the accuracy of the time accounting for part-time physicians employed by the VA. This review analyzed findings from audit reports, investigative reports, employee Hotline allegations as well as information obtained from DM&S. The analysis also considered the standard timekeeping practices under Title VI, U.S.C., as well as the Circular 00-79-23, Adjustable Work Hours for DM&S Part-Time Physicians.

The review of employment policy for part-time physicians indicates accountability improvements are needed in timekeeping procedures to accommodate the unique needs and varying circumstances at VA health care facilities. For example, part-time surgeons at active affiliated facilities with extensive patient care, research, and educational responsibilities frequently encounter emergencies and other unanticipated obligations that require them to depart or deviate from their scheduled tour of duty. Since

many of these employees rotate between VA and non-VA medical facilities during normal business and non-business hours, it is difficult to accurately maintain a record of time in pay status for physicians on a daily basis by designated employees who, because of differences in physical locations, may seldom see or observe work hours of the physicians.

Furthermore, the Circular 00-79-23 has not alleviated the timekeeping accountability problems even though the prescheduled tours of duty have been made more flexible. Only 15 facilities have implemented the circular placing only 330 part-time physicians under the adjustable work hour provisions. The most critical comments received from the various facilities not using the circular indicated that the daily sign-in/signout requirement was unacceptable to the physicians as being unprofessional.

Therefore, we proposed a modification to the circular which would keep the flexibility of the adjustable work hours; would meet the definition of "part-time" through prescheduled "core" hours necessary for leave and benefit calculations; and, would provide direct accountability to the part-time physicians for actual hours worked or leave taken.

This direct accountability is obtained through use of a subsidiary timesheet which is maintained by the part-time physician on a daily basis but submitted to the unit timekeeper on a weekly basis after being certified correct by the physician and initialed by his/her supervisor before it is posted to the official time and attendance report.

Presently, the Controller, with the help of Personnel Regulations Division and the Associate Chief Medical Director for Professional Services, is preparing the subsidiary time record form with an accompanying cover letter which has been submitted to GAO for review. Unless there are objections from GAO, this new procedure should be implemented for all part-time physicians employed by the Department in the near future.

ESTABLISHING ELIGIBILITY FOR EDUCATION BENEFITS

Last fall the Risk Analysis staff completed an analysis of DD Form 214, Report of Separation from Active Duty, to determine whether (i) fraudulent forms were being used to obtain benefits, and (ii) any other vulnerabilities existed in determining eligibility to education benefits. This analysis supplemented reviews of DD 214s performed by the Office of Investigations, using information obtained from a computer match with the Department of Defense. In concluding our study, we recommended that the DVB review approximately 12,000 claims that were identified as containing a potential bar to benefits to determine whether they were paid in error. One type of error we found consisted of Chapter 34 records which contain an Entered on Duty date later than 12-31-76, which is the expiration date of

eligibility for Chapter 34 benefits. DVB initiated a computer project identifying all such cases for review of eligibility. The project generated 9,245 cases which were sent to regional offices for review. Sixty-five percent of these cases have been reviewed to date. A total of 280 claims were found to be paid in error, involving erroneous payments of $249,555. Stop payment actions were initiated to prevent further overpayments.

DVB has also developed instructions and reporting procedures to review the 11,500 cases that contain a potential bar to benefits. This review is now in process. The first report of cases reviewed on this project is due in Central Office by May 1, 1980.

PENSION ACCURACY

The Department of Veterans Benefits has developed an ongoing sampling instrument to verify the accuracy of beneficiary reporting and VA payments. The Pension Verification Program is an outgrowth of the 1978 Pension Benefits Accuracy Study which identified an overall error rate of 26.2 percent; 15.9 percent of the cases involved underpayments and 10.3 percent involved overpayments.

During January and February 1980, the Department pretested the program at the regional offices. At that time, our review of three offices indicated satisfactory implementation. Currently, the Department is compiling this data; subsequently, the Office of Audit will provide further analysis. The annual process of sampling will extend from April to November of each year.

CHAPTER VI

INTERAGENCY ACTIVITIES

The Office of Inspector General is active in various activities which have improved coordination and cooperation among Federal, state and local audit groups. The Assistant Inspector General for Auditing serves on the executive committee of the National Intergovernmental Audit Forum and Field Office Directors are active in Regional Intergovernmental Audit Forums.

During this period we have participated in various interagency projects, some of which are covered elsewhere in this report. They are: (i) an audit of furniture with 17 other agencies which was led by the GSA Inspector General, (ii) a joint audit/investigation with the HUD Inspector General of VA's Loan Guaranty and HUD's Federal Housing Authority programs in Puerto Rico, and (iii) an investigation with the U.S. Army Criminal Investigation command of irregularities on the part of an American college which has a branch office in a foreign country. The other specific projects are:

a. A project to establish a working relationship with state audit groups was developed and is ready for implementation. The project is designed to: (i) coordinate audit activities with state officials, reduce duplication of effort, exchange reports, plans and schedules and establish procedures for the exchange of information concerning possible fraud and abuse in programs; and (ii) explore the possibility for joint audit efforts and contracting with the states for audits. We have received responses from 33 states and the District of Columbia indicating a willingness to cooperate in this effort, and anticipate responses from the remaining states soon.

b. At a meeting of Inspectors General, the VA was selected to take initial lead responsibility for establishing an interagency, proactive effort to identify and investigate educational institutions which may be involved in fraud against multiple Federal programs. In January 1980 we met with IG representatives from the Department of Labor and the Department of Health, Education and Welfare. As a first step, each Inspector General is to compile a list of schools which his agency has been particularly concerned about because of a past history of abuse, irregularity or other problems. Comparison of these lists should disclose whether there is sufficient potential for fraud, waste or abuse in multiple programs to warrant an interagency effort.

c. Our Risk Analysis Staff is developing procedures for a governmentwide computer match between Office of Personnel Management Central Personnel Data File and VA accounts receivable and pension records. The purpose of the match is to identify Federal

government employees who have received and failed to repay benefit overpayments or loans from the VA and are, therefore, indebted to the VA.

We are working closely with Office of Management and Budget staff so as to comply with the "Guidelines for the Conduct of Computer Matching Programs" dated March 30, 1979. Also, the Inspector General's staff of HEW has given us considerable help in the early stages of this project based on their considerable prior experiences in similar matching programs.

d. At the request of the National President of the Association of Government Accountants, two members of the Office of Audit staff are presently serving on the Task Force on Proposed Standards for Executive Reports on Internal Control. The task force mission is to help the General Accounting Office establish standards for annual internal control reports prepared by chief executive officers of Federal departments and agencies.

e. The Office of Audit played a leading role in developing an interagency training course for Federal, state, and local government auditors to address the prevention and detection of fraud and abuse. From late 1978 until mid-1979 an interagency task force under the leadership of one of our auditors conducted research, formulated lesson plans, developed case studies, and assembled study material. The resulting three-day course, entitled "The Prevention and Detection of Fraud and Abuse--An Awareness Course for Auditors," is administered by the Interagency Training Programs of the U.S. Department of Agriculture Graduate School. Since the Graduate School first offered the course in October 1979, response from all sectors of government has been favorable. As of March 28, 1980 a total of 290 government auditors have completed the course which is given an average of three times a month at various locations throughout the United States.

CHAPTER VII

REVIEW OF LEGISLATION AND REGULATIONS

NEW LEGISLATION AND REGULATIONS

During the past 6 months, we reviewed 39 bills and 28 proposed regulations. We submitted comments on 12 of the bills and 2 of the regulations, including the following:

We suggested that VA's proposed Regulation 15064, "Refund Upon Disenrollment," which implements 38 U.S.C., Chapter 32, be strengthened by adding a provision whereby the VA could offset any outstanding overpayments before refunding the amount remaining in an individual's account. This suggestion was adopted.

H.R. 6153 would amend 38 U.S.C. to permanently establish the special pay provisions for physicians and dentists of the VA in order to enhance the recruitment and retention, and for other purposes. This proposed legislation could be made more effective and economical if criteria for a periodic administrative review were added to provide for the adjustment of special pay provisions in light of the needs as shown in the marketplace. Also, if the provision to increase the annuity credit by "an additional year for completion of not less than one year of post-graduate training" remained as stated, the physician or dentist could obtain this training at or near the end of his VA employment, thus depriving the veteran patient of any benefit.

We reviewed H.R.6327, H.R.8581, and S.1872 dealing with GI Bill amendments, including the provision to expand "readjustment benefits for Vietnam-era veterans by promoting employment of such veterans through a program of job vouchers." The program, to be established by the proposed legislation, could be particularly vulnerable to fraud and abuse by employers acting alone or in collusion with eligible veteran employees. However, these vulnerabilities could be minimized by compliance reviews, if such compliance reviews would be fairly frequent and intensive; i.e., beyond the usual scope and depth expected of compliance reviews. Thus, the administration of such a program would be labor intensive and relatively expensive.

S.1188 to amend Chapter 31 of 38 U.S.C., Vocational Rehabilitation was also reviewed. This proposed legislation corrected deficiencies enumerated in GAO's report "New Legislation and Stronger Program Management Needed to Improve Effectiveness of VA's Vocational Rehabilitation Program." However, there were two areas which could have been, but were not covered in this proposed bill.

The first area has to do with entry criteria into the program. The GAO found these criteria to be lenient and we noted that Section 1502 of the proposed bill provided more leniency by eliminating the wording "Every veteran who is in need...."

The second area involved those veterans rated "individually unemployable." There appears to be great financial disincentive for this group to seek employment after vocational rehabilitation training because of the reduction in VA compensation benefits once employed. To minimize this, a provision should be included in this bill that requires comprehensive diagnostic evaluation of the veteran's rehabilitation.and work potential before they are considered for this rating, as GAO recommended.

Our review of the draft bill, "Regulatory Cost Accounting Act of 1980" showed that it contained weaknesses which could inhibit the economical and efficient operation of VA programs. One weakness was that the proposed bill did not attempt to measure the benefits of regulatory activity. For example; in the VA, certain forms and practices are required, but their purpose is to insure proper payments of benefits to eligible beneficiaries and to insure quality care for medical patients. In addition, the Federal sector does have an impact on private sector productivity; however, the precise magnitude of government regulation in distorting markets is not understood. The proposed bill lacks a balanced analytic approach to this problem while imposing excessive costs on the Agency. Also, the benefits proposed by this bill have an unknown impact on the timely and proper delivery of services.

Further, we reviewed several proposed bills concerning privacy of medical records; e.g., H.R.2979, H.R.5381, H.R.3444 and H.R.5935. H.R.2979 would adversely impact on the economy and efficiency of involved Government agencies. For example, Sec. 102(b)(1) would result in continued prevention of Federal, state and community Methadone Maintenance Programs from sharing names of participants. This ability to share information between the various programs is needed to prevent drug patients from participating in multiple methadone programs, and selling the dosages received in excess of their own needs. Subsequently, we reviewed the other related bills in conjunction with other Inspectors General. One alternate proposal, H.R.3444, would provide a practical alternative to the objections raised to H.R.2979.

We reviewed several other legislative proposals at the request of the Inspectors General Legislation and Congressional Relations Committee. S.1878 and H.R.2659, "General Accounting Office Act of 1979," were reviewed at the request of this committee. If enacted, this proposed legislation would hamper Inspectors General should an occasion arise to investigate allegations of irregularities concerning unvouchered expenditures,

e.g., any expenditure accounted for solely on the approval, authorization or certificate of the President or an official of an executive agency. At this time it would be difficult to project what impact the proposed legislation would have on the workload of the various IG offices.

S.240, the Computer Fraud Bill was reviewed. This bill has merit, and publicity at the time of passage and on a continuing basis could reduce efforts to abuse systems covered by the Act. However, we suggested that the bill be strengthened by adding a forfeiture provision which would permit the government to seize the assets or property acquired through a computer fraud scheme.

Review of the civil money penalty provisions of H.R. 5381 identified that the proposed penalties may be subject to inequitable application because of the variance in the types and amounts of penalties.

EXISTING LEGISLATION AND REGULATIONS

Reviews of existing legislation and regulations occur during an audit or investigation when the underlying causes for fraud, waste, or mismanagement are traceable to these sources. As a result of our analyses made during the last six months, we concluded that changes in legislation, regulations, or Agency policy were needed to enhance the efficiency and economy of current operations and to reduce the opportunities for fraud and abuse in some activities and programs. These matters were discussed in preceding chapters of this report.

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CHAPTER VIII

INSPECTOR GENERAL'S HOTLINE FOR VA EMPLOYEES

The Inspector General's Employee Hotline is in operation 24 hours a day, seven days a week. The system utilizes recording equipment outside of normal business hours. Since February 15, 1979, its inception, to March 31, 1980, there were 885 hotline contacts processed from 198 VA facilities. These contacts included 689 allegations from the VA hotline and 196 referrals from GAO.

Over three-fourths of the complaints were classified in the following 5 of the 18 established categories:

Hotline Category	Number of Contacts
Employee Misconduct	223
Wasteful Practices	144
Employee Grievance	114
Personnel	98
Beneficiary Abuse*	98

The allegations originated from 198 locations and were categorized by the following:

Type of Facility	No. of Allegations	Percent
Medical Centers	621	70
Regional Offices	181	20
Central Office	24	3
National Cemeteries	5	-**
Outpatient Clinics	19	2
Data Processing Centers	7	1
Other	16	2
No Specific Location	17	2
TOTAL	890***	100

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* In the category of beneficiary abuse, 80 of the 98 contacts were referrals from GAO. Many of these complaints were made by individuals who apparently do not fully understand that beneficiaries are not necessarily precluded from earning additional income when receiving compensation or pensions. In only ten of the closed cases have the allegations been substantiated.

** Less than one percent.

*** Some hotline contacts have allegations affecting more than one location.

Seventy percent of the 885 hotline contacts involved VA Medical Centers. Seventy-seven percent of those cases cited a particular service within a medical center in their complaints. In all, 42 services were mentioned; however, 10 services comprised 63 percent of all medical center cases.

Most Frequently Cited Organizational Elements in Medical Center Cases

Service	Number	Percent
Medical Center Management	67	11
Engineering	58	9
Nursing	56	9
Personnel	37	6
Pharmacy	34	5
Building Management	33	5
Medical Administration	32	5
Supply	30	5
Mental Health & Behavioral Sciences	27	4
Dietetics	24	4
TOTAL	398	63

Seventy-eight percent of all contacts have been closed as of March 31, 1980. Of these closed contacts, 24 percent have been closed with no reply requested, i.e., they were considered non-hotline matters (employee grievance). Fifty percent of all complaints were unfounded, while twenty-six percent were closed as founded or partially founded.

In addition, 219 of the complaints were considered serious or substantive in nature. Of these, 59 were referred to the Office of Audit, 73 were referred to the Office of Investigations, and 87 were referred to other appropriate departments or staff offices for handling. With the exception of staffing, these serious complaints were in all of the other established categories. Employee misconduct, theft of government goods, and the wasteful practices categories represent the majority of the serious complaints.

Fifty-seven percent of the 219 serious complaints have been closed. Of these, 22 percent were founded or partially founded; that is, all or part of the allegations were found to be true. Some examples are:

- A psychologist was found to be seeing private patients while supposedly on part-time duty at a VA medical center. The individual was charged appropriate leave and received an official reprimand. The doctor has since resigned.

- Allegations of time and leave abuse led to an investigation of a part-time VA Medical Center physician. The results of the investigation found that the doctor had been using duty hours to prepare for his lecture tours and had been using unauthorized leave for those lectures. The physician's immediate supervisor signed the time and leave record without assurance that the doctor had performed his required duties. The doctor's employment was terminated.

- Allegations were made that a veteran was receiving benefits to which he was not entitled. Review of the compensation award showed that the veteran had been overpaid by nearly $1,000 for claiming his former wife as a dependent when such was not the case. The overpayment is being deducted from the adjusted award.

- Caller alleged that a mentally disabled veteran was due monies from a relative's estate and that the guardian had defrauded him. While the charge did not initially appear to be VA related, followup action was taken which assisted the veteran in locating the court of jurisdiction so that he could review his estate accounts filed by previous guardians. Further investigation revealed that payments withheld by VA (in accordance with regulations), while the veteran was hospitalized, had not been resumed when he was discharged. The veteran, now declared competent, has been paid the approximately $16,000 due him from the withheld funds.

- Allegations were made that nursing service was understaffed at a psychiatric unit resulting in possible danger to staff and patients. Action was taken to reorganize the unit and reactivate the committee on violent patients. A recent nursing ceiling increase will assign more than half of the new employees that will be hired to the psychiatric service.

- A therapist was using the telephone for personal business and constructing personal projects in the VA shop during working hours. This employee was issued an admonishment and, where identifiable, billed for personal long distance telephone calls.

CHAPTER IX

OTHER REPORTS TO CONGRESS

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 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.

Based on these criteria, the Office of Inspector General did not identify instances that are pertinent to the statutes established by this section of the Act for the period of October 1, 1979 - March 31, 1980.

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.

APPENDIX

LETTER OF TRANSMITTAL

Office of Inspector General

Washington, D.C. 20420

Veterans Administration

MAY 5 1980

Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

At my confirmation hearing on April 6, 1979, you issued a series of challenges to be addressed by my office over the subsequent year. I am enclosing details regarding our accomplishments in relation to each of these challenges, as follows:

Enclosure

1	Accounts Receivable
2	Pension System
3	Grants for Health Manpower Training
4	Audits of Medical Centers
5	Specialized Medical Programs
6	Loan Guaranty Program
7	TARGET

I agree with the view you expressed at the confirmation hearing that the challenge to significantly reduce accounts receivable is the top priority. Not only has my office given it this level of attention, but also extensive efforts have been made by the Chief Benefits Director, General Counsel, Controller and their staffs. The objective to reduce accounts receivable by 50 percent has, however, proved to be most elusive. The actions which have been taken or are planned for implementation shortly will result in a further decline in education accounts receivable, but we do not expect that decline to reach a 50 percent reduction. The problem is that the corrective actions available to VA have impacts measured in terms of ones or tens of millions of dollars, rather than the hundreds of millions needed. This should not, however, detract from the worthwhileness of aggressively addressing these smaller impact opportunities.

As Enclosure 1 indicates, there are no options known to us that have large impacts other than the proposal to use tax refund offsets. This

In Reply Refer To: (50)

option is being studied by the OMB Debt Collection Project being conducted for the President's Management Improvement Council. I am hopeful that when the project is completed in August 1980, it will include an endorsement of this approach.

One other objective that I particularly want to bring to your attention is the one related to conducting audits of VA medical centers on a three year cycle (Enclosure 4). While we came very close to this objective -- missing by about 5 percent -- it has become increasingly clear that we cannot keep up this pace in the future. The loss of resources to our Office of Audit during FY 1979 totalled 21 positions, a drop in authorized strength from 295 to 274. Meanwhile, new workloads have been added, without adding the 10 positions we estimate would be necessary to stay even. This new workload, which will impact on our future operations, consists primarily of the ADP security audits required by OMB Circular A-73.

We are also finding high payoffs in other types of audits we are doing and do not feel these should be foregone to overly concentrate on the medical centers.

We tried a different audit approach in the last six months which consisted of more limited scope cyclical audits of medical centers targeted at selected areas. This allowed us to reduce the staff days for each audit from 275 to 150. The audit results were quite good, but we have concluded that this approach lacked sufficient flexibility to address other serious problems observed or suspected that fell outside the targeted scope. It is unacceptable to us to wait for the next cycle three years hence to address such issues.

We have concluded that a better balance of our efforts will be attained by reducing the cycle frequency for medical centers to about a 5 year cycle. I have advised the Administrator of the reasons for this change. Also, we sought resources, unsuccessfully, in FY 1981 Zero Base Budget to support a 3 year audit cycle and workload growth due to new programs. We will do so again in FY 1982, but I am not optimistic about our prospects for obtaining such a resource increase.

I look forward to appearing before the Committee on June 11 to discuss our progress and accomplishments and to respond to questions of continuing concern.

Sincerely,

ALLAN L. REYNOLDS
Inspector General

Enclosure

ENCLOSURE 1

ACCOUNTS RECEIVABLE

Objective: Reduce accounts receivable by 50 percent by March 31, 1980 and propose a plan to resolve the balance.

Background: As of March 31, 1979, VA accounts receivable for education, compensation/pension and loan guaranty programs were $577 million, of which education accounted for $398 million. Defaults on education loans at that date amounted to $7 million.

Accomplishments: Following is a comparison of accounts receivable as of March 31, 1979 and 1980.

	3/31/79	3/31/80 (in millions)	Difference (in millions)
Education			
Accoounts receivable	$398.4	$405.8	$ 7.4
Less:			
(1) accounts in a repayment status	52.0	80.2	28.2
(2) accounts referred to Department of Justice	38.0	61.9	23.7
Total subject to further collection action *	$308.2	$263.7	$ 44.5
Compensation/Pension and Loan Guaranty			
Accounts receivable	$178.6	$214.6	$ 36.0
Less:			
(1) accounts in a repayment status	75.0	85.1	10.1
Total subject to further collection action *	$103.6	$129.5	$ 25.9

* Accounts receivable subject to further VA collection action are, we believe, the proper measure of accounts receivable as they are adjusted for (1) accounts on which no further collection action is currently needed, and (2) accounts on which no further collection action can be taken by VA.

Defaults on education loans increased from $7 million to $18 million during the year.

The efforts to meet this objective by the Office of Inspector General have been directed at (i) exploring what can be done to avoid overpayments, and thereby avoid the creation of accounts receivable, and (ii) identifying what can be done to increase collections of existing accounts receivable.

Preventing Overpayments

1. We found that education overpayments of about $49 million (based on FY 78 program activity) could be prevented and ultimately a loss of about $5.4 million could be avoided. The latter results from VA's recently experienced rate of uncollectability for about 11 percent of the accounts receivable. This $49 million in overpayments can be avoided by adopting mail intercept procedures. The Postal Service will, if requested, stop delivery of erroneous benefit checks when VA learns of a change in eligibility too late to stop preparation and mailing of a benefit check, but prior to delivery of that check. Our tests indicated that this situation was occurring for 18.7 percent of all education overpayment amounts and that mail intercept procedures would be about 75 percent effective in such situations. As the result of our recommendations, on November 8, 1979, the Department of Veterans Benefits issued DVB Circular 20-79-25 providing detailed instructions for using mail intercept for education, compensation and pension benefit checks. The Department took action to emphasize the importance of immediately implementing these procedures. Subsequent experience indicates that the actual success rate of mail interception is varying in the range of 50-75 percent so the actual dollars in overpayment avoided will be less than the $49 million estimate, but still be quite significant.

2. We have recently issued a draft audit report to the Department of Veterans Benefits which recommends the additional actions to avoid overpayments by speeding up processing and adjustment/termination actions when notified of change in status which effects educational benefits. Our tests, based on a nationwide sample, indicate that average timeliness for termination actions ranged from 10 to 17 days and the timeliness for actions to reduce benefits ranged from 17 to 19 days. We are recommending actions which will set and observe priorities on timeliness for processing such transactions. This, coupled with the increasing availability of the TARGET system which provides the most expeditious means for deleting or adjusting benefit payments (TARGET cuts 4 days off previous systems) should significantly reduce overpayments and lessen reliance on mail intercept which, as previously indicated, has only a partial success rate.

3. The same draft report notes that 58 percent of the overpayments were attributable to delays by veteran beneficiaries and educational institutions in reporting terminations or reduction in training. Average timeliness by the educational institutions for reporting terminations ranged from 37 to 82 days and for reporting reductions in training ranged from 52 to 89 days. This contrasts with the general 30 day reporting requirement in existence since August 1975. Clearly a significant amount of overpayments can be avoided by obtaining improvements in the timeliness

of reporting by educational institutions. The problem, however, is how to make this happen in a manner that does not significantly increase paperwork and administrative costs. We have not identified a practical, global solution at this point in time, but plan to discuss the matter further with the Department of Veterans Benefits to see if one can be identified.

One partial solution we have identified is further enhancement of compliance surveys. We have seen improvements in this activity in recent audits of nine regional offices. However, our audits have also noted that further improvements can be made. At two regional offices, we judged the quality of the surveys to be poor based on a review of survey workpapers and our own on-site audits at educational institutions. The primary causes of the compliance survey deficiencies were: understaffing, lack of training, and ineffective supervisory and quality control reviews. The regional directors were receptive to our recommendations and are initiating corrective action. The Department of Veterans Benefits published a comprehensive training guide for compliance survey specialists in February 1979. We should see further improvements in the compliance survey program with the increasing use of this guide.

4. Other causes of overpayments were:

a. Retroactive terminations required because of the prohibition of payment for courses not taken to satisfy graduation requirements. This resulted in 20 percent of all overpayment amounts and probably should have been in a larger amount as we found that 6.4 percent of the cases sampled potentially understated the amount of overpayments because of errors in applying the requirement. Again, we see no easy answer to avoid this 20 percent plus overpayment problem, which occurs primarily when a veteran beneficiary withdraws from or drops a course and does not provided satisfactory justification to the VA.

b. We determined that 3.4 percent of the overpayments were due to special or advance payments. This is a dramatic improvement over the situation at the time of a March 19, 1976 GAO report which showed that 21 percent of overpayments were attributable to advance or prepayments. Prepayments were abolished by the 94th Congress.

c. During the past year, audits at 6 of 16 regional offices disclosed that systematic analysis of error trends of adjudication benefit claims were not being properly performed in adjudication divisions. Five audits identified problems with the quality of administrative decisions which affected overpayments. Regional office directors concurred in audit recommendations addressing these problems.

d. One audit, using a computer program developed by our auditors to match Education System master records by social security number and other characteristics, identified approximately 26,200 pairs of records containing the same social

security number. Ninety-five cases involving active awards were referred to the Department of Veterans Benefits for immediate action. These cases were sent to the appropriate regional offices where suspense and termination actions were taken to avoid further overpayments. Based on a sample of the remaining cases, the audit team estimated that 1,100 beneficiaries were overpaid $1.5 million. The Department has agreed to investigate these cases, to establish accounts receivable or stop payments, as appropriate, and to identify indications of fraud for possible referral to Justice.

The Department's initial analysis of the problem indicates that the majority of duplicate cases were established because VA's automated beneficiary locator system (BIRLS) did not locate the existing file number and established another. Twenty percent of the duplicate cases were attributable to errors by regional office employees. The Department, with technical assistance from our auditors, has developed the computer program and manual procedures needed to correct this problem. Periodic computer matches will be used by the Department to minimize the impact of these situations in the future. Automated system changes are also being considered to correct weaknesses in the existing system.

5. We are providing substantial audit coverage to areas that have a direct effect on reducing or preventing loan guaranty indebtedness. We also plan to continue monitoring the actions being taken or planned by the Department to reduce accounts receivable resulting from loan defaults.

6. One of our audits matched Active Compensation and Pension system master records by social security number. We identified a total of 321 beneficiaries who had more than one record and were receiving more than one benefit check. The Department of Veterans Benefits took prompt action to prevent further overpayments in these cases and established over $1.4 million in overpayments. The primary causes were errors in reporting by beneficiaries, by adjudicators, and in computer inputs. Operational improvements include requirements for two signature approval of adjudication determinations, and certain control enhancements will be available from full TARGET implementation.

Collecting Accounts Receivable

1. We recommended that action be taken to obtain locator address information and pursue 143,000 accounts, totalling $188 million for which no collection action had been taken in recent years because VA lacked valid address information. Locator information is being obtained from the Internal Revenue Service and the first collection letters, based on such locator information, were mailed on October 2. Through March 31, 1980 collection efforts using IRS locator information have produced the following: 6,172 accounts amounting to $6.1 million have established repayment plans, and 1,627 accounts have been paid in full. Total cash collections are $1.6 million. However, for individuals who do not respond to these

collection efforts, legal action by the Department of Justice will generally be precluded because locator information obtained from IRS cannot be redisclosed to obtain credit reports which are required by joint regulations promulgated by General Accounting Office and the Department of Justice (4 C.F.R. p. 105.3). The number of such non-respondents to date is 42,924. We expect this number to increase dramatically as time runs out on the effective period of the last collection letters, without any response or attempt to resolve the debt. In this regard, we have continued to advocate a proposal by the VA General Counsel to permit such redisclosure. This proposal has been pending in OMB since February 1979.

2. We have completed an audit of the Centralized Accounts Receivable System (CARS), which processes about 85 percent of the Department's compensation, pension, education and loan guaranty accounts receivable. We have a draft audit report which is recommending the following major actions:

a. Further test the advantages of telephone collection efforts. The current collection system, while meeting existing government collection standards, is a passive system which depends on debtor response to collection letters. Several tests using telephone contacts have been made in recent years -- the latest a three month test during 1978. These tests showed some positive results, but were inconclusive because data was not obtained on the impact, costs and effectiveness of this procedure. Based on a separate study, the Department of Veterans Benefits is proposing a one year, three station (regional office) test which will include personal contact with debtors.

b. Pursue collection action through government channels when the debtor is an employee of the U. S. Government. For example, we identified over 13,000 accounts receivable amounting to over $1.7 million which were due from service persons on which collection action had not been pursued to Department of Defense. The Office of Inspector General is taking the lead role in working out arrangements for a government-wide computer matching between VA accounts receivable records and the civilian personnel records of the U. S. Government in order to identify and pursue collection actions on such cases through government channels.

c. In another draft audit report, we have identified the need for significant improvements in identifying potential school liability for overpayments. Our tests indicate that the Department of Veterans Benefits Regional Offices were deficient in identifying 36 percent of the instances where there is a potential liability on the part of educational institutions.

Aside from accounts receivable administered through CARS, there are other accounts receivable subject to collection action by the regional offices and medical centers. More intensive and effective collection efforts are needed by many of these offices.

1. During the past year, audits at 10 of 16 regional offices found that collection efforts were ineffective. Deficiencies identified were: excess followup time; insufficient monthly payments or offsets against other benefits based on the debtor's ability to pay; failure to refer cases timely to GAO; lack of required contacts, especially personal contacts; and failure to pursue collection from a deceased veteran's estate before writing off the debt.

2. Five of our medical center audit reports identified problems with medical care cost recovery. For example, medical centers were not billing ineligible veterans, not billing insurance carriers, or not billing Medicare for medical services provided. Also, medical centers were not billing and collecting from affiliated universities for medical services provided. Our reports also identified overpayments to affiliated medical schools for residents whose services were not provided.

Our efforts have also extended beyond the VA in that, as Chairman of the Committee on Audit and Systems of the Executive Group to Combat Fraud, Waste and Abuse, VA's Inspector General provided guidance to other Inspectors General that suggested the needed emphasis and approach for addressing accounts receivable problems in their agencies.

Other Initiatives

Aside from these efforts by the Office of Inspector General, responsible program and staff offices have taken a number of initiatives to enhance collection efforts.

1. VA has sought legislative and administrative authorities to better deal with this problem. VA is seeking authority to redisclose IRS address information. This proposal is pending OMB clearance. Also, VA has legislation before the Congress to permit redisclosure of address and other information in order to obtain credit information on debtors, and, when appropriate, to disclose to consumer reporting agencies the existence of poor credit experience of specific veterans who have refused all efforts to settle debts to the VA. The Senate and House approved these proposals as part of the GI Bill Amendments Act of 1980 (H.R. 5288), and the legislation is pending a conference between the two houses.

Further, in September 1978, OMB was asked to approve VA's proposal to have IRS use its existing authority to offset debts due the VA against tax refunds. A subsequent GAO report in March 1979 supported the legality, feasibility and success (36 percent collection potential) of this initiative. For VA, this could produce at least a $150 million reduction in active accounts receivable and an even higher collection rate for thousands of small dollar accounts carried in suspense. These smaller (less than $600) accounts have collection potential as high as 61 percent according to the GAO study. Also, adoption of the offset arrangements should reduce administrative and legal costs and improve the public debt situation with a related reduction in interest on borrowing. Recent information from OMB's debt collection project, being conducted under the sponsorship of the President's Management Improvement Council, indicates that this proposal

is being considered, but that moving forward with a test at this time is risky and a decision should be deferred until August 1980 when the OMB study is completed. The basic risk identified by the OMB project concerns the reliability of government accounts receivable records.

With regard to this offset issue, as was indicated in our report to the Senate Veterans' Affairs Committee of November 6, 1979, the major need is an efficient, effective method to collect what are mostly small debts (averaging around $800). Indicative of the dimension of the problem in terms of the effectiveness of existing collection actions is that 72 percent of the education accounts receivable are more than one year old; 29 percent -- over $100 million -- are over 42 months old.

2. VA loan guaranty benefits are being denied to veterans with delinquent educational debts to the VA and, pursuant to Section 1810(b) of Chapter 37, Title 38, United States Code, are determined not to be good credit risks. This initiative of the Department of Veterans Benefits, adopted in April 1979, has produced cash collections through February 1980 of $5.4 million, and $1.6 million, in addition, is scheduled for collection through offset or by repayment plans.

3. At the initiative of the General Counsel, VA has been granted limited authority and resources for one year to establish an 11 site pilot program to test the feasibility of using VA attorneys for collections of small debts. There were about 817,000 such debtors owing less than $600, who collectively owed the VA hundreds of millions of dollars. The pilot program began recently. The first 12 weeks of effort showed a favorable dispostion rate of 72 percent of the cases where the debtors could be located and over $100,000 will be collected in the 270 cases where final and assured disposition has been made.

4. As of March 31, 1980, VA has referred over 72,000 accounts, totalling $83 million and amounting to over $600 each, to the Department of Justice for collection. To date, $8 million has been collected.

5. In September 1979, the Department of Veterans Benefits established a study team to determine whether the Department's fiscal operations were organizationally sound and effective. The team was also chartered to determine whether the collection system is effective and to identify changes warranted. The report of this study team, submitted in January 1980, contains many recommendations to prevent overpayments and to improve collection efforts.

These include: improved communication with beneficiaries through use of public media, periodic check stuffers, and revised award letters; procedural and regulatory changes; improved collection procedures; and a one year test, using selected regional offices, to determine the feasibility of decentralizing accounts receivable responsibility back to the regional offices, and obtaining personal contact with debtors while using the computer capabilities of CARS.

6. The Controller has also taken several debt collection initiatives including issuance of:

a. A statistical report has been developed on the status of selected medical receivables which includes ineligible and emergency hospitalizations.

b. Newsletters have been issued within the agency reminding staff that: (i) collection action on receivable accounts is to be taken on a timely basis; (ii) new Department of Treasury procedures require that bills of collection show a definite due date and that late payment charges will be assessed; and (iii) cautioning stations to search claims folders for evidence of a receivable in either the education or compensati n an pension systems when a benefits award is made.

Future Actions

Our future plans for further addressing the accounts receivable problem include two major initiatives:

1. As already discussed, we plan to match VA accounts receivable to government-wide employment records to identify government employees who owe the VA money. We will seek the support of other government agency heads to encourage such employees under their jurisdiction to settle these debts. In this regard, the government may not force such repayment except by legal action, collection from pay entitlements upon separation from Federal employment, collection from civil service annuities, or disciplinary action. In a report of January 15, 1980, titled "Unresolved Issues Impede Federal Debt Collection Efforts -- a Status Report", GAO says that these alternatives have proven to be largely ineffective, costly and/or time consuming. In their report, GAO states that it is considering recommending that the Congress authorize involuntary offset of such debts from current salary.

2. DHEW has been authorized to pursue collections by means not available to VA (e.g., use of collection agencies). We plan to analyze these added authorities of DHEW, and to attempt to measure what their impact might be if such legislative authorities were to be extended to VA debt collection activities.

3. We are currently auditing the education loan default program.

ENCLOSURE 2

PENSION SYSTEM

Objective: Reduce the error rate in pension benefits 50 percent by March 31, 1980 and identify further actions needed.

Background: A study published in October 1978 identified a gross error rate of 26.2 percent in pension cases -- 15.9 percent underpayments and 10.3 percent overpayments. The gross dollar error was 8 percent, with net underpayments exceeding net overpayments. With respect to the dominate category of errors -- underpayments for medical expenses -these represent a failure on the part of the beneficiary to inform the VA of unusual medical expenses which would have resulted in an adjustment to pension benefit entitlement.

Accomplishments: The Office of Inspector General has completed an analysis of the Pension Benefits Accuracy Study (PBAS). Unfortunately, the depth of this analysis was constrained because underlying material had been destroyed six months after the study was published. This precluded us from validating the study results, although we were advised that OMB and the Congressional Research Service found the study methodology and results complete. The lack of underlying records also precluded a determination of the types of errors in the medical expense category -which was the dominant category in terms of the frequency of errors found by the study. That is, medical expenses accounted for 50 percent of all underpayment errors and 20 percent of all overpayment errors. This is believed to be at least partially attributable to the fact that the questionnaire used for the PBAS was more detailed with respect to medical expenses than is the Annual Income Questionnaire. It is also of significance to note that while the over 72 age group represented only about 30 percent of the sample studied, they accounted for 50 percent of the errors while the predominate result was underpayment. This is demonstrated by the following schedule which shows the projected net under-and overpayments by age group:

Age Group	Amount Overpayments/(Underpayments)
Under 50	$ 215,073
50 - 64	3,697,439
65 - 71	(8,019)
71 - 77	(7,106,758)
78 +	(12,589,480)

The Pension Benefits Accuracy Study recommended that annual income questionnaires (AIQs) be required of beneficiaries age 72 and over in an effort to decrease incorrect payments. This recommendation went into effect in the 1978 AIQ cycle. However, two developments minimized any impact this recommendation could have on beneficiaries over the age of 72:

1. Rates are frozen for beneficiaries who do not elect the improved pension (PL 95-588). Over 92 percent of the older beneficiaries have not chosen the improved version. Beneficiaries who incorrectly reported medical expenses could adjust their rates without electing the "improved" pension rate by documenting previously unreported 1978 medical expenses. However, this option expired January 1, 1980.

2. The Department of Veterans Benefits will not send AIQs to elderly beneficiaries enrolled in previous pension programs where the rates are frozen. Thus, it is probable that for some recipients, pension payments will be frozen at an incorrect rate.

The PBAS also recommended an on-going sampling of active pension cases to verify payment accuracy. The Pension Verification Program was pre-tested earlier this year. We monitored the test at three regional offices and found satisfactory implementation. Currently, the Department is compiling the data from the pretest and we will analyze these results, when available. The annual process of the nationwide sampling program will extend from April to November each year.

There are three causes for errors as discussed in the following paragraphs:

1. The self-reporting system (AIQ) inherently lends itself to error and falsification. This represents a basic vulnerability which cannot be addressed in a cost effective manner. However, three initiatives (Data Exchange with Social Security Administration, Pension Verification Program, Increased Communication with Beneficiaries) will alleviate a portion of this problem.

a. Data Exchange with Social Security Administration. Errors in the reporting of Social Security income were the second most frequent type of error found by the PBAS. Further, approximately 75 percent of the Veterans Administration pensioners receive Social Security benefits. In order to verify the accuracy of Social Security income reported by pensioners, the Veterans Administration and the Social Security Administration have developed a cyclical information exchange program. This exchange has been hampered to some extent because some Social Security account numbers contained in the Veterans Administration records are not consistent with the account numbers contained in the records of the Social Security Administration. In addition, some VA accounts do not contain Social Security numbers since pensioners were not required to submit a Social Security account number in the past as a prerequisite for payment.

Recent regulatory changes, however, now require a Social Security account number for all new Veterans Administration accounts. A Social Security account number enumeration project is continuing to correct unverified account numbers contained in existing records. When verified numbers are received, the Social security Administration will be able to provide accurate payment data for these cases.

In view of the large percentage of pensioners receiving Social Security benefits, these changes should have a significant effect in reducing the number of incorrect payments based on beneficiary misreporting involving Social Security benefits.

b. Pension Verification Program. This process will sample both VA payment and beneficiary reporting accuracy, and will provide, on a yearly basis, a strong indicator of accuracy, particularly for those under the "improved pension law." The program was initially planned to be fully operational in the Fall of 1980. However, necessary computer programming for implementation has had to be deferred because of the commitment of resources to conversion projects (TARGET) and other projects nearing completion. Therefore, the Department of Veterans Benefits advises that a limited verification will be done in FY 1980 with the full program to become operative in 1981.

During a January and February 1980 pre-test of this program at the regional offices, our review of three offices indicated satisfactory implementation. Currently, the Department is compiling this data; subsequently, we will provide further analysis and continue to monitor error rates. Additionally, the Department will notify all beneficiaries of this program. This could provide a deterent effect in that the beneficiaries will know that their benefits may come under detailed scrutiny.

c. Increased Communication with Beneficiaries. Extensive use of the media can increase beneficiary awareness of income and expenses reporting requirements and, possibly, improve reporting accuracy. While the impact of this effort is difficult to measure, it remains a virtually untapped resource in the pursuit of accurate and timely payments.

2. Guidance accompanying the AIQ apparently is not as complete or detailed as necessary for medical expenses. We did not arrive at this conclusion in time to make recommendations for improvement in the AIQ cycle. However, we recommended, and the Department agreed to pursue a medical expense category and urged them to contact their local VA office of veterans service organization representatives for any needed assistance. Information Service prepared a press release dealing with the various aspects of the medical expense deduction for distribution to the news media and veterans organization. This material was designed to increase beneficiary awareness of this beneficial provision of the pension program and encourage applications for the unreimbursed medical expense deduction.

In response to our views on this point, the Department of Veterans Benefits has stated that the accuracy of pension payments is related to the beneficiaries' understanding of various provisions of the pension program. Although the Veterans Administration attempts to inform beneficiaries of benefits that may be claimed, it is impossible to insure that each beneficiary will claim all benefits to which he/she may be entitled. Although the AIQ instructions do not delineate the myriad of medical expenses that may be considered for exclusion, they do provide a sufficient explanation in this regard.

However, we believe that the results of the PBAS contradict this view. In fact, the AIQ guidance to the beneficiary is limited to the following:

> "FAMILY MEDICAL EXPENSES (ITEM 8) In this item enter the amount actually paid by you during the calendar year 1979 for medical expenses for yourself or for relatives you are under an obligation to support and for which you were not reimbursed by insurance or otherwise. You may include premiums paid for health, sickness or hospitalization insurance. In computing your income for pension purposes, the VA will deduct the amount you paid for medical expenses which exceeds 5% of your reportable annual income."

Increasing the length of these instructions by adding additional information concerning unreimbursed medical expenses would not be the most effective approach to this problem. Complete instructions, attached to the AIQ card, would be prohibited by space. Further, the category of unusual medical expenses is highly complex and is not absolute. The Department's Program Guide lists a full page of allowable deductions which is not all-inclusive. To further indicate the complexity, it is noted that the Internal Revenue Service's Publication, "Your Federal Income Tax" contains almost six pages of detailed instructions on deductible and non-deductible medical and dental expenses. This pamphlet is also not an all-inclusive listing. As a result of the PBAS findings and the inherent confusion that surrounds medical expenses, we are recommending that the department issue a special alert through its check stuffer system to advise beneficiaries to contact the VA if they have questions about these expenses.

3. Adjudication or processing errors are made within the Department. We have reviewed the adequacy of the Department's quality assurance program and compared it with that of the SSI program. We found three conceptual differences between these quantitative measurement systems: (i) the Department's quality control program does not account for dollar losses caused by adjudicative errors; (ii) the quality control process does not assess the entire case, but limits its review to certain transactions; and (iii) the Department's program does not utilize independent supervisory personnel to perform quality reviews. The Department has, however, integrated these features of the SSI program into the Pension Verification Program. This should provide a future basis for judging whether adoption of the SSI quality control features or some other changes are appropriate.

Also, we did identify a different type of problem not reflected in PBAS statistics. We found 321 beneficiaries of either compensation and pension programs, who had more than one master record and received more than one payment per month. The Department established overpayments in these cases, amounting to $1.4 million. Immediate action was taken by DVB to eliminate duplicate payments and to identify the causes thereof. The primary sources of errors were in (i) documents submitted by beneficiaries, (ii) documents prepared by adjudicators, and (iii) keying information for input to the computer. Current requirements for two signatures (adjudicator and authorizer) and certain control enhancements which will be available from full TARGET implementation should reduce these problems.

In summary, the PBAS findings indicated that beneficiaries, especially the elderly, tended to underreport their medical expenses, creating a projected underpayment of $20 million for this age group. Since 92.6 percent of them have not elected the improved pension, it is probable that many have been frozen at inaccurate pension rates.

The reliance on beneficiary reporting inherently lends itself to inaccuracy. In that sense, total accuracy of payments cannot be achieved. The Department has, however, taken steps to improve accuracy, notably the data exchange with the Social Security Administration and the Pension Verification Program. Added emphasis on direct contact with beneficiaries through check stuffers and increased utilization of media will also have a positive impact on accuracy. We will continue to monitor and analyze the Department's efforts, especially in the area of pension verification.

ENCLOSURE 3

GRANTS FOR HEALTH MANPOWER TRAINING

Objective: Complete audits of half of the health manpower training grants by March 31, 1980.

Background: The status of grant funding as of June 30, 1979 is:

Funds Authorized (1)	$525,000,000
Funds Appropriated (1)	$296,693,000
Funds Awarded - Direct Grant Costs (2)	$219,387,000
Number of Grants	155

(1) Funds authorized and funds appropriated include funds under Subchapters I and IV for facilities construction and improvement which are expended by the VA and not awarded to educational institutions.

(2) Grant funds are committed for the total project period for direct costs only. Indirect costs are awarded on a year-by-year basis depending on available funding. Total funds available for indirect costs for the Manpower Grant Program are $26,326,000. Therefore, grant funds awarded as of March 30, 1980 could be as much as $245,713,000.

Audits have been requested of 69 grants which account for $215.3 million (91%) of grant funds awarded or available for direct and indirect costs. Since almost all of these grants have been awarded to educational institutions which are under the audit cognizance of the DHEW Inspector General, it has been necessary to arrange for audits by his staff. Since DHEW audits these facilities on a cyclical basis, the audits are normally accomplished whenever the grantee is scheduled for cyclical audit. Although DHEW has honored requests for audits outside the normal audit cycle, this is the exception rather than the rule, and is basically dependent upon having audit resources available at a particular time.

Accomplishments: Since audits can only be conducted of actual costs incurred, the proper measure for monitoring our accomplishments should be this amount, which was $91.2 million at June 30, 1979. In this regard, at the time of my testimony before the Committee, I used funds awarded numbers, which represented the only information we had available at that time. This is, nonetheless, a much less meaningful number. The following schedule may help clarify this point.

	Funding	Costs Incurred	Number of Grants
Total	$237 million	$91.2 million	155
Audits requested	215 million	89.3 million	69
Audits completed	125 million	50.2 million	36

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Dollars audited of $50.2 million represent 55 percent of costs incurred and reported through June 30, 1979 on all grants ($91.2) million). As a result of these audits, the auditors have questioned costs totaling $309,000. The Grants Officer has sustained $183,000 of this amount. Costs of $17,000 questioned were not sustained. The remaining $109,000 have not yet been resolved. This amount consists of $88,000 from recently issued reports and $21,000 included in the previous report. Also, the auditors did not render an opinion on $14.3 million of costs due to accounting system deficiencies, primarily salary distribution not in compliance with Federal Management Circular 73-8. Generally, such problems are widespread within the accounting systems of these universities and affect not only VA grants but grants and contracts with all Federal agencies. DHEW will be the lead agency in resolving this problem. The General Accounting Office has addressed this problem in its report, "Need for More Effective Audits of Federal Grants and Contracts Administered by Institutions of Higher Education" (July 19, 1979). The Inspector General of DHEW responded to the report by saying ". . . a major program of reform is underway to include (i) simpler Federal regulations without loss of safeguards; (ii) improved procedures for the prompt resolution of audit findings; (iii) early audit review service on proposed changes in institutions' accounting systems; and (iv) sanctions against institutions and individuals when corrective actions are not taken in a reasonable time period."

The foregoing relates to costs incurred as of June 30, 1979 and the results of audits of these costs. Additional costs are continually being incurred and we anticipate the new total will be about $138.2 million at June 30, 1980. Audits necessarily lag up to a year behind the incurrence of costs due to (i) the time required by the institutions to record and claim their costs, and (ii) audit rescheduling constraints, including the cyclical audit approach to educational institutions described earlier. Nonetheless, we expect audit reports by September 30, 1980 on an additional nine grants which will include costs incurred in the amount of about $13.7 million. This will bring our audit coverage up to $63.9 million, or 70 percent of $91.2 million costs incurred and reported through June 30, 1979 and about 46 percent of the estimated $138.2 million in costs to be incurred by June 30, 1980.

ENCLOSURE 4

AUDITS OF VA MEDICAL CENTERS

Objective: Audit one-third (54) of VA Medical Centers by March 31, 1980 with particular attention to security, medication handling, patient records and patient abuse.

Background: Between April 1, 1979 and March 31, 1980, audit reports were issued on 51 medical centers. This included 3 types of audits. Twenty-eight full scope audits consisted of a preliminary analysis of all major functions and activities of a medical center and a selection based on that analysis of major areas to be probed in depth by the audit. Nineteen limited scope audits focused attention on selected medical center operations, including those noted in this Objective. In addition, four followup audits were completed to determine the effectiveness of actions on prior audit findings. Following is a listing of these 51 audits:

VA Medical Center, Bonham, TX
VA Medical Center, Batavia, NY
VA Medical Center, Iron Mountain, MI
VA Medical Center, Shreveport, LA
VA Medical Center, Murfreesboro, TN
VA Medical Center, Hines, IL (Followup)
VA Medical Center, Tucson, AZ
VA Medical Center, Roseburg, OR
VA Medical Center, Buffalo, NY
VA Medical Center, Brockton, MA (Followup)
VA Medical Center, Fayetteville, AR
VA Medical Center, Prescott, AZ
VA Medical Center, Livermore, CA
VA Medical Center, San Francisco, CA (Followup)
VA Medical Center, Fort Wayne, IN
VA Medical Center, Lebanon, PA
VA Medical Center, Oklahoma City, OK
VA Medical Center, Kerrville, TX
VA Medical Center, Dallas, TX
VA Medical Center, Montrose, NY
VA Medical Center, Philadelphia, PA
VA Medical Center, San Diego, CA (Followup)
VA Medical Center, Big Spring, TX
VA Medical Center, (Audie L. Murphy Memorial VA Hospital), San Antonio, TX
VA Medical Center, Indianapolis, IN (Limited Scope)
VA Medical Center, Palo Alto, CA
VA Medical Center, Lexington, KY
VA Medical Center, St. Cloud, MN
VA Medical Center, Baltimore, MD (Limited Scope)
VA Medical Center, Knoxville, IA (Limited Scope)
VA Medical Center, Topeka, KS (Limited Scope)

VA Medical Center, Hampton, VA
VA Medical Center, Butler, PA (Limited Scope)
VA Medical Center, Los Angeles (Wadsworth), CA (Limited Scope)
VA Medical Center, Dublin, GA
VA Medical Center, Manchester, NH (Limited Scope)
VA Medical Center, Iowa City, IA (Limited Scope)
VA Medical Center, Boston, MA
VA Medical Center, Lyons, NJ (Limited Scope)
VA Medical Center, Coatesville, PA
VA Medical Center, Amarillo, TX (Limited Scope)
VA Medical Center, Denver, CO (Limited Scope)
VA Medical Center, Portland, OR (Limited Scope)
VA Medical Center, Asheville, NC
VA Medical Center, Vancouver, WA (Limited Scope)
VA Medical Center, Highland Drive, Pittsburgh, PA (Limited Scope)
VA Medical Center, Fresno, CA (Limited Scope)
William S. Middleton Memorial Veterans Hospital, Madison, WI (Limited Scope)
VA Medical and Regional Office Center, Wilmington, DE (Limited Scope)
VA Medical and Regional Office Center, Wichita, KS (Limited Scope)
VA Medical and Regional Office Center, Fort William H. Harrison, MT (Limited Scope)

In addition, special purpose audit work was done at 93 VAMCs during the year. This included:

1. Twenty-eight audit reports related to areas of limited inquiry at specific medical centers because of indicated problems or because the subject area was considered sensitive to problems. These audits were:

   ° VAMC, Ft. Howard - to determine validity of allegations of waste and mismanagement, particularly in Engineering and Nursing Services.

   ° VAMC, East Orange - to assess the adequacy of administrative controls to prevent and detect pilferage, fraud and unauthorized expenditures.

   ° VAMCs, West Roxbury, Wilmington, Baltimore, Lyons, Boston, and Manchester, to assess the adequacy of arrangements for contracted maintenance.

   ° VA Prosthetic Center, New York - to determine the accuracy of outstanding financial obligations from prior years.

   ° VAMCs, Sepulveda, San Diego, Bay Pines, Tampa, Long Beach, Miami, Lake City and Gainesville - to review ADP activities.

   ° VAMC Washington, DC - to evaluate procurement practices involving maintenance and construction contracts.

° VAMCs New York, NY and Durham, NC - to evaluate the adequacy or internal controls over beneficiary travel payments.

° VAMC Providence, RI - audited twice - to determine adequacy of controls to prevent fraud and unauthorized expenditures of funds in fiscal and supply services, and - to investigate misuse of the medical care appropriation to support research.

° VAMC Waco, TX - to assess the patient anti-abuse program.

° VAMC Birmingham, AL - to audit the operations, responsibilities and functions of VA Medical District No. 10.

° VAMC Durham, NC - to assess the accuracy of time and attendance reporting for medical center staff.

° VAMC San Juan, PR - to review contract compliance, expenditures of funds and controls over services provided by contract hospitals, nursing homes and satellite clinics.

° VAMC Fort Wayne, IN - to inquire into patient care, employee relations and management practices.

° William S. Middleton Memorial Veterans Hospital, Madison, WI - to determine the validity of complaints concerning personnel management.

2. Several audits were completed that included audit work at multiple medical centers. The most important of these audits are:

a. DM&S Educational Resources - Audits were conducted at 15 VAMCs which accounted for about half of the resource investment and annual operating costs of the educational TV system. This audit was undertaken at the initiative of the Inspector General's Office after routine cyclical audits at a couple of medical centers disclosed significant underutilization of expensive TV production equipment.

b. Warehouse Security and Inventory Control - Eight medical centers and two supply depots were audited to evaluate the adequacy and effectiveness of procedures and practices to safeguard expendable warehouse supplies and subsistence. Specific areas reviewed included receipt and issue of warehouse stock, identification of items in stock, protection of stock against diversion, extent of inventory issues, investigations of losses, followup and receipt of overdue shipments, and the silver recovery program.

c. ADP Installation Audits, Medical District No. 12 - Audits were conducted at the five VA medical centers in Medical District No. 12 to identify ADP resources and to evaluate usage, staffing, duplication of applications, and adequacy of facilities.

d. Overtime- Overtime costs are increasing and we decided to give special attention to this issue at 16 high use locations, including 12 medical centers.

e. Drug Dependence Clinical Support System - This system, an ADP system providing administrative support for Drug Dependence Treatment Centers (DDTC), was audited for efficiency and effectiveness. It was found to be a useful automated tool for the management, counseling and clinical treatment aspects of patient care. The significant recommendation, not directly involving DDCSS, was to identify the prescription records of drug abuse patients so that the pharmacists could notify doctors who prescribed other drugs contraindicated with drug abuse treatment, thereby preventing possible complications. During the course of the audit, eleven locations were visited, including eight medical centers and two outpatient clinics.

f. Silver Recovery Program - Audits were conducted at 15 VAMCs to determine why there had been a decrease in the amount of silver recovered during the past two years.

g. Procurement and Monitoring of Pacemakers - Several investigations and an audit were conducted in response to allegations of serious irregularities in the procurement and monitoring of pacemakers.

Accomplishments: The results of these audits, in both subject areas highlighted by the objective as well as in other significant areas are as follows:

1. Security. Twenty of our medical center audit reports addressed the need for improved physical security measures to deter or prevent loss of government supplies and equipment. Physical security deficiencies included inadequate or nonexistent alarms, doors, locks, windows or walls for agent cashiers' offices, pharmacies, drug storage areas, medical supply areas, warehouses, canteens and silver recovery areas. The need to limit access and control keys to areas particularly vulnerable to theft was identified at five medical centers. On February 25, 1980 the Department of Medicine and Surgery issued a circular to its field activities highlighting physical security requirements for precious metals and films because of their increased vulnerability to theft. One instance of loss of an undetermined amount of subsistence items and linens valued at $40,000 because of poor security was identified in our audits. Because of the value and nature of supplies and equipment maintained at medical centers, security requires continued periodic review.

2. Medication Handling. Drug costs totaled about $225 million in FY 1979. Medication handling involves the receipt, storage, distribution, control, accountability and administration of drugs. Controlled substances are drugs which have a potential for psychological or physical dependency with harmful side effects if abused. The distribution, recordkeeping and security of these drugs are explicitly regulated to minimize intentional or unintentional diversion.

   a. Thirty-two medical center audit reports showed the need to improve medication handling in one or more of the following respects:

(1) At 11 medical centers audited, the physical security of the pharmacy was not adequate.

(2) At 19 medical centers, weaknesses in security for and accountability of controlled substances were identified. At 11 medical centers, controlled substances were not properly secured in clinic and ward areas. Discrepancies in inventories of controlled substances were found at 10 medical centers. At 4 medical centers, controlled substances shown on inventory records as having been administered to patients were not recorded in patients' records. Control weaknesses included pharmacists not monitoring drug usage on wards as required and inspectors not randomly comparing entries on the Controlled Administration Records with the applicable patients' medical records.

(3) At 13 medical centers, drug inventory and storage practices needed improvement. At one medical center, for example, the lack of an adequate drug inventory created situations where regularly used drugs were not available when requested. This made local purchases for requested items necessary at potentially higher costs than if acquired through the VA supply system. At 6 medical centers outdated drugs were found on the wards. Some drugs had been outdated for over one year. At one medical center, ten patients had been administered an outdated controlled substance.

b. We have performed a vulnerability assessment of medication handling. The estimated dollar loss for drugs which may be stolen, dispensed without appropriate records, destroyed without correcting records, or otherwise lost is $18 million. This consists of $17.4 million which occurs in hospital inpatient medication distribution systems, and $.6 million in station warehouse inventories. An additional cost of $4.7 million from filling prescriptions on a fee-basis could be substantially reduced through identification and elimination of program abuses. Further, losses due to duplicate prescriptions constitute a multi-million dollar problem; however, existing information is too limited to develop a reasonably reliable system-wide estimate of the loss. A cost/benefit study is currently being conducted by the VA to obtain this information. An inventory accountability system, that could account for all drugs or drugs involved in major dollar losses as they flow through the system, does not exist. Department and Staff offices' comments delineated steps that would resolve issues; however, the pace and degree of improvements to the inpatient medication distribution system remain unresolved. The solution requires extensive manpower, computers and other resources.

3. Patient Medical Records. Emphasis on patient record reviews has continued in our audits of VA medical centers. The following deficiencies most frequently recurred:

   a. At 21 medical centers, failures to fully document patient consent for surgery or anesthesia, to participate in research, or to use investigational drugs were found.

   b. Since the chargeout system was ineffective, medical records could not be easily located at 8 medical centers.

   c. A problem with timely completion of medical records was reported at 19 medical centers.

   Continued emphasis on medical records is needed. A summary of audit findings on quality controls for patient care, to include medical records, is being prepared and will be provided to the Chief Medical Director.

4. Patient Abuse. A priority of the VA is to ensure that beneficiaries receive the best possible care. The VA has adopted the firm policy that under no circumstances will patient abuse or mistreatment by any employee of a VA health care facility be tolerated. At 16 medical centers special emphasis was placed on determining adherence to this policy. The December 12, 1979, summary report of this audit concluded that, although the VA medical system is not experiencing a severe patient abuse problem, over half the medical centers audited had procedural weaknesses in implementation of the anti-abuse program, as follows:

   a. Failure to establish formal training programs to asure that staff members can effectively deal with patient crisis situations, although insufficient employee training in and understanding of patient behavior are the major causes of patient abuse incidents and/or

   b. Failure to incorporate VA policy in local policy statements and to assure its dissemination to all employees, along with the absence of periodic reviews of employee understanding of this policy.

   The Chief Medical Director agreed with the summary report recommendations for immediate action by medical center directors to correct these weaknesses.

A separate, special audit of the anti-abuse program at VA Medical Center, Waco, Texas, identified more specific local weaknesses. All were related to failures on the part of center management to reinforce, support, investigate, and enforce the program. The audit team recommended corrective actions and the center director concurred and has initiated specific activities aimed at correcting the identified shortcomings. An investigation was undertaken at Waco to address specific hotline allegations of patient abuse.

Audits recently completed at individual medical centers continue to show that there is not a great deal of cause for concern regarding patient abuse within the VA health care system. The possibility exists, however, that unreported/uninvestigated cases of patient abuse might surface through the employee hot line or by other means.

5. Educational TV. Equipment acquired mostly in the early 1970s at a cost of $15.3 million and staff (113 positions) costing $2 million annually were committed at a large number of medical centers to provide audiovisual production activities for medical education purposes. However, audits at 15 medical centers found that these capabilities are largely underutilized and this level of resource commitment is unwarranted in light of the limited benefits obtained. Causes for this include the probability that the actual needs for and benefits of a program of this size were overstated, there was not the quantity and quality of personnel resources needed to produce first class training films at such a large number of production centers, and there was insufficient linkage between those responsible for identifying and arranging to meet educational needs and those who operated the audio-visual production centers. Our principal recommendations are:

   a. Eliminate television production capabilities at all medical centers other than VAMCs St. Louis and Salt Lake City and reduce staffing and equipment levels accordingly.

   b. Eliminate holdings of educational and general purpose closed circuit television systems and networks at all medical centers except at VAMC Temple, Texas; reduce staffing supporting CCTV activities accordingly.

   c. Establish procedures for determining needs for videotape productions and for reviewing and evaluating the use of such productions.

   d. As needed for minimal videotape recordings for local use at the medical centers, retain or acquire adequate equipment for these purposes. Cost of such equipment is in the range of $28,000 which contrasts with the current capabilities of some medical centers which have equipment acquired at a cost of up to $786,000.

While the Chief Medical Director has agreed with the objectives of the first two recommendations, the Department of Medicine and Surgery has elected to freeze, rather than eliminate, television resources at current levels through a comprehensive moratorium. Existing resource data is being analyzed to consider appropriate distribution of resources and to explore possibilities for the most effective organizational relationships between the two production centers and the Regional Medical Education Centers. Cost estimates are being developed for dismantling the general purpose closed circuit television systems and networks so that funds can be identified and actions taken when final determination has been reached regarding the extent of the phase down.

The Chief Medical Director has accepted the latter two recommendations. To strenghten Academic Affairs' management of television activities, the Department reported that it has developed pre - and post-production review processes; refined audiovisual software networking procedures; and revised and standardized data collection procedures and formats for field medical media activities and for audiovisual utilization data.

6. Other Equipment. The acquisition and utilization of expensive specialized equipment for research and patient care has been subjected to extensive GAO review for several years. We have continued to find utilization problems with this type of equipment, some related to the underutilization of specialized medical programs as discussed in a separate enclosure. Further, we completed reviews of equipment maintenance contracting at six medical centers. Improvements were needed at five of the centers to assure greater competition. Of the five facilities lacking competition, four had what were essentially automatic renewals of previous years' agreements with the same contractors. Negotiated contracts lacked statements to justify negotiation instead of competitive bidding. Four facilities had maintenance agreements which could have been consolidated because the contracts were for servicing similar equipment by the same vendor. Consolidation could result in potential cost savings through blanket contracts for similar equipment. The maintenance contract audit findings are similar to those our cyclical audits have often found at other medical centers.

7. Warehouse Security and Inventory Control. The audit found that the potential for unauthorized diversion of supplies was significant for the following reasons:

   a. Inaccurate and unreconciled inventory accounting records even after physical inventories had identified some of the inaccuracies.

   b. Improper control over receipt and destruction of outdated drugs and other controlled substances.

c. Inconsistent VA policies and lack of definitive guidelines governing intrusion alarms and other areas of warehouse security.

d. Incomplete maintenance of general ledger accounts in regard to posting of receipt or cancellation of orders, requesting monetary credits on cancelled orders, and reconciling unliquidated advance payments with Supply Service records.

8. Construction Planning. Weaknesses in evaluation and justification for one or more proposed construction projects at eight different medical centers were found during the year. These weaknesses included improper application of space criteria, failure to consider existing underutilized space, and insufficient workload justification for expansion. As a result of these findings, we reviewed 48 major and minor medical facility construction projects included in the FY 1980 budget request to evaluate project justification. One major project, estimated to cost $7 million, was found to have insufficient justification. In accordance with our recommendation, this project has been suspended pending accumulation and analysis of workload or demographic data.

9. ADP Installation Audits, Medical District No. 12. The audit team found that staffing for ADP systems was adequate, no duplication of ADP effort was apparent, and no violations of the Privacy Act were detectable. Significant findings of the audit include:

a. No exchange or interchange of ADP information, software, or systems existed within the district although one center had a number of administrative support systems which could be shared if compatible equipment existed at other centers.

b. Some ADP equipment at each of the centers had not been entered into the ADP equipment inventory.

c. Improvements were needed in facility access control at two centers, inadequate storage for backup and security files and programs at two centers, fire detection and control at two centers, and air conditioning at one center.

d. One center had experienced so much equipment downtime due to power failures and fluctuations caused by electrical storms that it was preparing a justification for an uninterruptable power supply.

The Chief Medical Director and the Assistant Administrator for Data Management and Telecommunications have stated that recent reorganizations in their departments have created a new environment for managing ADP resources which should overcome or counteract many of the problems cited in the reports. Each medical center director concurred in all findings and reported initiation of corrective actions.

10. Beneficiary Travel. During FY 1979, $68 million was spent compensating beneficiaries for travel expenses. Audits were conducted at five medical centers which had $4 million in annual beneficiary travel expenses. We found instances of fabricated receipts, a lack of eligibility determinations and a lack of control over duplicate payments. At one medical center with an outpatient clinic, accountability and control over $340,000 of public transportation tokens was unsatisfactory. The audit uncovered no major discrepancies in the $208,000 worth of tokens on hand at the medical center. However, the associated outpatient clinic was unable to account for $37,500 of its $132,000 worth of tokens. Records and reports were inaccurate, and internal audits were either in error or so superficial that they were meaningless. We also found that two recommendations for improved public transportation token control which we made during a previous audit at the same facility remained unimplemented. Corrective actions reportedly have been taken and the Department of Medicine and Surgery is coordinating with the Controller to improve procedural requirements governing beneficiary travel payments. Efforts to control beneficiary travel costs were found to be good at two medical centers. New authority under the Veterans Health Programs Extention and Improvement Act of 1979 (Public Law 96-151), is expected to improve control over eligibility for this program and result in reduced costs.

11. Eligibility for Non-Service-Connected Treatment:

a. Financial Need: Veterans who do not have a service-connected need for medical care are eligible for inpatient and related outpatient care if they cannot otherwise afford medical care. No financial needs criteria or test -- the latter is precluded by law -- is applied so that adherence to this financial needs requirement is essentially an honor system, and vulnerable to abuse. Because of the availability of income information, we computer matched all VA employees to inpatient information and found, based on income and estimated medical expenses, that there were 465 highly questionable cases out of 21,188 instances of inpatient care provided to VA employees for non-service-connected medical care since 1971. We have recommended cost recovery from the 465 VA employees where appropriate, and the development of criteria for assisting all veterans in determining whether they are financially eligible for non-service-connected care. A decision is still pending on the draft audit report recommendations.

b. Medical Need: Under Department of Medicine and Surgery policy, non-service connected outpatient care is restricted to a period of no longer than 12 months after inpatient discharge unless it is medically determined that a longer period is required.

Audits at three medical centers disclosed that patients were not systematically evaluated to determine their medical need for continued outpatient care. Of 101 cases sampled, 32 had been in an active outpatient status from 1 to 9 years without documented evidence to support the need for continued medical care.

c. Third Party Reimbursement: Audits at four VA medical centers found that these medical centers failed to seek reimbursement from third party health plans for hospital care provided by the VA to beneficiaries acknowledging coverage on admission. At one medical center, 10 cases were identified in which potential reimbursement of $27,000 from Medicare should have been claimed under the Federal Medical Care Recovery Act (Public Laws 95-142 and 87-693). At the other three medical centers, sampling of 220 applications for admission disclosed that 19 patients indicated they had health insurance and 49 did not answer the question on health insurance coverage. The medical centers did not seek clarification or reimbursement in these cases. A problem was the feeling by some medical center personnel that most health insurance policies contain clauses excluding payment to the Veterans Administration for medical services provided the insured. Department of Medicine and Surgery policy provides that medical center personnel should not assume all health insurance contracts are the same. Therefore, we concluded that claims should be initiated whenever the possibility of recovery exists. In March 1980, the Chief Medical Director reemphasized the Department's policy in a letter to medical center directors. The VA has proposed legislation to facilitate recovery of costs from insurance carriers, employers and other sources from which the veteran may be entitled to complete or partial reimbursement for medical expenses. This legislation was introduced in the 96th Congress as S. 759 and H.R. 3475.

12. Overtime. Personnel costs amounted to $4 billion in FY 1979, including $38.1 million in overtime. Overtime increased over FY 1978 costs by 20.6 percent. Our review of overtime at 16 selected high-use locations, consisting of 12 medical centers, three regional offices, and one data processing center, found that overtime use in these facilities followed the trends of their respective departments. In the medical centers where overtime is increasing, there was frequently a lack of proper monitoring and control. Overtime was often authorized after the fact, alternatives to overtime were weak. Some facilities, recognizing that overtime use was high, initiated procedures or developed alternative methods to reduce overtime use.

Time and attendance records were found in general to be complete, properly maintained, correctly verified, and in most cases, reflected correct regular duty, part-time and overtime hours. However, at some

medical centers, timekeeping procedures for part-time physicians were inadequate, thereby causing errors in accounting for pay and leave. Further, several investigations have disclosed instances when physicians have taken advantage of such weaknesses, and did not provide the hours of work for which they were paid. The Department of Medicine and Surgery issued new timekeeping procedures in June 1979 for part-time physicians which permit adjustable work hours whereby certain hours of duty prescheduled at the beginning of a bi-weekly pay period can be performed at other authorized times within the pay period. Special timekeeping procedures are designed to ensure that standard controls are in effect.

At medical centers, increased training of timekeepers is needed, particularly initial training. In some facilities, quarterly audits were not being performed. There was a direct correlation between errors found and the quality of training and quarterly audits. As a result of our audit report on overtime, part-time, and time and attendance records and other audit reports identifying payroll discrepancies, the Controller issued supplemental information to the heads of departments, staff offices, and field stations. This information was provided in a September 5, 1979, newsletter to all VA facilities. It addressed overtime authorizations, salary limitations, reductions and calculations of overtime, and quarterly audits of timekeepers, emphasizing that the audits serve as valuable training mechanisms. The Controller suggested rescheduling work shifts to reduce overtime. Such an adjustment of routine work schedules to overlapping time periods permits transfer of keys, narcotics counts, and the like, thus avoiding use of 1/4-hour regularly scheduled overtime at midnight.

13. Time and Attendance of Part-Time Physicians. As a followup to audit report findings, investigations of alleged work hour abuse by part-time physicians and other information from the Controller, the Department of Medicine and Surgery, and allegations from the employee Hotline, we performed a special analysis to ascertain the accuracy of the time accounting for the 3,977 part-time physicians employed by the VA. The basic problems identified were that existing timekeeping procedures are (i) unrealistic in light of the need for part-time physicians to often deviate from scheduled tours of duty (ii) unrealistic because timekeepers often do not know of changes from scheduled tours, and (iii) vulnerable to fraud and abuse.

New procedures adopted in VA Circular 00-79-23 published June 18, 1979 have not alleviated the timekeeping accountability problems even though the prescheduled tours of duty have been made more flexible. Only 15 facilities have implemented these procedures placing only 330 part-time physicians under the adjustable work hour provisions. The most critical comments received from the various facilities not using these procedures indicated that the daily sign-in/sign-out requirement was unacceptable to the physicians as being unprofessional.

Therefore, we proposed a modification which would keep the flexibility of the adjustable work hours; would meet the definition of "part-time" through prescheduled "core" hours necessary for leave and benefit calculations; and, would provide direct accountability to the part-time physicians for actual hours worked or leave taken.

This direct accountability is obtained through use of a subsidiary time sheet which is maintained by the part-time physician on a daily basis. The time sheet is submitted to the unit timekeeper on a weekly basis, after being certified correct by the physician and initialed by his/her supervisor. It is then posted to the official time and attendance report. Presently, this proposed modification has been submitted to GAO for review. Unless there are objections from GAO, this new procedure should be implemented in the near future.

14. Silver Recovery. All VA medical centers have equipment to recover silver from X-ray processing solutions. VA had an efficiency recovery rate of 79 percent in 1977 and was cited by GAO as "among the most efficient agencies in the recovery of silver from film and photographic material". However, our audit of this well-run program identified opportunities to significantly increase the amounts of silver recovered by improving recovery processes. Some medical centers use an "overflow" recovery process which loses approximately 9 percent of potential yield as compared with "batch" collection systems. Projected VA-wide such losses could total some 28,000 ounces. Additional amounts of silver are lost due to a failure to collect spent silver fixer solutions from all low volume processors. The Chief Medical Director concurred with all recommendations made. Clarifying instructions on the Silver Recovery Program have been issued to all medical centers.

15. Procurement and Monitoring of Pacemakers. Investigations of pacemaker procurement and monitoring services revealed that three VA physicians at two VA medical centers were involved in apparent conflicts of interest in performing evaluations of pacemakers for manufacturers. The audit of VA Central Office and eight medical centers identified the need for improved procurement and inventory controls, competitive bid purchases, credits for returns of used pacemakers, and standardized services for pacemaker patients. DM&S has issued policies to strengthen program shortcomings.

16. Mini-Computer Acquistion. Audit and investigation activities have been addressed to allegations regarding mini-computers acquired in FYs 1978 and 1979 at a cost of about $15 million. We have not yet completed work on the FY 1978 allegations. Our key findings on the FY 1979 are:

    a. The procurement decisions were hurried and some lacked the disciplined planning, coordination and thoroughness appropriate for procurements of this magnitude.

b. The Administrator's guidance was not appropriately interpreted and adhered to, particularly with respect to "user" involvement and application of criteria which calls for greater discipline as the proposed dollar level of investment increases.

c. Significant costs for site preparation, file conversion and peripheral hardware were not fully addressed and decision makers were not provided an estimate of such additional costs to be incurred.

We are developing a separate report on our recommendations for clarifying and strenghtening ADP guidelines.

17. Trend analysis. Trend analysis produced three topics which, while of less import then the preceeding topics, are worth mention.

a. Patient's Valuables. The need for increased protection of patients' valuables was found during 11 medical center audits. Five centers were not performing the required semi-annual audits of patients' valuables; 4 centers failed to take action to return valuables to patients upon discharge; and of 260 patients' valuables records reviewed, 82 percent of the records were neither signed by the patients nor their representatives and 46 percent of the records were not co-signed by VA employees.

b. Fire/Safety Program for Contract Community Nursing Homes. The program was reviewed during 11 medical center audits. At two medical centers pre-contract inspection teams did not include physicians - as required; while, at two medical centers, the quality of fire/safety inspections needed improvement. Four medical centers need to improve procedures for insuring that cited fire/safety deficiencies are corrected.

c. Emergency Preparedness. Emergency preparedness planning was tested at 33 medical centers. We found that emergency preparedness plans at 5 medical centers were not current and plans were not complete at 12 medical centers.

Management has agreed to take corrective action on recommendations addressing these three topics.

ENCLOSURE 5

SPECIALIZED MEDICAL PROGRAMS

Objective: Reduce underutilization of specialized medical programs by promoting sharing of resources within the Federal Government and with the community.

Background: In July 1975, the Department of Medicine and Surgery first published productivity/utilization standards for specialized medical programs. These standards have been revised and updated. The current applicable standards, which were adopted in November 1978, are in the process of being revised. Monitoring utilization against these standards is to be carried out at each medical center, and by the central office through standardized reporting systems. One of the recognized options for improving substandard utilization is sharing.

Two tasks were undertaken by the Inspector General's Office to address this objective:

1. Explore barriers to sharing (e.g., reimbursement arrangements) and make recommendations for needed actions to remove such barriers.

2. As part of individual medical center audits, determine if current sharing policy is being observed.

Accomplishments: An October 29, 1979, survey report on the barriers to sharing concluded that, although some real barriers do exist that inhibit sharing, there are more artificial barriers that really preclude the most efficient and effective utilization of resources. Barriers identified in the report included legally established priorities for VA health care which provide that (a) non-veterans and non-Federal patients have lowest priority for care, and (b) only those specialized resources operating below maximum effective capacity can be shared; reimbursement and fund distribution methods; and program officials' reluctance, in some cases, to fully support or encourage sharing. The survey concluded that these barriers should be investigated by site visits to medical centers and discussions with VA medical center and local hospital (private and Federal) managers. For this reason, we are instructing our auditors to give emphasis to determining whether sharing options are being aggressively pursued when appropriate.

The results of individual medical center audits performed during the period April 1, 1979 to March 31, 1980, were analyzed. Nearly one-half (22 of 51) have one or more findings regarding underutilization of specialized medical programs (SMPs). The most frequently underutilized SMPs were bed type programs, i.e., intensive care units (ICUs) and respiratory care units (RCUs). Following is a frequency distribution of our findings:

8 - Respiratory Care Units
5 - Intensive Care Units
6 - Electron Microscopes
6 - Cardiac Catheterization Laboratories

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1 - Computerized Axial Tomographic Scanner
2 - Nuclear Medicine Units
1 - Renal Transplant Unit
1 - Hemodialysis

Of these 22 audits (the frequency distribution figures above do not equal 22 since five centers had more than one underutilized program); three are still pending response from the Department. The Department's SMP productivity/ utilization reports for the last half of Fiscal Year 1979 (latest available) were reviewed. Of those recommendations made during the past year when sufficient time subsequently elapsed to determine actions or trends, these reports showed improvements in utilization of 14 SMPs, but 6 remain at an unacceptable level.

Reviews are currently underway to determine whether the electron microscopy and hemodialysis programs at selected medical centers are properly justified and efficiently and economically operated. Problems relating to underutilized cardiac catheterization laboratories at selected medical centers were addressed in a March 1980 letter report to the Chief Medical Director, to which comments are pending. Further, the problem of underutilization of specialized medical resources will continue to receive attention in our audits.

ENCLOSURE 6

LOAN GUARANTY PROGRAM

Objective: Put remedial measures in place by June 30, 1979, to minimize the types of frauds which our investigations have identified in this program.

Background: On July 5, we reported to the Senate Veterans' Affairs Committee on the corrective actions that had already been taken and the additional recommendations we were making to the Department of Veterans Benefits. We also discussed proposed actions to revise our investigative strategy and to provide audit oversight to assure that actions taken by the Department were properly implemented by the regional offices.

Accomplishments: The following is the status of the Department of Veterans Benefits' actions in response to our recommendations:

> Recommendation: Reinforce the system for the regional offices to maintain adequate lender files and to periodically report instances where lenders have an abnormal frequency of discrepant cases involving misstatement of assets, debts, employment, etc.

The Department of Veterans Benefits has, by Change 47 to Manual M26-1, required that regional offices maintain more complete records in their lender files. Prior to this change, the regional offices were required to place a copy of correspondence to the lender which requested information on loan applications or which was critical of how the lender handled a particular application. The change requires that, in addition, a copy of every post-audit product, good as well as bad, be placed in the lender's file. This gives a full picture of the experience with the lender. Also, the Chief, Loan Processing Section, is now required to periodically review each lender's file.

The Department of Veterans Benefits also added an affirmative reporting requirement to post-audit procedures, requiring quarterly reports by each regional office on the results of post-audit review. The first of these reports was due on January 20, 1980.

> Recommendation: The foregoing information and claims experience of the lender should be analyzed and the most serious cases referred to the Assistant Inspector General for Investigations. Also, monitoring of suspect lenders should be intensified.

The Department of Veterans Benefits has reported that they completed their review of findings reported by regional offices for the first affirmative reporting period. The results were analyzed to determine if an abnormal frequency of discrepant cases exist in the guaranteed loans approved by a particular lender. Since many lenders do business in more than one state, Central Office analysis of the quarterly reports would disclose any patterns or unusual frequency of discrepancies which might not be evident to the individual offices. The Department of Veterans Benefits advised that of the 50 regional offices responding, 36 reported finding

no significant discrepancies for the period. Of the discrepancies reported, 30 were considered significant and 8 could possibly be determined to be significant. This is a very small number of instances when compared to the total number of guaranteed loans approved by lenders on the prior approval basis (91,691). The Department of Veterans Benefits also advised that their overall review of the information contained in the first quarterly report did not reveal any apparent pattern of collusion, fraud or misrepresentation on the part of any lender or real estate broker. However, we do not believe that a single three-month period is sufficient to come to any conclusion regarding the existence of patterns. The Department of Veterans Benefits will continue to monitor the reports as the information becomes available.

Existing instructions already provide for enlarging post-audit sampling of cases submitted by particular lenders.

> Recommendation: In order to improve the content or control over the reliability of information supplied by veterans, lenders, sellers, etc., we suggested several specific additions.
>
> 1. VA loan processors be alerted to the need to obtain necessary clarification when the possibility of overstatement of earnings is suggested by the veteran's occupation or the veteran is self-employed.

The Department of Veterans Benefits considers that current instructions to loan examiners are adequate. Quality control reviews are stressed in this area and this was an agenda item at conferences with Chiefs of Loan Processing Sections in Phoenix and Atlanta in November 1979.

> 2. Coordinate with HUD to provide penalty warning above the employer's signature block on the Verification of Employment form.

This has been accomplished after some discussion with HUD and the following statement was added to the form:

> "Federal statutes provide severe penalties for any fraud, intentional misrepresentation, or criminal connivance or conspiracy proposed to influence the issuance of any guaranty or insurance by the VA Administrator, the HUD/FHA Commissioner, or the USDA Farmer's Home Administrator."
>
> 3. Where a multi-unit purchase is involved, require the lenders to obtain a notarized statement from the seller regarding the name, tenure of residence, monthly rentals and other data regarding current tenant.

The Department of Veterans Benefits considers that current instructions to loan examiners are adequate. The methods by which income can be

verified on multi-unit dwellings was discussed at conferences with Chiefs of Loan Processing Sections in Phoenix and Atlanta in November 1979.

4. Establish a pilot project at one or more regional offices to accumulate information on discrepant cases by brokers as well as by lending institutions.

Action is being deferred pending evaluation of the information obtained from quarterly reports. However, based upon information from the first quarterly report, there is no reason at this time to establish such projects.

The Department of Veterans Benefits has also provided further information regarding a pilot project to obtain backup credit reports. Computer terminals to order backup credit reports have been installed in Jacksonville, Philadelphia, and San Francisco. Although detailed records have not been maintained of the benefits of this capability, regional offices have experienced a definite reduction in the frequency of instances where the completeness and accuracy of credit reports provided by lenders is not substantiated by the backup credit reports. Placing credit report terminals in the regional offices has not resulted in uncovering significant discrepancies which might be attributed to fraud. However, it has resulted in improved quality of the credit reports submitted by lenders. It appears likely that the greatest value of the credit report terminals is as a deterrent. Their existence in the regional offices has been widely publicized and seems to have discouraged program participants from furnishing false or incomplete information.

In addition to recommending the foregoing series of actions, we increased audit oversight of the Loan Guaranty Program. Audits of selected aspects of the program were conducted at seven regional offices between November 19, 1979 and February 20, 1980. The objectives of the audit were to be determine if operations are efficient, effective and economical; if procedures comply with applicable laws and regulations; and if controls over local operations are sufficient to minimize the potential for fraud and abuse. The audit findings include:

1. Post audits of prior approval home loan submissions are conducted; however, none of the seven regional offices has identified any instances of an abnormal frequency of discrepant cases in the total commitments made to a lending institution.

2. The required number of post audits, during Fiscal Year 1979, was not initiated at six of the seven regional offices; 81 percent of the required number were initiated. During December 1979 four of these offices corrected their procedures and were performing the required number.

3. Post audit employment and deposit verifications are not adequate. Follow up is not always accomplished when requested information is not received. At five of seven regional offices all required verifications were not requested, and complete verifications were not returned in all cases. Only four of seven regional offices were following up when requested information was not received; the follow up action was effective in obtaining the information.

Other findings concerned the need for improvement of servicing of home loans in default, property management and loan processing.

Recommendations for improvement of operations were made to regional office directors during the audit. Additional audits will be conducted during FY 1980.

ENCLOSURE 7

TARGET

Objective: Continue close monitoring of TARGET implementation, with particular attention to protection against fraud, error and unauthorized disclosures.

Background: Soon after the January 1978 establishment of the Inspector General's office, the Administrator directed that priority be accorded to monitoring and development of the new TARGET system. Preinstallation audit reviews commenced in August 1978 and will continue throughout the system development period which extends into 1983.

A just completed audit at the time of my April 1979 confirmation hearings had disclosed that documentation standards did not exist in all requisite areas, nor did documentation exist even when a standard did exist; contracting procedures did not adequately define the standards for judging an acceptable product or for insuring the government is properly protected in terms of damages and payment standards; more definitive guidance needed to be provided by central office to the regional offices in implementation of the Privacy Act, and the risk analysis being conducted did not include all of the areas that it should, according to industry standards. Specifically, on the subject of privacy, we observed that there were no standard procedures in use by the regional offices to verify the identity of persons requesting information and standard procedures for the physical protection and destruction of records to adequately safeguard an individual's privacy had not been issued. Corrective action was reportedly taken on these findings.

Accomplishments: In the past year we have issued a number of reports on TARGET, as follows:

1. TARGET System Risk Analysis Effort, Central Office, May 25, 1979. This report pointed out the slow progress, lack of adequate coverage of regional offices, and lack of a standardized approach in the risk analysis studies required by OMB Circular A-71. Such studies are intended to measure the vulnerability of computer installations so that security resources can effectively be distributed to minimize potential loss. Corrective action was taken on the recommendations from this audit.

2. Protection of Individual Privacy in the TARGET System, Central Office, June 4, 1979. This report stated that reasonable measures had been taken to establish procedures and controls for protecting individual privacy in the TARGET System at this stage of the system's development and use. The report also listed additional measures which were being or should be considered to meet future needs.

3. TARGET System Risk Analysis, February 21, 1980. The audit found that progress has been made but the TARGET system risk analysis effort was not completed. Insufficient coordination and control was being exercised by the Risk Analysis Oversight Committee. Needed actions included compiling and integrating these results of station-by-station risk analysis to identify all risks and countermeasures, establish a

schedule for implementation of countermeasures, develop plans and timetables for future risk analyses, improve guidelines for future risk analysis, and ensure that such guidelines are uniformly applied. Also, the Risk Analysis Oversight Committee should be reactivated. Responsible VA officials agreed to take these actions.

4. Privacy/Security at Regional Offices using the TARGET System, February 19, 1980. This audit found that progress had been made in insuring the privacy and security of claimants' records. Improvements were recommended to enhance the use of security violation logs, to improve security of veteran employee files, to account for information disclosures, and to provide more Privacy Act training.

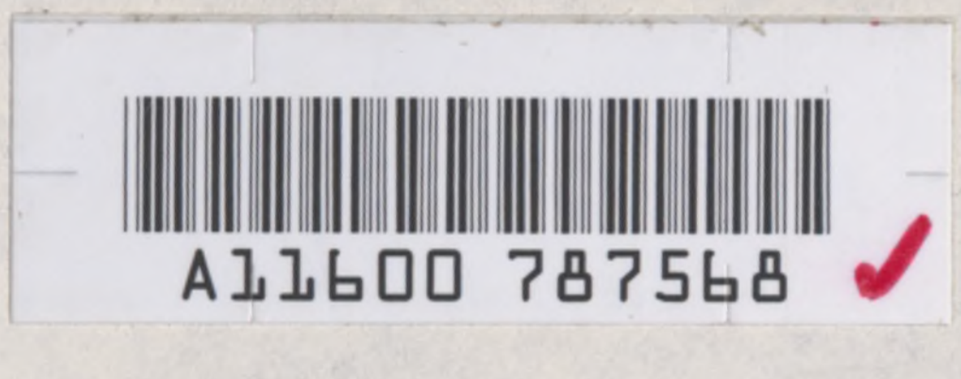
5. TARGET Privacy/Security at Central Office, February 20, 1980. This audit found that VA Central Office elements have taken action to protect the privacy and security of personal data within the TARGET system. The only discrepancies noted were the lack of periodic security audits of data processing centers and the lack of adequate procedures to control or protect claims folders in the Office of General Counsel, the Board of Veterans Appeals, and the Office of Controller.

6. Privacy/Security at VA Data Processing Centers Processing TARGET Applications or Transactions, February 21, 1980. This audit found that, in most cases, controls had been established and implemented to minimize unauthorized disclosure of information and to maintain the security of data and equipment used by the TARGET system. However, additional measures should be taken to further improve TARGET system security. Operating system controls would be improved by using other available security features and by standardizing and following existing security procedures. TARGET production system access was not properly controlled, and disaster recovery plans were not adequate. Data Processing Center (DPC) security officers have been appointed, but responsibility for overall TARGET systems security was not clearly defined and all security functions were not being performed. Physical security was generally adequate. However, overall security improvement was needed at Philadelphia DPC and procedures for monitoring visitor access was needed at 2 of 4 DPCs, inspection of packages at 3 of 4 DPCs. Also, clearance procedures for separating employees needed improvement.

With regard to the four most recently completed audits (3-6 above), no instances of unauthorized disclosure or use of information contained in the TARGET system were found. Reasonable measures have been taken since our original audit to insure that the individual privacy of records is being maintained within the TARGET system. While the discrepancies identified in these latest audits do not indicate major weaknesses in the system controls, the report recommendations will further strengthen existing controls. The VA staff offices and departments agreed with the audit recommendations. Most have implemented or are planning to implement corrective measures. The Office of Data Management and Telecommunications is including correction of operating system controls, TARGET production system access, security officer performance and security of the facilities

in their TARGET Risk Analysis Implementation Plan. The Department of Veterans Benefits is revising appropriate policies and procedures and is planning to implement additional controls to insure compliance with procedures. Other offices have developed similar plans for corrective actions. The Office of Audit will monitor development and implementation of these corrective measures as part of quarterly audit tracking procedures.

The Assistant General Counsel identified a privacy/security aspect which was not specifically addressed by the audits. This was accounting for mass computerized disclosures from VA systems of records made under "routine use" provisions that do not require the consent of the individual. This area will be scheduled for audit in Fiscal Year 1981. In addition, we are committed to continuous monitoring of TARGET throughout its implementation.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