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SEMIANNUAL REPORT OF THE
INSPECTOR GENERAL

(April 1, 1980 to September 30, 1980)

A REPORT

PREPARED BY THE

VETERANS' ADMINISTRATION

(Pursuant to Section 5(b) of Public Law 95-452)

SUBMITTED TO THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE



DECEMBER 2, 1980

Printed for the use of the Committee on Veterans' Affairs

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RESEARCH REPORT OF THE
INSTITUTE OF POLITICAL SCIENCE

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(II)

REPORT

RESEARCH REPORT OF THE
INSTITUTE OF POLITICAL SCIENCE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE



Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1950

LETTER OF TRANSMITTAL

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420



**Veterans
Administration**

DECEMBER 2 - 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 April 1, 1980, through September 30, 1980.

As may be seen from the Semi-Annual Report, the Office of Inspector General has developed a number of initiatives and recommendations upon which the Agency has acted in order to minimize fraud, waste, and mismanagement in the administration of benefits to veterans.

A primary effort of the Inspector General has been in response to the challenge given to him to explore means by which the sizable accounts receivable in the Veterans Administration could be reduced by 50 percent. During the past year, considerable effort has been given to the collection of overpayments of VA educational benefits under the test project authorized by Congress last year. We believe the results under the test project have been satisfactory, and that recently enacted legislation, Pub. L. No. 96-446, will greatly enhance our ability to collect overpayments. However, there are two significant factors which must be considered in anticipating and measuring the effectiveness of the collection program.

First, although Pub. L. No. 96-446 removes many of the impediments which have been largely responsible for the inability to conduct an effective collection program, implementing these changes is going to be very costly in terms of resources. Until we are authorized sufficient budgetary authority for those items, we will be unable to use these new "tools" fully. For example, without sufficient personnel to bring suit in courts on the debts, the results will be minimal. In addition, many other matters must be considered. For example, the VA must enter into contracts with at least six organizations in order to begin utilizing Consumer Reporting Agencies. In addition to our

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Honorable Alan F. Cranston

lack of personnel for this program, the resources which are presently available to the VA under the continuing congressional funding resolution do not permit the VA to make the necessary changes in our computerized referral system to implement these new practices. Passage of an Agency appropriation act which provides additional resources is a prerequisite to commencement of effective Agency action on most of the provisions of the law.

In addition, our more aggressive posture with regard to collection of debts, particularly educational assistance overpayments, is and must be tempered with concerns for procedural fairness. This concern was underscored for the VA and other Federal agencies by the Supreme Court's recent decision in the case of Califano v. Yamasaki, 442 U.S. 682 (1979). The decision in that case, involving procedural requirements which an agency must follow in attempting to recover benefit overpayments, requires this Agency to afford a beneficiary certain procedural rights prior to instituting the Agency's offset recovery authority. It is difficult to assess the impact of this decision on Agency recovery efforts, particularly in light of other changes which are occurring simultaneously, but we believe that the cost of these necessary procedural changes could be as high as \$30 to \$40 million annually.

The establishment of a Medical Inspector Unit has been a positive step in ensuring that allegations regarding quality of care are thoroughly and independently investigated, and appropriate action is taken to remedy problem situations. This unit was proposed by the Inspector General and is a joint effort with the Chief Medical Director. The Medical Inspector Unit will function to assist the Inspector General in investigations requiring medical expertise, as well as to conduct investigations concerning patient care, including quality of care provided and competence of medical professionals.

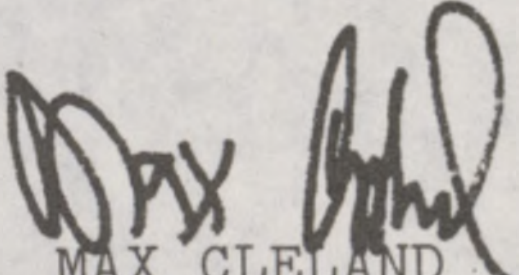
Overall, we believe the Inspector General has assisted in making significant progress in detecting and preventing fraud, waste, and mismanagement in the operation of the Agency. We take seriously the challenges Congress has put before us in that regard, and will continue to support the

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Honorable Alan F. Cranston

Office of Inspector General in its efforts to meet those challenges and to consider and implement as timely and efficiently as possible the recommendations they offer.

Sincerely,



MAX CLELAND
Administrator

Enclosure (1)

Enclosed for the Hon. J. V. Belmont
Director of Investigation, Federal Bureau of Investigation
Washington, D. C. are two copies of a letter and
affidavit as above. The investigation was made.

Respectfully,
[Signature]

[Signature]
[Signature]

Very truly yours,
[Signature]

Enclosure

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CHAPTER I

OVERVIEW

The Inspector General Act of 1978 requires the Office of Inspector General in the Veterans Administration, to:

1. Conduct and supervise audits and investigations.
2. Provide leadership, coordination and recommendations to promote economy, efficiency, and effectiveness and to prevent and detect fraud and abuse.
3. Keep the Administrator and Congress fully and currently informed about problems and deficiencies and the necessity for and progress of corrective action.

In carrying out these responsibilities in an Agency as large and complex as the Veterans Administration, opportunities for improvement will obviously continue to be identified. We believe the measure of success of implementation of the Inspector General Act should not only be the findings and recommendations of our audit, investigation and other reports, but also the aggressiveness and success with which responsible Agency management officials address and resolve these problems. Most of the major problems discussed in this report have been or are being corrected.

The following paragraphs summarize the major findings, conclusions and corrective actions stemming from activities of our office. They also indicate the major initiatives taken by VA's management on these matters.

BENEFIT PROGRAMS

VA benefit programs, administered by the Department of Veterans Benefits, comprise approximately two-thirds of the Agency's budget. For FY 1980, benefits for compensation, pension, and education totalled \$13.6 billion and were paid to approximately six million veterans, dependents, and survivors. In addition, loan guaranties for home purchase loans totalling \$14.7 billion have been made to 289,000 veterans. As previously reported, we have not found widespread fraud in these programs. However, VA continues to have problems with overpayments, defaults, and collection of accounts receivable because of error, abuse, and lack of effective collection procedures and legislative authorities. We believe that

initiatives taken and authorities recently obtained or proposed should materially affect the accounts receivable balance. Because of lead time for implementing new initiatives, however, the impact will not be realized for a period of time.

Accounts Receivable. Benefit programs accounts receivable and amounts where collection action was terminated during the fiscal year are:

<u>Program</u>	<u>Bal of Accts Rec. - 9/30/80</u> Thousands	<u>Terminated Amt - FY 1980</u> Thousands
Education	\$420,683	\$ 798
Loan Guaranty	\$154,660	\$ 2,351
Compensation & Pension	\$ 68,366	\$ 2,233

NOTE: Appendix I contains more details about these and other accounts. Such information is required by the Supplemental Appropriation Act of 1980 to be included in our semi-annual reports. The appendix does not, however, include information on the amount of accounts overdue. Current accounts receivable systems will have to be modified to produce this data.

a. Overpayments and Defaults. We have continued to pursue the causes of overpayments and to monitor collection action taken on accounts receivable. The education accounts receivable balance remains a major problem. While the balances declined from \$483.9 million in FY 1977 to \$420.7 million as of September 30, 1980, the balance increased by \$14.9 million in the last six months. There was a \$7.6 million reduction in the amount of new overpayments established in this period. However, this was more than offset by a 22 percent decline in the collection or other disposition of accounts receivable.

The reduction in dispositions is largely due to a procedural change. Since March 1, 1978, VA has referred uncollectible cases directly to U.S. Attorneys rather than to GAO. Before that date, uncollectible education debts over \$600 were referred to GAO and removed from VA's accounts receivable records. Now VA maintains accountability for referrals. In addition to this procedural change, VA is no longer terminating the "under \$600" debts on a large scale. VA is awaiting the outcome of a pilot program being conducted by General Counsel to resolve these debts through litigation.

Our review of centralized accounts receivable records determined that education overpayments were 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 by veterans and educational institutions in reporting changes in training status (58 percent). The first of these causes, untimely processing, can be partially corrected by setting and observing priorities on timeliness. Also, the availability of a new automated system (TARGET) provides a more expeditious means for adjusting benefits. We are reviewing alternatives with the Department of Veterans Benefits to reduce the impact of the other causes.

The education loan program has a default rate of about 60 percent. As of September 30, 1980, the amount in default was \$22.4 million. Previous legislation required that applicants must have been denied a guaranteed student loan by at least two lenders to be entitled to a VA education loan. This provision tended to limit VA loans to applicants who were poor credit risks. This requirement was eliminated by new legislation in January 1978; however, defaults continue to increase. We are currently auditing this program.

Defaults on guaranteed home loans also continue to be an increasing source of potentially uncollectible debts. As of September 30, 1980, loan guaranty indebtedness had risen to over \$154.7 million. During FY 1980, \$32 million in new indebtedness was established. Slightly more than \$14.7 million in indebtedness was disposed of by collection and offset against other benefits (\$6.8 million); waiver and compromise (\$5.6 million); and termination of collection activity (\$2.3 million).

b. Initiatives to Reduce Overpayments and Improve Collections. In our last report we noted that the General Counsel was to perform a one-year test to evaluate the cost effectiveness of pursuing collection by instituting civil actions against small debtors. This test has begun and Phase I is complete. Phase I of the three-phase pilot program involved pursuit of about 975 "under \$600" accounts retrieved from terminated status by GAO for the test. However, a large number of these veterans could not be located, thus limiting successful pursuit of these cases. Of the 975 cases, 88 totalling \$27,373 have been paid in full and repayment plans have been established for 181 cases totalling \$69,353. Phase II involves referral of active "under \$600" education accounts presently in the centralized accounts receivable system

to ten selected stations. This phase of the program began in May 1980 and is expected to average referrals of 3,000 cases per month. To date, over \$49,000 has been collected and repayment plans have been established on 322 cases totalling over \$99,000.

Phase III will use consumer reporting agencies (CRA's) to locate veterans and to notify them of anticipated action and the effect the credit rating of debtors who fail to resolve indebtedness within a reasonable time. Referral to CRA's is expected ultimately to affect both terminated and active cases. Implementation of this phase of the program, which could potentially involve 1.4 million accounts, had to await enactment into law on October 17, 1980 of the "Veterans Rehabilitation and Education Amendments of 1980". The prior restrictions on the use of CRA's effectively precluded use of this method of debt collection. In addition, full implementation of Phase III will be contingent on VA's ability to obtain substantially expanded computer and staff resources necessary for such a massive program.

The General Counsel and the Department of Justice signed a Memorandum of Understanding on October 21, 1980 to expand the pilot program to all geographic areas, to address all types of indebtedness and to change the dollar limit on debts which may be pursued by the VA from \$600 to \$1,200. Statistics indicate that the majority of VA debts are in amounts of \$1,200 and less, thus the proposed new delegation would shift the burden of collection from the Department of Justice to the VA for most of the Agency's debts. Implementation of this program is expected by December 1980.

The Department of Veterans Benefits is continuing its policy of refusing loan guaranty benefits to veterans who have delinquent educational debts to the VA, and who are determined not to be good credit risks. For the period May 1979 through September 1980, the following results have been obtained:

Home Loan Application - Education Overpayments
May 1979 through September 1980

<u>Status of Indebtedness</u>	<u>Number</u>	<u>Amount</u> <u>(\$ Millions)</u>
Paid in full	20,337	7.7
Repayment plan established	3,810	2.7
Plan to offset against new benefits by reentering school within 45 days	364	.2

Initial cash received as full or partial settlement amounted to \$8.5 million. There are additional potential collections totalling about \$2.1 million. In accordance with its policy, the Department denied loan guarantees to 9,177 individuals, who collectively owe the VA about \$5.8 million.

VA is continuing to refer cases to the Department of Justice. As of September 30, 1980, the VA had referred over 85,000 cases for collection. These cases, each in excess of \$600, represent a total liability of \$98.6 million. To date, \$10.6 million has been collected.

Based on our recommendations, in October 1979 the VA entered into an interagency agreement with the Internal Revenue Service to obtain current address information. Through September 1980, approximately 288,000 accounts have been referred for IRS locator service, 5,277 accounts (total value of \$5 million) have established repayment plans, and 2,662 have been paid in full. The Agency recovered almost \$2.9 million through the end of September 1980.

A new computer application was developed to periodically match accounts receivable records with VA employee pay records. When a match is found, a letter is sent giving the employee 30 days to resolve the indebtedness. If the employee does not resolve the debt, the employee's supervisor is notified and requested to counsel the employee. Funds may be deducted from the employee's salary if the employee agrees, or the retirement account and accrued salary if the employee leaves VA employment before the debt is liquidated. As of September 30, 1980, there were 3,351 employees with accounts receivable totalling about \$2.7 million. Of this total, 721 accounts (21.5 percent) representing over \$.5 million (18.9 percent) are under a repayment plan.

We have also established a computer matching project to identify employees in other Federal agencies who are in debt to the VA and to pursue collection from these employees through government channels. This match will also compare compensation and pension records to Federal personnel records for the purpose of identifying instances of possible fraud or abuse in obtaining VA benefits. The computer match, between VA accounts receivable records and Office of Personnel Management records is being run at this time and we expect collection action will begin by January 1981.

A VA legislative initiative, the "Veterans' Rehabilitation and Education Amendments of 1980," was enacted on October 17, 1980. This law gives VA the authority to deduct by offset from other VA benefits all sums owed the VA, with procedural protection afforded the debtor. The law provides for disclosure of information to

consumer reporting agencies as previously discussed. It also provides for the use of VA attorneys to pursue collection actions. The law requires the Administrator to issue by January 1, 1981, implementing regulations for collecting interest and administrative costs on all delinquent debts. Interest will be at a rate based on the cost to the United States for its borrowing and may be avoided by payment of the debt within a reasonable time after notice.

Anticipating passage of this legislation, the VA has held agencywide debt management meetings and has developed a policy on charging interest. The General Counsel, Department of Veterans Benefits, Controller, and Office of Data Management and Telecommunications are working on plans for implementation; however, extensive work must be completed prior to implementation. Although regulations on charging interest and administrative costs are required by January 1, 1981 computer programs and implementing procedures will have to be developed. The Controller's office plans to work on specifications for referrals to consumer reporting agencies but, since they have determined VA lacks expertise in this area, assistance is being requested from GAO.

In our prior reports, we pointed out problems in obtaining and using current address information from Internal Revenue Service. The House passed a bill, H.R. 4155, on June 17, 1980, which would permit IRS to disclose to the Department of Education addresses of student loan defaulters for loan collection purposes. On September 19, 1980, an amendment was proposed in the Senate to H.R. 4155 to permit such disclosure to the VA for several debt collection purposes. This Bill is now pending action in the Senate Committee on Finance. The proposed Amendment would also permit the VA to redisclose addresses to facilitate debt collection by the Department of Justice, GAO or any other Federal agency; and by VA contractors who locate debtors and prepare asset and income reports; and consumer reporting agencies.

We believe that pursuit of the initiatives described will have a marked impact on collection of education and other accounts receivable. However, many of these processes are slow, and some are expensive. None 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 indicates that offsets against tax refunds are being considered but a test at this time is risky. A decision will be deferred until the study is completed. The basic risk identified by the OMB project is the reliability of government accounts receivable records. However,

our studies and those of the Department show that error rates in VA's accounts receivable records are not excessive. Only between 2.7 and 3.4 percent of these accounts are over-stated.

Other Aspects of Benefit Programs. Two other major problems were addressed during the past six months.

a. On-the-job Training and Apprenticeship Programs. Although not completed, our audit of public on-the-job training and apprenticeship programs has uncovered a serious problem. (Public programs are those run by city, county and/or state governments for such positions as firefighters and police officers.)

As of October 1, 1980 there were 4,112 trainees in public programs with benefits paid to them of \$7.9 million. Our audit has found that public agencies were often not implementing these programs properly. The audit disclosed one or more violations of approval criteria in 71 percent of public on-the-job training programs and in 67 percent of public apprenticeship programs reviewed. Total benefits remaining to be paid in these programs at the time of our audit were \$313,000. When we realized the scope of the problem we issued an interim report. As a result, the Chief Benefits Director instructed regional offices to review all active public on-the-job training and apprenticeship programs and to suspend further enrollments and education benefit payments to trainees already enrolled in programs with discrepancies. Further information on the results of these reviews will be included in our next semi-annual report.

b. Loan Guaranty Program Fraud. The extent of detected program fraud and abuse is greater in this program than in any other VA program. Even so, the number of known cases is quite small in relation to total program activities. As discussed in our prior semi-annual report and in Chapter 4 of this report, a number of initiatives have been taken by the Department of Veterans Benefits and our office to enhance the ability to detect fraud.

We are developing a series of fact sheets designed to increase employee awareness of the potential for fraud, waste and abuse in VA programs. The first fact sheet concerns this program. The fact sheet is intended to bring known program abuses to the attention of auditors, investigators, and program employees to assist in identifying and preventing these abuses. It details three types of schemes uncovered by our investigators, VA loan guaranty program officials, and others. These are: (i) fraud perpetrated by third parties, i.e., lenders, real estate brokers/salespersons, credit agencies, fee appraisers, builders and sellers; (ii) veteran or beneficiary fraud; and (iii) fraud by VA employees.

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, the District of Columbia, and 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. During FY 1980, 89 Vet Centers were established to provide readjustment counseling for Vietnam Era Veterans. Of VA's FY 1980 budget, \$5.8 billion or 28 percent is allocated for the Department of Medicine and Surgery. The Department's 190,000 employees represent 89 percent of VA's FY 1980 staffing. A medical system of this size is complicated by the need to maintain and upgrade the skills of medical professionals, to adjust the physical plant for changes in technology and patient population and to provide research and development in solving problems found in the veteran population.

Professional Services Programs. Professional services programs (formally designated specialized medical programs) include those programs or services that because of their specialized nature and attendant expenses (e.g. highly trained staffs, expensive equipment, etc.), are intended to be restricted to facilities demonstrating a need and the ability to maintain a fairly high productivity/utilization rate. Among the more than 30 specialized medical services offered by VA medical centers are: electron microscopy units, cardiac catheterization laboratories, computerized axial tomography (CAT) scanners, hemodialysis units, supervoltage therapy units, nuclear medicine units, and renal transplant units. In FY 1979, VA spent over \$710 million and employed over 25,600 personnel to operate these programs.

During the last six months, 33 medical center audits covered the productivity/utilization of 67 specialized medical units. Based on the Department's productivity/utilization standards, 50 units were efficiently used and 17 units were underused, with cardiac catheterization laboratories (CCL's) and respiratory care centers being most frequently identified.

In our March 19, 1980, report regarding underused CCL's at five medical centers, we pointed out that some underused CCL's were allowed to continue operations long past the prescribed grace period for meeting utilization standards. Actions were not always taken to assure that specialized VA medical resources available within a medical district were coordinated. We were concerned about continued operation of one or more underutilized CCL's within a medical district without any action to improve utilization. The Chief Medical Director responded that steps had been taken to close

two underused CCL's and that the impact of the closures would be studied. If no serious consequences result, the Department plans to implement closure actions at selected medical centers with chronic underutilization problems. The Department will also continue to work closely with the Federal Health Resources Sharing Committee in an effort to increase sharing between the VA and other federal agencies and to stress sharing among VA medical centers. Since the issuance of our report, the Agency has revised a number of standards for specialized medical programs, including CCL's. We will continue to monitor progress in achieving the revised standards.

Three audits identified instances where the planned establishment of specialized medical programs was not fully justified based on costs, current and projected workloads, and availability of similar services from nearby VA or community facilities. For example, it was determined that a VA medical center's current and projected Computerized Axial Tomography (CAT) scanner workload could be adequately accomplished by referral to other VA or community facilities, rather than obtaining an in-house CAT scanning capability.

Conversely, two audits found that sharing, which is a recognized option for improving substandard specialized medical programs, was not always feasible. In one audit, it was determined that the costs of providing supervoltage therapy service at a VA medical center was one-fourth of purchasing this service. Another audit found that a proposed sharing agreement for cardiac catheterization services between a VA medical center and a non-VA hospital was not approved because VA Central Office officials felt that the costs involved were excessive. Also, our audits revealed that sharing was not feasible for 18 specialized medical units which were fully utilized. According to VA standards, specialized resources operating below maximum effective capacity can be shared.

Medication Handling. In FY 1980, about \$254 million was spent for drugs and medicines. Medication handling involves the receipt, storage, distribution, control, accountability, and administration of drugs. Controlled substances are drugs which have 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 continued the review of medication handling with emphasis on physical security requirements for the prevention of controlled substance losses.

Audits of 24 medical facilities showed the need to improve medication handling in one or more of the following areas: physical security of drug storage (14 medical centers); inventory control and accountability of controlled substances (13 medical centers and 1 supply depot); and drug inventory and storage practices (7 medical centers).

With regard to controlled substances at five medical centers, some shown on inventory records as having been administered to patients were not recorded in patient records. At three medical centers and one supply depot, stock levels of some controlled substances did not agree with inventory records. At three medical centers outdated drugs were found on wards, in clinics, or in the pharmacy. Some drugs were outdated for over a year.

A June 1980 GAO report, "Reassessment of Veterans Administration's Controls Over Drugs: Million-Dollar Problem Still Exists," concluded that although GAO reported on the VA's pharmacy system shortcomings in 1975, VA's efforts to strengthen drug controls have been largely ineffective. GAO's recommended controls over drug dispensing practices have not been implemented, and few pharmacies have been converted to the unit dose system. As a result, GAO believes potentially dangerous drugs are vulnerable to pilferage and abuse. GAO recommended that steps be taken to (i) implement interim ward stock control measures; (ii) revise the pharmacy manual to include interim control measures; (iii) require VA Central Office Pharmacy Service to conduct periodic compliance checks at the medical center level; (iv) ensure that pharmacy units do not fill incomplete or inaccurate prescriptions; and (v) strengthen security over prescription forms. GAO also recommended that the VA identify funds necessary to permit system-wide conversion of ward stock systems to unit dose and provide the resources required to achieve total conversion.

In September 1980, the VA responded to the GAO report, setting forth interim measures to strengthen drug controls and future plans to convert all VA medical center pharmacies to unit dose. These interim measures include: (i) a pharmacy manual revision which will incorporate all recommended changes dealing with drug control and accountability including the development of a systematic internal review process that can be applied to the prescribing, dispensing and drug utilization review component of the VA health care system; and (ii) a set of standards, criteria, and measuring instruments which will be used by the Department of Medicine and Surgery to evaluate drug controls at the medical center level.

As indicated in our prior report, we believe two major and expensive steps (unit dose distribution and computerization) are needed to significantly enhance controls to prevent drug diversion, abuse and waste. A unit dose dispensing system is needed to prevent losses within the medical center. We estimated such losses to be \$16.4 million yearly. Unit dose dispensing systems, which are extensively used in the private sector, have the added advantage of reducing the potential for medication error. In responding to the GAO report, the Department of Medicine and Surgery said that the cost for a complete unit dose system (the current systems cover only a small portion of total drugs dispensed), would be \$39.4 million and would also require almost 2,000 more employees.

Computer systems are also needed to prevent losses attributable to abuse by beneficiaries (i.e., obtaining duplicate prescriptions from multiple VA medical facilities). However, sufficient information was not available at the time of our review to determine the cost/benefits of such computer systems. As we recommended, VA's Office of Planning and Program Evaluation conducted a cost/benefit analysis. The results indicate a 10 year savings of over \$127 million and a favorable cost/benefit ratio of 1 to 1.3. The break even point is less than three years. Efforts are proceeding to design and install the computer system.

Eligibility for Medical Care. Outpatient non-service connected care is restricted to no longer than 12 months after inpatient discharge unless it is medically determined that a longer period is required. Our last report noted that at three medical centers patients were not systematically evaluated to determine their medical need for continued outpatient care. During this reporting period, audits disclosed similar omissions at three more medical centers. At one of these medical centers no review of medical need had been performed for at least 16 months. In 21 of 46 cases sampled at the other two centers, patients had been in an active outpatient status for longer than one year without documented evidence to support the need for continued medical care. Twelve of these patients were receiving treatment for conditions other than those for which they were placed in the program.

Audits at three other medical facilities found inadequate efforts to determine eligibility for treatment. Two medical facilities did not request verification of eligibility in 32 of 111 admissions reviewed. At one medical center, 430 of 616 requests for eligibility verification were more than 30 days delinquent, and no followup efforts were planned.

Billing and Collection. Our audits continue to identify deficiencies in the accounts receivable activities at medical centers. Ineligible patients are not identified, not promptly identified, or collection action is not taken to recover medical care costs. An audit report was issued on policies and operating procedures for admission processing, eligibility determination, and cost recovery based on reviews at 16 VA medical centers. The report concluded that admission/eligibility personnel inconsistently screen applicants regarding ability to defray expenses. Also, cost recovery was neither systematically recognized nor actively pursued. In addition to this report, our audits at other medical centers showed: one center not verifying applicants' veteran status, two centers not verifying eligibility on a timely basis, five centers not billing for reimbursable medical care, four centers not processing followup letters on overdue receivables, and six centers not processing followup letters on a timely basis. Reimbursable services provided under the medical care appropriation were valued at \$23.2 million for federal agencies and \$20.7 million for non-federal sources in FY 1980. Cumulative receivables outstanding as of September 30, 1980 for these accounts were \$10.4 million and \$13.6 million, respectively.

Beneficiary Travel. The cost of beneficiary travel was \$74.5 million in FY 1980. During this semi-annual reporting period, findings reported in four audits continued to indicate that management needs to apply greater attention to control of beneficiary travel. Two medical centers lacked accountability over local transit tokens. This resulted in a loss of tokens worth about \$40,000 at one facility and \$37,500 at the other. The latter was reported in our last semi-annual report. Management at one of these medical centers had been so deficient in reviewing and controlling the transit token program that the losses, whether real or a matter of poor record keeping, cannot be traced to any individual. At a third medical center we reviewed records of non-service connected patients who are required to submit current income affidavits to qualify for beneficiary travel reimbursement. We found that 15 of 26 income affidavits were over a year old and two records did not contain any required affidavits.

In the New York metropolitan area, we reviewed contracts for providing about \$2 million a year in transportation services. Our analysis indicated that this was almost twice as costly as reimbursing beneficiaries for using public taxis. Because of pending requirements to award new contracts for FY 1981, we issued an interim report to the Chief Medical Director recommending eliminating these contractual services or, in the event time was too short, to adopt the option of reliance on taxis. A senior contracting specialist from the Central Office was assigned to negotiate the

new contracts. We have been advised that the current contracts at two VA medical centers were allowed to expire on September 30, 1980. These medical centers will use metered cabs on a trial basis to determine if this method will be more economical to the government. A third medical center will continue to use contract service. If a determination is made that metered cabs will result in significantly lower cost then the decision could be made to use metered cabs at that medical center.

Patient Abuse. The conclusion of our December 1979 report on the Agency's anti-abuse program was that patient abuse was not a major problem at the 16 medical centers reviewed. The most significant weaknesses noted were 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. This was covered in 21 audits completed during the past six months, and we found the majority (16 of 21) had effectively adopted and implemented VA's policy and the related reporting and employee training procedures. The remaining five facilities, however, required significant improvements in these areas. The Department of Medicine and Surgery has issued additional directives to strengthen its program. For example, on September 2, 1980, each facility was instructed to ensure that VA's firm policy against patient abuse was adequately reflected in local policy, communicated to all employees, and evaluated annually as part of their systematic internal review program. We are satisfied that appropriate attention is being devoted to preventing the occurrence of patient abuse. Although we no longer plan to include patient abuse as a primary audit area, we will continue to pursue allegations indicating potential patterns of patient abuse received through the employee hotline and other sources.

Controls Over Quality of Patient Care. Our analysis of audit or investigation findings at 66 medical centers identified one or more problems where quality controls over patient care could be improved. There was a need for better implementation of VA and medical center policies and closer monitoring of patient care activities. Improvements were needed in supervision of resident surgeons, delineation of clinical privileges, conduct of ward rounds, documentation of medical records, operation of Clinical Executive Boards, and performance of quality assurance reviews. Corrective actions have been taken or planned to address the identified control deficiencies. To further support these actions, the Department of Medicine and Surgery is reviewing directives relative to the controls over quality of patient care and will issue new or revised directives as necessary.

Patient Medical Records. Our last report noted that audits frequently disclosed three medical record problems: failure to fully document patient consent; ineffective systems to locate medical records; and untimely completion of medical records. These and other problems have been reported to the Chief Medical Director in a summary audit report. Since medical records serve as an important control to assure quality patient care, emphasis on them has continued in our audits of VA medical facilities. During the last 6 months, medical records were satisfactory at 5 facilities. However, problems similar to those in our summary report were found at 26 medical centers.

The Department plans to address deficiencies regarding patient consent in a circular to be published. Concerning medical record availability, the department plans a program guide on file management to expand on and emphasize the general policies and procedures. The Department also advised of experiments with semi-automated and automated techniques to improve record availability. In the meanwhile, a Department circular will be prepared to focus on the problem areas which field facilities should constantly monitor. Further, the Department recognized that VA health care facilities continue to experience difficulties in insuring timely completion of hospital summaries and has issued a policy to tighten controls.

Incentive Therapy Programs. Incentive therapy seeks to rehabilitate patients using constructive work assignments with nominal remuneration. One of the program's primary objectives is to return patients to the community on a permanent basis. Accordingly, work activities are prescribed in line with patient treatment and rehabilitation goals, rather than with the intent of keeping patients busy or providing a means for them to earn money for incidental expenses.

In audits at four VA medical facilities, we found one had a very effective program, but two medical centers and one domiciliary were not providing adequate direction to insure compliance with the program's intent. These facilities' incentive therapy programs, which involved about 480 patients, had one or more deficiencies related to monitoring patient progress or assuring that work activities were appropriate. Directors at each facility agreed to take immediate action to strengthen direction and control over their incentive therapy programs.

Other Trends. We elaborated on the preceding topics due to significance, frequency or sensitivity. Additionally our trend analysis of medical center audits produced five other topics related to physical security, patients' valuables, fire and safety, equipment accountability and agent cashier.

Audits at 18 medical centers identified some type of physical security problem. The most prevalent problem was non-existent, nonworking, inadequate or untested alarm systems at 13 centers. Alarm deficiencies existed at pharmacies, drug storage areas, warehouses, and cashier offices. Other identified deficiencies included inadequate key control procedures, insufficient locks, substandard security screens, and unsecured windows.

Our last semi-annual report expressed concern about handling of patient's valuables. Audit reports issued in the last six months continued to disclose the need for increased attention to protection of patients' valuables. Of seven medical centers with reported deficiencies: three failed to maintain proper records of valuables placed in safekeeping with the VA; three failed to perform required semi-annual audits of valuables; three failed to provide adequate security for valuables; and two failed to return valuables to patients upon discharge. At one medical center, 249 of 274 sets of valuables in storage belonged to former VA patients. Audits at an additional four VA medical centers found the handling of patients valuables to be adequate.

At eight medical centers, we identified the need to improve workplace safety and to eliminate fire hazards. Deficiencies found include: excessive quantities of flammable liquids on hand in laboratory work areas; flammable liquids improperly stored in pharmacy; compressed-gas cylinders not chained or supported by other means although security chains were available; patient owned electrical appliances (toaster ovens, coffee pots, televisions, etc.) in use which had not been inspected; fuel dispensing systems improperly vented and not equipped with flame arrestors and protective barriers.

Our audits found that equipment accountability records were inaccurate at 11 medical centers with some items missing due to loss, theft, or poor record keeping. At five other medical centers, equipment accountability was correct. Excess equipment totalling \$497,000 was found at nine medical centers. Additionally, accountability was inadequate at five medical centers for over \$353,000 of dialysis equipment loaned to veterans for home use.

Our audits identified some type of deficiency in the agent cashier activity at 18 medical centers. Deficiencies in cash-on-hand funds government-wide have been reported recently by the GAO. Their report, "Continuing and Widespread Weaknesses in Internal Controls Result in Losses Through Fraud, Waste and Abuse," outlined deficiencies in physical security, performance of unannounced audits and excessive amounts of cash on hand. Our audits identified 11 instances of physical security deficiencies, 13 instances of problems with unannounced audits, and 4 instances of excessive cash balances.

MEMORIAL AFFAIRS PROGRAMS

The VA operates 140 cemeteries; provides interment for veterans and other eligible beneficiaries in these cemeteries; and also provides headstones or markers in private cemeteries. The FY 1980 budget of \$30.6 million includes funds for an estimated 50,000 interments and 292,000 headstones or markers. Our reviews of cemetery activities have not disclosed major problems.

FUNCTIONAL ACTIVITIES

We have continued to assess major functional activities within the Agency, with particular attention to procurement and construction activities.

Procurement. During FY 1979 the VA spent \$1.5 billion to acquire services, equipment and supplies. In the past six months we have addressed or begun reviews to address the following subjects:

a. Acquisition of ADP Equipment and Services. The acquisition of ADP hardware and software was the subject of a special report to the Administrator during this reporting period. Issues raised by Congress and OMB regarding FY 1978 and FY 1979 procurements and our investigative and audit work on various ADP projects showed the need for policy and procedural changes in this highly technical area. Our report, "Policies and Procedures for Acquiring ADP Hardware and Software," called for strengthening management controls over ten aspects of the acquisition process to insure informed decisions at the appropriate managerial level. Specifically our report was aimed at insuring that proper authorization for system development is obtained before work begins; that systems are neither developed nor implemented on a piecemeal basis; and that funds are not wasted on inadequate products or services. The ten areas addressed by the report are: planning, user involvement, cost/benefit analysis, procurement, sequencing acquisition of ADP resources, risk taking, benchmarking, controls, accountability, and accounting for the investment of ADP resources.

The Administrator took immediate action to insure development of concrete proposals to strengthen the areas highlighted in the report. The highest levels of management were tasked with the responsibility of developing these proposals and reporting to him within sixty days.

Six weeks after issuance of our report, GAO issued a report "VA Must Strengthen Management of ADP Resources to Serve Veterans' Needs." This report addressed many of the same areas as our report, albeit in more detail. However, the steps taken to comply with our report should rectify the similar problem areas reported by GAO.

b. Consulting Services. VA reported expenditures of \$3.8 million for FY 1979 consulting service contracts. The FY 1980 Supplemental Appropriations Act contained a requirement that, effective October 1, 1981, for application in fiscal year 1982, the Inspector General shall submit to Congress, along with the Agency's budget justification, an evaluation of the agency's progress to institute effective management controls and improve the accuracy and completeness of data provided to the Federal Procurement Data System regarding consulting service contracts. OMB issued instructions with respect to improving procurement practices in general and consulting service contracts in particular. We worked with VA officials and made recommendations which were included in the VA plan submitted to OMB on August 1, 1980, and approved on September 22, 1980. OMB's approval was conditioned by a requirement that we conduct annual audits.

An audit staff member was assigned to an interagency task group to develop a standard government-wide audit guide for auditing consulting service contracts. The guide is being used to audit VA Central Office and field facility consulting service contracts. Scheduled audit completion date is December 31, 1980, and the results of the audits will be submitted with the Agency's FY 1982 budget.

c. Other Procurement Findings. Increased competition for contract awards was needed at five medical centers. Three medical centers were certifying contractor's maintenance service billings for payment without adequate assurance that the services had been performed. At four medical centers, contracts were awarded without analyzing costs of doing the work in-house. OMB Circular No. A-76 directs that commercial or industrial products and services should be provided in the most economical manner through cost comparison of private sector and government performance.

d. Contract Award and Administration.

(1) Technical Reports. Of the 73 contract audits completed in the last six months for which cost and pricing data was required, 63 reports were qualified due to the absence of a technical report. Such a report represents engineering and technical personnel inputs that permit an evaluation of functions that cause costs to occur. These are vitally important to understanding cost projections as they relate to the job to be done. For example: technical analysis can provide an informed and useful opinion about the validity of projections for direct materials and usage factors; about the number and types of personnel it takes to do a job; and about differences between the estimated labor mix and planned operations. According to the Federal Procurement Regulations (FPRs), 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. This problem was previously reported and has been discussed with responsible officials. Recent indications are that corrective actions are being initiated and improvements should be noted during the next reporting period.

(2) Cost or Pricing Data. The FPRs state that it is the contracting officer's responsibility to require that the contractor submit written cost or pricing data. However, in the 73 completed audit reports for which cost and pricing data was required, there were 16 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. When this situation occurs, the contracting officer is at a disadvantage during contract negotiations because reliable information as to the reasonableness of proposed costs is not available. We are working with contracting officers to improve the quality and acceptability of cost and pricing data submitted by contractors.

(3) Pre-Award Audits. The FPRs provide that audit reviews shall be requested prior to the negotiation of any contract or modification resulting from proposals in excess of \$100,000 which are firm fixed-price or fixed price with economic price adjustment or proposals in excess of \$250,000 of any other types when the price is based on cost or pricing data submitted by the contractor. In some cases, however, the VA did not obtain the required pre-award audits. Instead, contracts were awarded subject to audit with the provision that the contract price could be adjusted downward based on audit results. We had viewed this procedure as preferable to no audit when time constraints severely limited the time for preaward audits. However, in several recent situations it became obvious that the Government's options were restricted when contractual activities proceeded pending pre-award audit. Further, the Office of Federal Procurement Policy has recently taken the position that the Government has no legal right to negotiate after award. Accordingly, we informed responsible officials that we would only perform pre-award audits prior to contract award.

(4) Cost Analysis for Section 8(a) Awards. In a 1979 Report to the Congress, GAO noted confusion as to which government agency should arrange for a cost analysis for an award authorized by Section 8(a) of the Small Business Act which authorizes the Small Business Administration (SBA) to award contracts for goods and services to small companies owned by socially or economically

disadvantaged persons. For such awards, the procuring agency awards a contract to SBA which in turn contracts with the subcontractor to provide the goods or services. As a result of this GAO report we contacted SBA and learned that SBA was not performing cost analyses of the 8(a) contracts which VA awards. Consequently, during FY 1980 we have been obtaining pre-award audits of the 8(a) contracts awarded by VA to the SBA. This has increased our pre-award audit workload about 35 percent.

(5) Contract Audit Initiatives. During the course of arranging contract audits we have noted certain deficient contract practices and/or provisions which we have brought to the attention of the contracting officer for correction. In one instance, questions which we raised resulted in the deletion of a \$470,236 contract modification. The examination of another contract revealed that the contractor had overbilled \$35,950 on one invoice and that the price effects of a contract amendment had not been considered, resulting in overstated costs to the VA of \$34,690. Although the primary purpose of a contract audit is to provide information to the contracting officer to be used in the negotiation process, we believe that such audits can also be a useful tool in identifying internal procurement problems such as those noted above. Therefore, we contemplate expanding the scope of our contract audit function as resources permit.

Construction. The VA's construction program is one of the largest in the Federal Government. The FY 1980 construction budget totaled \$321.3 million for major construction and \$72.2 million for minor construction and for general administration costs of the Office of Construction. The major construction program provides for constructing, altering, extending and improving any VA facility, including planning, architectural and engineering services, and site acquisition, where the estimated cost of a project is \$1 million or more (increased to \$2 million FY 1981). The minor construction projects appropriation provides for constructing, altering, extending and improving any VA facility where cost of a project is estimated to be less than \$1 million (increased to \$2 million FY 1981).

During this report period, we completed two audit reports concerning VA construction activities. A review of VA's construction approval steps assessed planning, approval, control and coordination activities of VA organizational units responsible for processing approval requests to the Administrator for 16 construction program milestones. We attempted to identify delays within each step and determine their causes. Audit results show Office of Construction is aware of delays and documents their causes. Significant actions have been taken by all organizational elements to reduce processing time from six to eight weeks to the current four weeks for each

approval request. Such improvements in timeliness offer significant cost savings in light of the inflationary impacts of unnecessary delays in awarding construction contracts.

The Report of Survey of VA Replacement Medical Center Construction projects was the third in our series of semi-annual surveys. We have been tracking the progress of nine replacement medical center projects through various construction milestones. Two of nine projects have had costly delays.

We briefed the Administrator on construction activities and the results of our audits in this area. The major highlights concerned planning for projects that were not adequately justified to be included in the agency budget and attendant delays that may contribute to cost escalation:

CHAPTER II

IMPLEMENTATION OF THE INSPECTOR GENERAL ACT IN THE VETERANS ADMINISTRATION

OPERATIONAL CHANGES

Several changes were implemented to improve the effectiveness of our efforts to address fraud, waste and mismanagement. The principal changes related to development of investigative priorities, expanding the scope of hotline activities to handle complaints received from other sources, and coordinating with the Department of Medicine and Surgery in developing an Office of Medical Inspector in that Department.

In order to become more responsive to addressing the requirements of the Inspector General Act and the needs of the agency, distinct priority areas were developed for the Office of Investigations. These priority areas were designed to provide an increased emphasis to fraud, waste or mismanagement in Veterans Administration programs, with the first priority given to cases involving violations of law or serious misconduct by ranking VA officials; cases involving large monetary loss; very sensitive matters involving high level interest; or cases involving significant threats to the integrity of the VA and its ability to provide services and benefits to veterans and other beneficiaries. Highest priorities are also accorded to investigations into allegations of job-related misconduct by professional staff members of the Inspector General's office and into allegations which indicate a pattern of serious patient abuse by employees at a VA station. Lesser priorities were established for other violations of law or serious misconduct.

The Office of Inspector General has been the focal point for receipt of complaints about the Veterans Administration through the employee hotline and complaint mail referred or directed to us. These complaints were handled by the Risk Analysis Staff, and the Office of Investigations, respectively. Now, all complaint mail and the employee hotline are handled by the Inspector General's Complaint Center. We have also added improved screening processes in order to better identify the seriousness of the allegations before referring the complaints for an audit or investigation. We expect to achieve the following advantages: (i) quick recognition of those duplicate complaints received through the complaint mail and the hotline; (ii) increased capability to recognize and coordinate multiple complaints from one station; (iii) increased analytical capability; and (iv) greater consistency in handling/processing of complaints and allegations.

The Office of Inspector General has occasionally investigated allegations regarding the quality of medical care provided at VA medical facilities. While the issues raised by such allegations are of grave concern, they often have a remote relationship to the fraud, waste, abuse and mismanagement priorities established by the Inspector General Act. Further, we concluded that it would be very difficult and expensive to establish a capability within our office to provide the range of medical specialists to address these primarily quality of care cases. Nonetheless, we believed that VA needed a more independent and disciplined capability to address the more serious quality of care allegations. In July 1979, we recommended to the Chief Medical Director that he establish an office, accountable directly to him, to carry out quality of care medical investigations. This office, called the Office of Medical Inspector, was activated on August 8, 1980. The following relationships have been established between the Medical Inspector and the Inspector General:

1. For those cases requiring joint efforts by the Office of Inspector General and the Medical Inspector, the Inspector General will have lead responsibility.

2. For cases referred to the Medical Inspector by the Inspector General, there will be preconsultation on the proposed scope and resources to be used on the investigation. The investigative report will be reviewed by the Inspector General for adequacy and appropriateness of recommendations.

3. For cases which are undertaken by the Medical Inspector as the result of allegations received from sources other than through the Inspector General, the Inspector General will be advised of such allegations and provided a copy of reports resulting from their investigation.

OFFICE OF THE INSPECTOR GENERAL STAFFING

The staff as of September 30 was as follows:

Professional Staff	
IG	2
Risk Analysis	5
Audit	229
Investigation	<u>51</u>
Subtotal	287
Administrative and Clerical Staff	<u>52</u>
TOTAL	<u>339</u>

RESOURCE APPLICATION

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

	<u>Staff Assigned*</u>	<u>Percentage of Effort</u>
<u>Objective 1: Vulnerability Assessments</u>	4	2
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.		
<u>Objective 2: Preinstallation Reviews</u>	5	3
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.		
<u>Objective 3: Special Initiatives on Fraud, Waste and Mismanagement</u>	39	19
To initiate timely and effective special audits and investigations to actively seek out fraud, abuse and waste and other serious problems.		

*All references to staff assigned represent the average number of professional staff directly dedicated to these objectives during the six-month period. These figures do not include management, staff and administrative time.

	<u>Staff Assigned*</u>	<u>Percentage of Effort</u>
<u>Objective 4: Cyclical Audits</u>	120	59

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.

<u>Objective 5: Reactive Investigations</u>	34	17
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To investigate complaints of serious criminal and administrative irregularities and to assure that corrective actions are taken.

In addition to the resources allocated to the foregoing objectives, staff resources were applied to carry out the following other activities:

	<u>Staff Assigned</u>
Liaison with GAO, including coordination of responses to GAO reports	3
Personnel and document security programs	3
Employee hotline	2

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 as follows:

	<u>Staff Assigned</u>	<u>Percentage</u>
Preinstallation reviews	5	3
Special Initiatives for fraud, waste and mismanagement	33	21
Cyclical audits	120	76

Audits completed during the reporting period pertaining to the above objectives are listed in Appendix 2.

PREINSTALLATION REVIEWS

Three preinstallation reviews were completed during the current period--Survey of Replacement Medical Center Construction Projects; Target Modification 3 to the Honeywell Information System; and Preinstallation Audit of Affiliation Assessment Project. The important results of the first two reviews are contained in the Overview section of this report.

Our preinstallation audit of the Department of Medicine and Surgery Affiliation Assessment Project was completed in May 1980. The purpose of the audit was to assess the adequacy of established or planned controls which would assure effective and efficient project development. Project management, contracts, ADP System Life Cycle, and privacy/security areas were examined. The review found sufficient control for monitoring project funds. Contractual controls regarding timely delivery of an acceptable product were adequate in most instances.

SPECIAL INITIATIVES FOR FRAUD, WASTE, AND MISMANAGEMENT

Sixteen reports completed during this period and other continuing audit activity identified cost avoidance and collection recommendations totalling \$3.4 million. The following summarizes the more significant initiatives performed and completed during the last six months that have not already been discussed in the Overview section of this report.

PREP Audits. We have identified 39 schools which have potential liability to the VA for surplus funds accumulated under the Predischarge Education Program (PREP). We have referred 28 of these schools to the Office of Controller for action which, if successful, would result in collection of about \$8.5 million. During this six-month period we referred six cases for collection of \$576,000 of surplus funds. Audit reports for the remaining eleven schools are still in process.

Eligibility for Non-Service-Connected Treatment. 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 had been precluded by law -- is applied, so that adherence to this financial needs requirement is essentially an honor system, and vulnerable to abuse. Further, as indicated in the Overview section of this report, there are weaknesses in the procedures for determining eligibility for care at some medical centers. Some months ago, 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 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 nonservice-connected care. On May 12, 1980, the Deputy Administrator directed action to implement these recommendations and to "issue a letter to all stations reemphasizing eligibility requirements for hospitalization and other medical care for non-service-connected veterans." The Department did not take steps to implement these directives until September 1980, and the implementation instructions then issued went beyond our recommendation and the Deputy Administrator's direction. The implementation instructions have been suspended pending further consideration of this matter.

Public Law 96-330, approved August 26, 1980, no longer precludes a financial needs criteria and defines evidence of inability to defray necessary expenses. VA medical facilities have not been instructed to implement this change pending its interpretation.

Multiple Education Benefit Payments. As reported in our last semi-annual report, one of our audits matched education system master records by social security number. The audit identified 87,852 records as possible duplicates. These were referred to the Department of Veterans Benefits for review. As of September 1980,

48 percent of the records had been reviewed and 21,837 duplicate master records had been identified. Overpayments amounting to over \$1.4 million have been established in 1,067 cases. One hundred seventeen potential fraud cases are being reviewed by the VA for possible referral for legal action. The Department's analysis of the problem indicates that most of the duplication occurred because the VA's automated 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. Periodic computer matching will be used to identify these problems, thereby reducing the size of the overpayments. Prevention of the duplicates caused by the automated locator system should be accomplished by the redesign of the system. Systems redesign has been approved and it is anticipated that contracts will be awarded by late FY 1981.

Department of Memorial Affairs Procurement of Headstones and Grave Markers. VA purchases of marble headstones and bronze, granite and marble grave markers amount to about \$8 million a year. Because no one supplier has been capable of satisfying all the requirements for each type, more than one contract is awarded for each of the four types. Monthly purchase orders are to be placed from the lowest bidder up to that bidder's maximum monthly bid capacity, with additional purchases made from the next lowest bidder, and so on, until total monthly requirements are filled. However, orders were not being placed in accordance with these contract provisions due to a failure to keep track of orders to suppliers versus their monthly production capacity. Orders were sometimes placed with other suppliers before the lowest bidder's monthly capacity had been reached. In other instances, orders were placed that exceeded monthly production capacities. These practices leave the VA vulnerable to breach of contract suits. As a result of our findings, the Department of Memorial Affairs instituted additional controls to prevent or detect ordering errors.

Maintenance Contracts. The audit results of maintenance contract practices at six medical centers were reported in our last report. Improvements were needed to assure greater competition and improve compliance with VA Procurement Regulations. Based on an assessment of problems common to the several sites, recommendations were made to program officials. They agreed to increase technical reviews, require exchange of bidders' mailing lists within medical districts, stress the need to document receipt of maintenance services before authorizing payment, and make a study of the costs of using VA bio-medical engineering staff to perform equipment repairs versus use of outside maintenance contractors.

Special Inquiries.

a. A special inquiry was conducted at VA Medical Center, Salt Lake City, Utah, at the request of the Merit Systems Protection Board. The Board received allegations of impropriety at the medical center from the American Federation of Government Employees on behalf of medical center employees. The allegations addressed theft of VA property and failure to report losses; inaccurate reporting of the number of beds for purposes of obtaining additional funds; unauthorized storage of Air Force property at the medical center; gambling on VA premises; and individuals on the payroll who were not employees of the medical center. The first three allegations were unfounded. The majority of gambling equipment on the premises belongs to the local Elks Lodge and the rest was donated to the medical center. This equipment is used semi-annually for an event sponsored by the Elks for the patients. No money is wagered. Patients are provided with free play money. The Elks provide coupons to the patients as prizes redeemable at the VA canteen. In order to receive a clear definition of what constitutes gambling equipment when used for therapeutic benefit, the VA General Counsel was requested to review the situation. In the interim, the equipment will be stored and not used. Three persons alleged to be nonemployees on the medical center's payroll are VA employees. These employees are included in the personnel ceiling for VAMC Salt Lake City and are currently on duty at the VA Central Office. A determination of the propriety of this arrangement is being pursued.

b. In response to an anonymous "hotline" letter, a special inquiry was conducted at VA Medical Center, Northport, New York. The majority of the allegations made were essentially correct. Expenditures for VA quarters maintenance and minor improvements were inappropriately charged to other cost centers and limitations were exceeded without required VA Central Office approval. Also, facility labor had been used to provide firewood for use of quarters occupants. Allegations involving discrepancies in roofing and fire alarm contracts were not supported by available evidence. The Deputy Chief Medical Director has reported corrective action taken on recommendations made by the audit team.

CYCLICAL AUDITS

During this six month period we issued 59 internal audits, including audits of 31 medical centers, 3 regional offices, 1 supply depot, 1 marketing center, 1 domiciliary, and 1 outpatient clinic. One audit report included summary information on audits of 16 national cemeteries and a national cemetery area office. Separate audit reports were completed on an additional 7 national cemeteries. Audits of 13 other program entities were completed,

including 1 health care program, 2 benefit programs, and 10 functional and support activities. Estimated savings for the 59 reports, primarily in the nature of cost avoidance, totalled \$2.5 million.

The 113 completed external audits of contractors, grantees and other external organizations participating in VA programs represented \$64 million of audited costs. Cost adjustments of \$2.6 million were recommended and \$2.4 million in unsupported costs were identified. VA contracting officers must resolve unsupported costs by having contractors obtain adequate documentation; adjusting proposed contract costs; or refusing contract proposals. External audit reports resolved or closed this past 6 months, consisting primarily of those issued in prior periods, resulted in a savings of about \$1.4 million.

Following are significant audit findings and recommendations reported in completed cyclical audits and not included in other sections of this chapter.

BENEFIT PROGRAMS

VA Medical and Regional Office Center, San Juan, PR

Finding. Finance Division operations at the Center are at an unacceptable level. Numerous failures to comply with Agency policy and procedures were found, and discrepancies noted on previous audits remain uncorrected. Financial records are inaccurate and impair proper planning. Many routine control and review procedures are not properly performed. Supervisory-level employees are too involved in clerical level work, thereby further lowering their effectiveness. The lack of proper training is apparent at all levels, although many of the supervisors and staff have been in their positions for some time. Improved supervision, training, and better staff utilization (including staff realignment) are needed.

Recommendation. Provide needed direction and financial expertise to correct noted deficiencies. Improve supervisory skills and job knowledge, particularly at section levels.

HEALTH CARE PROGRAMS

VA Medical Center, Washington, DC

Finding. The Automated Hospital Information System (AHIS) has limited capabilities and is not cost effective. It functions primarily as a communications system rather than a total hospital/patient care information system. Also, the system equipment is obsolete and subject to recurring maintenance problems.

VA Medical Center, Washington, DC (Con't.)

Recommendation. Discontinue system enhancements except as required for current system maintenance. Initiate a successor system and reduce system and operations staff.

Finding. Staffing criteria justify 76 full-time technical/clerical employee equivalents (FTEE) in Laboratory Service. There are presently 87.7 FTEE.

Recommendation. Conduct an in-depth analysis to determine staffing needs based on current workload.

Finding. There is a need for improved direction and supervision of construction contracts. A percentage of contract payments should be retained to protect the government's interest pending acceptance of the work as satisfactory. Construction cost estimates and negotiated contract prices are not properly documented.

Recommendation. Require accurate and detailed construction progress reports. Prepare written certifications of satisfactory completion of work. Withhold a percentage of payment until certification is received. Support contracts by adequate documentation of estimated or agreed-upon price.

VA Medical Center, Brentwood, Los Angeles, CA

Finding. The scope of the Health Services Review Organization - Systematic Internal Review (HSRO-SIR) program needs to be expanded and more effective action needs to be taken to resolve identified problems. Utilization reviews need to be conducted to evaluate appropriateness of admissions, discharge practices, and utilization of services.

Recommendation. Establish a more adequate and effective HSRO-SIR program. Develop utilization standards and conduct appropriate utilization reviews.

Finding. Insufficient action has been taken to correct major deficiencies identified during reviews in May 1977, September 1977, and November 1978 in the Compensated Work Therapy Program. Continuing deficiencies include lack of a permanent, full-time program director, noncompliance with VA guidelines, lack of patient progress evaluations every 3 months as required, insufficient patients in the program, and lack of financial reviews by Fiscal Service.

VA Medical Center, Brentwood, Los Angeles, CA (Con't.)

Recommendation. Correct Identified deficiencies promptly.

VA Medical Center, Albuquerque, NM

Finding. Medical records were not always properly or promptly completed. Consent forms for operations and other procedures were not always completely filled out or signed by physicians counselling surgical and medical patients. Consent forms for patients involved in experimental treatments and problem lists (which constitute an agenda for later diagnosis and treatment) were blank, missing, or incomplete in Surgical Service. Also, discharge summaries and operation reports were not being completed and signed promptly by physicians.

Recommendation. Provide direction and control to ensure proper completion of medical records through continuous training and critical reviews.

Finding. Narcotics shown on ward records as having been administered to patients were not recorded in patient medical records in 57 of 581 instances reviewed.

Recommendation. Implement controls to ensure that all medications are recorded in patients' medical records, monthly narcotic inspections are complete, and discrepancies identified during inspections are investigated.

Finding. Controls over nonexpendable equipment and supplies need to be strengthened to assure that all property is accounted for and unneeded equipment and supplies are disposed of properly. Fifty-eight items of equipment costing \$39,000 could not be located. Unneeded equipment costing about \$44,000 had not been turned in as excess.

Recommendation. Implement controls to strengthen the property management function.

Finding. The medical center's update of its application for approval of an electron microscope for Laboratory Service understated the availability of other microscopes at the medical center and the University of New Mexico. Also, costs of purchasing and operating the microscope exceed the costs of having clinical electron microscope studies performed at the University. The microscope, ancillary equipment, and installation will cost about \$206,000.

Recommendation. Reevaluate the need, costs, and benefits of acquiring a second electron microscope versus other alternatives.

VA Medical Center, Bay Pines, FL

Finding. Management has not provided direction and control for the fee-basis program. The total cost of fee-basis programs at this station in FY 1978 was \$15 million.

Recommendation. Management should establish control over the fee-basis program by providing needed direction and participation in the development and approval of clinic policies.

Finding. The fee medical program is not adequately controlled. Fee-basis cards have been issued to veterans living in the vicinity of VA medical facilities without documentation of medical needs; fee card holders are not periodically screened; professional review has been improperly delegated to administrative personnel; high-earning fee providers have not been evaluated; monthly fee limitations have been arbitrarily increased to avoid professional review; and fee-basis surgical procedures have been authorized by clinic staff although prohibited by Department of Medicine and Surgery guidelines.

Recommendation. Action be taken to ensure that: fee-basis cards are issued to veterans living within 40 miles of a VA medical facility only when medically indicated; screening procedures are developed to properly evaluate continued medical eligibility; professional reviews are performed by VA physicians; utilization reviews are conducted of all high-earning fee providers; monthly fee limitations are increased only when medically necessary; and reimbursement for outpatient surgical procedures be denied.

Finding. Controls over the hometown pharmacy portion of the fee-basis program are inadequate. In FY 1978 the hometown pharmacy program cost \$2.7 million. There is a lack of: sufficient professional and administrative review; appropriate referral for medical evaluation by a VA physician; and timely and appropriate followup on evaluation results. Also, the cost of over-the-counter items purchased through hometown pharmacies is excessive; drugs are prescribed in less than 30-day quantities; the VA pharmacy is not used to fill recurring prescriptions; and the clinic of jurisdiction pays for ineffective drugs prescribed by fee-basis physicians.

Recommendation. Improve controls over the hometown pharmacy program by: establishing regular reviews for appropriateness and quantity of drugs prescribed; referring questionable cases for evaluation by a VA physician; implementing timely follow-up action on evaluation results; ensuring that charges by hometown pharmacies meet VA criteria; having fee physicians prescribe on a

VA Medical Center, Bay Pines, FL (Con't.)

30-day basis when long-term therapy is planned and make maximum use of the VA pharmacy; and developing a local policy to prevent payment for drugs classified as ineffective.

Finding. Bed utilization has been neither appropriate nor efficient. Surgical patients have been admitted 5 to 28 days in advance of the anticipated date of elective surgery. Discharge planning of medical and surgical patients is inadequate and has resulted in excessive lengths of stay. Also, management's philosophy regarding the purpose of a domiciliary has resulted in domiciliary members not being encouraged to reenter the community.

Recommendation. Direct the Utilization Review Committee to identify unjustified lengths of stay, inadequate discharge planning, and inefficient resource scheduling. Also, initiate adequate discharge planning, and prohibit unnecessary admissions in advance of anticipated surgery solely to obtain an available bed.

Finding. In FY 1978 the medical center spent \$1.7 million for community nursing home contracts. About \$440,000 was paid for renewed 6-month nursing home contracts after non-service-connected veterans had been admitted to the medical center for 1-day diagnostic work-ups. The purpose of the 1-day admissions was to justify beginning new 6-month periods of eligibility for contract nursing home care. The practice of using short-term rehospitalization to justify additional eligibility for nursing home care is a violation of VA policy.

Recommendation. The Chief of Staff review and approve all subsequent contracts for community nursing home placement following rehospitalization, and that eligibility requirements be considered for extensions beyond 6 months.

Finding. A personal care program is needed. This program would improve bed utilization by providing an additional alternative for patient discharge planning.

Recommendation. Implement a pilot program for personal care placement.

VA Medical and Regional Office Center, Fargo, ND

Finding. The medical center's 5-year plan proposes constructing 10,000 square feet of additional research space. This would cost about \$1.1 million. However, studies have not been conducted to estimate space requirements based upon potential research projects and number of research-oriented physicians. The proposal

VA Medical and Regional Office Center, Fargo, ND (Con't.)

for the research building also did not consider the possible use of space in the new University of North Dakota annex building attached to the medical center.

Recommendation. Withdraw proposal from 5-year plan and determine research needs based on studies using VA criteria.

Olin E. Teague Veterans' Center, Temple, TX

Finding. Control over accounts maintained for incompetent patients is unsatisfactory. Of 67 accounts reviewed, 43 were restricted accounts (49 percent) with balances exceeding the \$1,500 maximum estate limitation by a total amount in excess of \$115,000.

Recommendation. Determine the source of all funds to be deposited; prevent account balances from exceeding established limitations; and return excess funds accumulated from VA payments for accounts that already exceed the \$1,500 limitation.

Finding. Construction estimates prepared during fiscal years 1977 through 1980 for 10 projects totalling \$2.3 million did not reasonably approximate actual construction costs. They differed by approximately \$500,000 from construction bids. The low bids submitted for these 10 projects ranged from 41 percent below the VA estimate to 82 percent above, and averaged 23 percent higher than the VA estimate.

Recommendation. Develop and document estimates which reasonably approximate the price the medical center should pay for contracted construction work; establish procedures to review contract estimates to ensure that they are properly prepared; and readvertise or negotiate a contract when the Government estimate is considered reasonable but varies significantly from the range of contract bids.

Finding. Inspections for contracted construction work are not adequate. Contract construction work does not always receive final guaranty inspections prior to the expiration of warranty periods, resulting in additional costs to the medical center of over \$8,000 for one project. In addition, inspections done prior to acceptance of contracted construction work are not adequate. In a fire door renovation project not yet fully completed, work performed by the contractor was not done in accordance with contract specifications for 7 of 10 fire doors checked in one

Olin E. Teague Veterans' Center, Temple, TX (Con't.)

of the main fire exit corridors. An inspection conducted by the District Safety and Fire Protection Engineer at our request showed that work as performed could pose a fire-safety problem.

Recommendation. Guaranty inspections of contracted construction projects be conducted on time, be well documented, and be done in compliance with VA manual guidelines. Engineering Service improve future monitoring of construction contract work. Inspections should be conducted more frequently to insure that work is being performed in accordance with contract specifications; project manager should document in inspection reports all items that do not meet contract specifications; the fire door renovation project should not be accepted as complete until all discrepancies have been corrected by the contractor and work not done in accordance with contract specifications is corrected; and final inspection of this project should be adequate to detect all workmanship discrepancies and work not performed according to contract specifications.

VA Medical Center, Minneapolis, MN

Finding. The Cardiac Catheterization Laboratory has an x-ray apparatus and four pieces of associated equipment that are not needed. The depreciated value is \$126,000.

Recommendation. Excess the x-ray apparatus and associated equipment.

VA Medical Center, Ft. Lyon, CO

Finding. Questionable expenditures in terms of documentation of need or compliance with VA policy and procurement regulations include: construction of a larger swimming pool than approved by VA Central Office; construction of an adjacent bathhouse without approval of VA Central Office; purchase of two additional farm tractors; purchase of split rail fences; purchase of carpet and draperies for Medical Center Director's suite; purchase of dishwashers for employees' quarters; and purchase of photographs of the medical center.

Recommendation. Provide adequate documentation of need for purchases of equipment, supplies, and contractual services; and ensure compliance with VA policy and procurement regulations.

VA Medical Center, Durham, NC

Finding. Housekeeping service is in need of significant improvement. Although VA Central Office visits in January 1979, and January 1980, identified unsanitary housekeeping conditions and made recommendations for improvement, we found restrooms uncleaned

VA Medical Center, Durham, NC (Con't.)

for several days, corridors with a buildup of dirt and grime along baseboards and on floors, and roaches in the vending area and in the ninth floor lobby. We also received complaints from employees and visitors concerning building cleanliness.

Recommendation. Implement previously recommended measures to improve Building Management Service operations.

Finding. Control over nonexpendable equipment is not adequate. Inventories scheduled for 1979 in 24 of 45 property records had exceeded the 12-month time limit. The property record for Supply Service had not been updated since 1974. We found 44 items of unused television equipment, valued at \$17,107, stored in Medical Media Production Service. We also determined that 13 dialysis machines, valued at \$80,256, are excess to program needs.

Recommendation. Conduct property record inventories at least once every 12 months, to include identification of excess equipment. Excess unused television equipment and dialysis machines.

VA Medical Center, Grand Junction, CO

Finding. Supply Service personnel, charged with the responsibility for administering negotiated contracts, are not sufficiently trained or properly supervised to assure compliance with the statutory requirements of Federal and agency procurement regulations. Current practices for awarding negotiated contracts are not in compliance with regulations and provide opportunities for fraud, abuse, and increased cost to the Agency. Dietetic equipment, valued in excess of \$26,000, was procured without required formal advertising because purchasing agents failed to consolidate 10 purchase requests received the same day. Prices were established on the basis of individual item quotations obtained by telephone from only two vendors. Required documentation did not exist to verify whether negotiations were conducted for six construction contracts totalling \$404,862.

Recommendation. Provide specific, formal training in procurement by negotiation and the provisions of Part 1-3 of the Federal Procurement Regulations, and take action to assure compliance.

Finding. Provisions and practices for securing and safeguarding VA property, funds, and records are not in compliance with Agency regulations and are not adequate to prevent loss or diversion.

VA Medical Center, Grand Junction, CO (Con't.)

There is no remote monitoring equipment for alarm systems in the Agent Cashier's Office, Supply Warehouse, Drug Storage Room, Pharmacy, and Canteen. The facility was rekeyed in 1978 at a cost of \$11,282, but the issuance of new keys was not properly controlled. Employees were not locking their work areas during non-business hours, and police officers were not reporting unsecured areas.

Recommendation. Improve security by connecting alarm systems to a remote monitoring device; rekeying the hospital and properly controlling new keys; and publishing and enforcing a policy on employee responsibilities for security.

VA Medical Center, New York, NY

Finding. Controls over beneficiary travel payments at the Outpatient Clinic are unsatisfactory. As a result, an estimated \$37,500 worth of bus and subway tokens were not accounted for. Available reports of tokens issued to veterans do not account for the total tokens withdrawn for use at the Outpatient Clinic.

Recommendation. Strict accounting methods be implemented to control total tokens used and issued to beneficiaries. The staff who issue beneficiary travel payments and their supervisors be held accountable for all discrepancies found in the use of tokens.

Finding. Narcotic inspections of the Outpatient Clinic and security over controlled substances in storage are inadequate. Unused methadone issued from the daily allotments at the Methadone Clinic is not returned to the pharmacy at the end of the day. The distribution of cocaine solution on one ward of the medical center is not recorded as required by Agency policy.

Recommendation. Narcotic registers should be fully documented and reviewed as required. Narcotic inspections should be validated for accuracy. Unused methadone should be returned to the pharmacy at the end of the day. Distribution of cocaine solution should be recorded showing the recipient and the amount administered.

Finding. The Cardiac Catheterization Laboratory (CCL) is underutilized although renovation costing \$801,462 is underway. The CCL at VAMC Bronx is also underutilized, and underutilization of CCL's at nearby VA medical centers is indicated. Sharing of CCL's within the Medical District has not been considered.

VA Medical Center, New York, NY (Con't.)

Recommendation. Sharing of VAMC New York's CCL be offered at the Medical District level to promote optimal utilization.

VA Medical Center, Richmond, VA

Finding. Managerial leadership, direction, coordination, and control of service activities need improvement. Employee attitudes needed strengthening and there was no management policy or function addressing this area. This resulted in deficiencies in some areas such as dictation of discharge summaries, safety and security, and ineligible treatment in the outpatient program. In addition, the lack of clear delineation of responsibilities for activities which cross service lines resulted in inadequate coordination of interservice activities and ineffective and inefficient operations in such areas as pest control services and possession and use of contraband items in the medical center. Further, management was not aware of problems in the cardiopulmonary resuscitation activity, use of ineffective drugs, veterans denied medical care by unauthorized personnel, and timekeeping irregularities in Medical Service.

Recommendation. Managerial leadership be strengthened and employee attitudes be addressed on a continuing basis; direction and coordination of operations be improved by reviewing and updating medical center policy directives on a continuing basis and ensuring areas of responsibility are clearly delineated; and appropriate managerial controls be established.

FUNCTIONAL AND SUPPORT ACTIVITIES

Audit of Data Security at the VA Data Processing Center (DPC), Austin, TX

Finding. The uncontrolled access to critical data sets (data sets containing sensitive information or information essential to the processing of computer applications) seriously threatens data security at the DPC. An example of data sets subject to unauthorized access is the Personnel and Accounting Integrated Data System records which contain sensitive information on all VA employees. The SECURE-software protection, if installed on all critical data sets, would provide the level of security necessary to protect sensitive data. This protection would apply to all data processing systems at the DPC.

Audit of Data Security at the VA Data Processing Center (DPC),
Austin, TX (Con't.)

Recommendation. All critical data sets be identified and protected under the SECURE package, and a comprehensive security policy to monitor accessibility and protection of critical data sets be established.

Finding. Remote Operating System Conversational On-Line Environment (ROSCOE) does not provide a log of unsuccessful attempts to access the computer system.

Recommendation. The ROSCOE software be modified to establish a security violation log for possible followup by the Data Security Officer.

Finding. Should a user leave a computer terminal without signing off ROSCOE, the terminal remains signed on and subject to misuse.

Recommendation. The ROSCOE software be modified to sign the terminal off when not used for a certain period of time.

Review of Equitable Adjustment Claim Under VA Contract at VA Medical Center, Sepulveda, CA

Finding. The contractor's claim was for \$1,229,362 for an air conditioning project. The audit established total questioned costs of \$379,025 and unsupported costs of \$385,186. The questioned and unsupported costs represent costs claimed by the contractor and subcontractor for extended overhead costs, extended field costs, extended job expense (additional overhead and other expenses which are alleged to have been incurred as a result of the contract being performed in a different period from that scheduled), loss of productivity, and escalation.

Recommendation. Reduce the contractor's claim by the questioned costs of \$379,025 and require documentation for \$385,186 of unsupported costs. (If the contractor cannot provide satisfactory documentation, the costs should be disallowed. The final decision must be made by the contracting officer.)

Evaluation of Proposal for Installation of A Fire Sprinkler System in the VA Replacement Hospital, Bronx, NY

Finding. The contractor's proposal was for \$2,561,591 to install a fire sprinkler system. The audit questioned costs of \$174,249 which represent direct costs and overhead costs. Also, a profit adjustment of \$16,218 and unsupported costs of \$60,129 were identified.

Evaluation of Proposal for Installation of A Fire Sprinkler System in the VA Replacement Hospital, Bronx, NY (Con't.)

Recommendation. Reduce the contractor's claim by \$190,467 of questioned costs and profit adjustment. Require the contractor to substantiate unsupported costs. (If the contractor cannot provide satisfactory documentation, the costs should be disallowed. The final decision must be made by the contracting officer.)

Evaluation of Time and Materials Contract for Integration of Improved Pension Processing and Implementation of Resultant Programs Into Honeywell Production Environment at VA Data Processing Center, Hines, IL

Finding. The contract was for an amount not to exceed \$349,619. The audit revealed total questioned costs of \$162,767 resulting from contractor's use of labor categories other than those specified in the contract.

Recommendation. Reduce the claim amount by costs questioned of \$162,767.

Evaluation of Proposal for Anesthesiology Services at VA Medical Center, Seattle, WA

Finding. The University of Washington (contractor) proposed to provide anesthesiology services for \$373,000. Each member of the contractor's Anesthesiology Department is a contractor employee, and also a member of the Associated University Physicians (AUP). There is no subcontract or other formal arrangement between the contractor and AUP. Salary cost on the proposed contract was split 45 percent contractor and 55 percent AUP. The audit revealed questioned costs of \$573 for incentive pay, and unsupported costs of \$213,957 representing AUP salaries and related costs, because AUP books of records were not made available for the auditor's review.

Recommendation. Formal agreement be established between the contractor and AUP.

FOLLOWUP SYSTEM ON AUDIT REPORTS FROM THE OFFICE OF INSPECTOR GENERAL

The Inspector General Act of 1978 requires that our semi-annual report include an identification of each significant recommendation described in previous semi-annual reports on which corrective action has not been completed. At the time of our last report, we reported 22 significant recommendations for which corrective

action had not been completed. For 11 of these, actions have now been completed and the status of the other 11 are reported by program area in the following paragraphs. In addition, of the 156 significant recommendations reported for the period October 1, 1979 to March 31, 1980, corrective action has been completed on 136. The remaining 20 are also identified by program area in the paragraphs below.

The Senate version of the FY 1981 appropriation bill and OMB Circular A-73 (revised) require identification of all audits which have been unresolved for over six months after completion of the audits. An audit is considered unresolved when it has one or more recommendations on which either an implementation plan has not been developed because there is disagreement with the recommendation(s) made, or an implementation plan has been developed but is unsatisfactory because it does not meet the intent of the recommendation. At this time, one audit report, VA Medical Center, Indianapolis, IN, (identified in the paragraphs below) has two significant findings and recommendations unresolved for over six months.

Also included as the last section is a summary of open audit reports as of June 30, 1980. Open audit reports are those for which corrective actions have not been fully completed on all audit report recommendations. These reports are tracked in our followup system from the date the audit reports are issued until a determination is made that satisfactory corrective action has been taken on all audit report recommendations. The summary provides the number of open audit reports and recommendations, and the length of time the reports have been open.

HEALTH CARE PROGRAMS

Automated Fee-Basis System*

Recommendation. Establish procedures for control of and accountability for the VA Outpatient Medical Treatment Information Card.

Implementation Status. Redesign of the card to a numbered, accountable form with mandatory signature of each veteran for identification purposes is expected to be completed and forwarded for necessary concurrences in November 1980. Publication and distribution of the form is expected in April 1981.

*These recommendations were also reported as not completely implemented at the time of our last semi-annual report.

Automated Fee-Basis System (Con't.)

Recommendation. Establish and implement procedures for reevaluation of the veteran's condition and the current treatment. 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.

Implementation Status. Interim instructions have been sent to all clinics of jurisdiction extending the provisions for mandatory periodic review of each veteran's fee-basis authorization to determine continuing need for such authorization. Resources have not been available to develop the computer programs necessary to implement these recommendations. Computerized Medical Systems Office plans to brief the Chief Medical Director on the resources required for the needed system enhancements. Improvements to the system will be delayed pending a decision on the request for additional resources.

Recommendation. Establish controls to ensure fee-basis prescriptions are filed by veteran name and periodically review files to determine if the program is being abused.

Implementation Status. The Department of Medicine and Surgery reports that procedures require fee-basis prescriptions to be filed by patient's name and that a prescription profile review be performed before dispensing any prescriptions. However, additional actions are needed and will be recommended from the Department regarding establishment of controls and periodic reviews.

Recommendation. Develop and implement a standard billing form which would be signed by the veteran and physician and show type of treatment.

Implementation Status. The Department of Medicine and Surgery has delayed developing the form pending receipt and evaluation of a form being developed by the Department of Health and Human Services (HHS). Officials from HHS have developed a standardized form but do not expect to implement use of the form until December 1981. In view of this delay, development of a VA standard billing form will be initiated in January 1981. The target date for submission of the form to OMB for clearance is June 1981.

Department of Medicine and Surgery Educational Television Resources*

Recommendation. Eliminate television production capabilities at all medical centers other than VAMC's St. Louis and Salt Lake City, which should be established as national production centers, and reduce staffing and equipment levels accordingly. 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 these activities accordingly.

Implementation Status. The Department of Medicine and Surgery has drafted a circular expected to be published in October 1980 which provides guidance for the elimination of television production capabilities at VA medical centers. The Department has begun transferring equipment and staff from medical centers where they are not needed to the facilities designated as national production centers.

VA Medical Center, St. Cloud, MN

Recommendation. Close the Medical Media Production 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.

Implementation Status. Implementation of these recommendations was delayed pending the outcome of the audit entitled Department of Medicine and Surgery Educational Television Resources (see preceding item). Implementation will proceed based on the guidance provided in the DM&S circular described above.

VA Medical Center, Indianapolis, IN

Recommendation. Determine if utilization of the cardiac catheterization laboratory could be improved by establishing sharing agreements for catheterizations with local medical facilities.

Implementation Status. Medical center management has satisfactorily shown the services of the Cardiac Catheterization Laboratory are not available from other sources. However, the intent of the recommendation was VA to improve the utilization of the laboratory through sharing of its services with other community/area groups or federal agencies. This recommendation is unresolved.

*These recommendations were also reported as not completely implemented at the time of our last semi-annual report. However, we consider the delay reasonable in light of the magnitude or complexity of the corrective action required.

VA Medical Center, Indianapolis, IN (Con't.)

Recommendation. Close the renal laboratory and transfer workload, staffing, and equipment to Laboratory Service.

Implementation Status. The Department of Medicine and Surgery does not agree that the renal laboratory should be closed. This recommendation is unresolved.

VA Medical Center, Topeka, KS

Recommendation. Increase the size of the respiratory unit from 20 to 24 beds, and close 13 general medical beds in Medical Service.

Implementation Status. Increase in size of the respiratory unit is planned for fiscal year 1984. Additional information is needed and will be requested from the Department of Medicine and Surgery on whether the 13 general medical beds have been closed and if the nursing staff assigned for these beds have been reassigned.

BENEFIT PROGRAMS

Audit of TARGET System Privacy and Security at Regional Offices*

Recommendation. The TARGET operations manual should require TARGET security officers to document their review of security violations and corrective actions. Also ensure the TARGET Sensitive File is complete and that employee claims folders are properly secured.

Implementation Status. The TARGET operations manual is being revised and updated and will incorporate the recommendations that TARGET security officers: document their review of security violations and corrective actions; ensure that the TARGET sensitive file is complete; and ensure that employee claims folders are properly secured. The TARGET operations manual should be distributed in January 1981.

Audit of TARGET System Risk Analysis Effort

Recommendation. Complete the report on the Agency's TARGET system risk analysis which discusses all risks and counter-measures.

*TARGET is an on-line computer system being installed to replace existing automated VA compensation, pension and education benefit payment programs.

Audit of TARGET System Risk Analysis Effort (Con't.)

Implementation Status. The report has not been completed pending receipt of input from one assisting contractor.

FUNCTIONAL AND SUPPORT ACTIVITIES

Overtime, Part-time, Time and Attendance*

Recommendation. Improve control of overtime payments and compensatory time. Make independent reconciliations of records comparing overtime authorized and worked to employees' time and attendance reports.

Implementation Status. The Department of Medicine and Surgery issued a circular requiring medical center directors to initiate actions to monitor and control overtime usage. However, specific actions for the control of compensatory time and the requirement for independent reconciliations were not addressed. We will request additional information from the Department.

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

Implementation Status. Proposed manual change to institute this procedure has been completed by Office of Controller and released for necessary concurrences.

Statement of Transactions, Centralized Accounting for Local Management (CALM) System**

Recommendation. Develop and implement an automated procedure to enable daily reconciliation of all CALM payments on the generated Voucher and Schedule of Payments.

Implementation Status. Projected completion of the necessary automated program is April 1981.

*These recommendations were also reported as not completely implemented at the time of our last semi-annual report.

**This recommendation was also reported as not completely implemented at the time of our last semi-annual report. However, we consider the delay reasonable in light of the magnitude and complexity of the corrective action required.

Review of Privacy and Security Pertaining to TARGET within Central Office

Recommendation. Perform periodic security audits at VA Data Processing Centers.

Implementation Status. The Office of Data Management & Telecommunications reports that periodic security audits are an ongoing function performed twice yearly and include security and privacy. Since our audit found these reviews were not being done, we will request additional information to include the schedule of audits, the activities audited, and the dates of the audits since January 1980.

Privacy/Security at VA Data Processing Centers Processing TARGET Applications or Transactions

Recommendation. Establish and follow a schedule for changing passwords. Standardize and follow procedures for using "privacy". Determine feasibility of using additional Honeywell security features. Improve control over access to the TARGET production system. Develop and implement a TARGET security program for the Data Processing Centers.

Implementation Status. The Office of Data Management & Telecommunications reports that because of the lack of human and financial resources to perform risk analysis and other security-related activities, the improvements have not been made. The office plans to consider these recommendations in conjunction with a comprehensive risk analysis package which is being studied, and an overall approach to security enhancement will be developed.

Audit of Technical Assistance at VA Data Processing Center, Philadelphia, PA

Recommendation. Develop procedures for assigning, changing, restricting and protecting passwords for the Honeywell Insurance System. Procedures to be developed should include methods for installing and testing Honeywell operating system changes.

Implementation Status. The Office of Data Management and Telecommunications reports the procedures are in the final stage of being implemented.

Evaluation of Equitable Adjustment Claim Under VA Contract at VA Medical Center, Perry Point, MD

Recommendation. Reduce the contractor's claim by the questioned costs of \$305,684.

Implementation Status. Negotiation in process.

Review of Claim for Equitable Adjustment Relative to Alleged Government Caused Delay for Boiler Plant Replacement Contract at VA Medical Center, Manchester, NH

Recommendation. Reduce the claim amount by costs questioned of \$629,351.

Implementation Status. Negotiation in process.

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

Recommendation. Reduce the claim amount by costs questioned of \$156,443.

Implementation Status. Negotiation in process.

Summary of Open Audit Reports. Program officials responsible for open audit reports (reports on which corrective action has not been completed) have a maximum of six months after the final audit reports have been issued to make written determinations on all audit report recommendations. Corrective actions to carry out these determinations must proceed as rapidly as possible thereafter. A summary of open internal and external audit reports follows.

a. Internal Audit Reports. The chart below summarizes all internal audit reports and recommendations open for over six months as of June 30, 1980. Written determinations have been made on all the recommendations and the corrective actions required to carry out these determinations are in various stages of implementation.

OPEN INTERNAL AUDITS

<u>Length of Time Open</u>	<u>Number of Audit Reports</u>	<u>Number of Recommendations</u>
6 Months to One Year	33	270
Over 1 Year	<u>12</u>	<u>39</u>
TOTALS	45	309

b. External Audit Reports. External audit reports are considered open until a Record of Price Negotiation (RPN) is received. The RPN is required by Section 1-3.811 of the Federal Procurement Regulations and is a memorandum which sets forth the principal elements of a contract price negotiation, the pertinent advisory audit report recommendations, and the reasons for deviations (if any) from such recommendations. There are a variety of reasons that a contract audit would remain open for an extended period of time, such as litigation or a lengthy negotiation process. In other cases, audit recommendations have been implemented and the negotiation process completed but an RPN has not been prepared and/or transmitted to us.

There are two types of open contract audit reports. The first is audits of contracts which have been awarded and for which we are awaiting decisions by program managers on whether to adjust or collect questioned costs. These are significant in that collection of funds from contractors and decreases in funding paid to contractors can and does result in savings to the VA. The chart below summarizes the status of these open reports as of June 30, 1980.

OPEN EXTERNAL AUDITS WHICH INVOLVE COST RECOVERY

<u>Length of Time Open (Days)</u>	<u>Reports</u>	<u>Dollar Costs (\$000)</u>	
		<u>Questioned</u>	<u>Unsupported</u>
0 - 90	1	-0-	1.6
91 - 180	5	18.7	3,612.3
181 - 365	4	78.5	474.9
365+	<u>8</u>	<u>112.6</u>	<u>881.0</u>
TOTALS	18	\$209.8	\$4,969.8

The second type are audits of contract proposals before the contracts are awarded. These required audit reports are advisory in nature for use by the contracting officer in establishing the contract price. As of June 30, 1980, there were 126 of these open audit reports with questioned costs of \$5.1 million and unsupported costs of \$4.9 million. This compares with 84 open audit reports as of December 31, 1979, with questioned costs of \$2.4 million and unsupported costs of \$3.8 million.

CHAPTER IV
INVESTIGATIVE RESULTS

During the past six months, investigative activities have been directed as follows:

	<u>Staff Assigned</u>	<u>Percentage</u>
Special Initiatives for fraud, waste and mismanagement	6	15
Reactive Investigations	34	85

SPECIAL INITIATIVES FOR FRAUD, WASTE AND MISMANAGEMENT

Loan Guaranty. In FY 1979, we developed an analysis of the steps that could be taken by the Department of Veterans Benefits to minimize the opportunities for fraud and abuse in the Loan Guaranty Program and to improve the capability to detect such irregularities. Our analysis indicated that the Department had taken some significant steps to obtain these objectives, and we identified and made recommendations on other aspects of program procedures which are important to the detection of fraud and abuse. Our recommendations set forth procedures designed to better identify suspect lending institutions and realty brokers engaged in fraud by falsifying credit, employment and other information. The Department has implemented our recommended procedures.

About two years 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 in accordance with procedures adopted at our recommendation, refer the most serious cases to us for investigation. During the current reporting period the Department of Veterans Benefits has provided us with two reports of the results of their post audits. The first report, which covered the period October through December 1979, did not show any pattern of collusion, fraud or misrepresentation on the part of lenders or real estate brokers. However, the second report, which covered the period January through March 1980,

indicated significant discrepancies regarding two loans on the part of a lender in one city and significant discrepancies regarding three loans on the part of a lender in another city. Inquiries are being made by the Office of Investigations into the operations of these two lenders.

We previously reported that a joint VA/HUD audit and investigative effort had been initiated in San Juan, Puerto Rico. Investigations of a number of brokers are presently being coordinated with the Department of Justice. In addition, during this period our investigations of six lenders involving 80 individual loan guaranty cases were completed. Thirty-four of the cases were referred to the Department of Justice.

Medical. We are presently working on a special initiative to uncover and investigate possible fraud in the VA Fee Basis Medical Program. This program is administered by 80 VA clinics nationwide to provide outpatient medical care to eligible veterans and dependents. In FY 1979, this program cost the VA about \$46.3 million, and involved about 2.2 million patient visits. Past investigations have shown instances of false billings and we believe there may be other improper or illegal activities.

Disability. We are also participating with several other federal agencies in a pilot project in the 8-state Atlanta Region to identify recipients of fraudulent benefits under the Federal Employees Compensation Act of 1974. The purpose of this project, which is being coordinated by the Department of Labor, is to determine whether a sufficient number of violators can be identified to justify using similar investigative techniques in the other regions of the country. The objectives of the project are to obtain criminal prosecutions of violators, to recover funds fraudulently obtained, and to deny future payments to ineligible claimants. This project has been coordinated with those U. S. Attorneys having jurisdiction. Field work is scheduled to begin on this project in early November 1980.

REACTIVE INVESTIGATIONS

During the reporting period, 41 investigations involving allegations of serious administrative or criminal irregularities were completed. Of these, 22 investigations were predicated upon complaints received from VA employees and officials, five of which were received on the Inspector General "Hotline". Two of the investigations resulted from information developed by the Office of Audit, three were referred by Members of Congress, one by a United States Attorney, one by the FBI and three were received by the GAO "Hotline". Of the remaining nine investigations, six resulted from

anonymous complaints, two resulted from complaints by VA contractors and one from a concerned citizen. The following paragraphs describe some of these investigations and, when appropriate, the status of actions to address the investigative findings.

At VA Medical Center, Palo Alto, California, numerous allegations made by employees of the VA Police Section about drugs, crime increase, law enforcement, and extortion received much Congressional and media attention. The majority of the complaints made by the police were of occurrences that had happened two to five years previously, and details were sketchy. Resentment appeared to have precipitated many of the complaints, as the police officers were frustrated at what they considered to be low pay and a perceived unwarranted restriction of their duties. Our investigation found that most of the specific complaints were unfounded. The Federal Bureau of Investigation and the Drug Enforcement Administration assisted in areas of interest to their agencies. Disciplinary actions against some of the police officers appear warranted; however, in view of the Office of Special Counsel's current inquiry into complaints made by some of these officers, and in light of prohibited personnel actions against whistle blowers, we are not recommending actions at this time pending response from the Office of Special Counsel.

An investigation which was begun last year at one medical center established that human body organs from the medical center were being sold to biological supply houses. A VA resident physician and a faculty member with the affiliated medical school were found to be involved initially. Our investigation is continuing under the guidance of an Assistant U. S. Attorney and the FBI is now also involved.

At the VA Medical Center, Waco, Texas, an investigation disclosed that three nursing assistants physically abused patients. Allegations of patient abuse by eight other nursing assistants were not substantiated. Actions have been initiated to remove one employee and to counsel and reassign another. The third employee retired, precluding further actions. The director of another medical center made personal use of a government garden tiller, government freezer space and used government quarters (after moving out and terminating the rent). The director's retirement precluded disciplinary action. An allegation that the director of another medical center stopped a station investigation into station thefts, altered testimony and covered up the results of the investigation was not sustained. Further, the allegations of theft were also not sustained. At another medical center, a research endocrinologist disregarded VA policy and warnings from his supervisor by personally receiving and administering extra-VA research funds rather than

depositing them in the General Post Fund. Removal action has been initiated in this case. At another facility, the supply service chief directed supply personnel to purchase cleaner concentrate for the medical center from a local school to support a project in which his children were involved. Further, on more than one occasion, he converted to his personal use certain VA drugs and medical supplies obtained by members of his staff. Actions have been initiated to reprimand the supply service chief and to admonish the staff members who obtained the drugs and medical supplies for him. Two cardiologists engaged in research activity with a pacemaker manufacturer giving the appearance of a conflict of interest. Actions to admonish the two cardiologists have been initiated. In another case, an associate chief of staff for research obtained contributions for a "slush" fund by distributing a VA produced hormone to non-VA researchers. Removal action has been initiated. At a different facility, a staff pharmacist entered fraudulent data in a drug register for four prescriptions of a controlled drug but resigned prior to action being taken. At another location, a supervisory radiology technician removed a considerable amount of unexposed x-ray film, but he also resigned, precluding disciplinary action. In these last two cases, prosecution was declined by the United States Attorney.

Several investigations involved irregularities in the Department of Veterans Benefits. One involved a field investigator at a Regional Office who engaged in a conflict of interest by acting on behalf of the conservator of an incompetent veteran for which he was remunerated, while also conducting field examinations pertaining to the veteran as part of his VA duties. The field investigator has been removed and the case has been referred to the Department of Justice. At the same Regional Office, a contact representative solicited and accepted a bribe from two veterans and used his position to gain favor with a veteran's estranged wife by falsifying at least one document in that he failed to report himself as a member of her household while living with her as man and wife. Actions to remove the contact representative have been initiated and the case has been referred to the Department of Justice. At another Regional Office, a veterans rehabilitation specialist caused an untold number of overpayments to a consulting psychologist, who was under contract to the VA, by submitting payment requests with altered or unverified documentation supporting veteran attendance at the psychologist's sessions. The rehabilitation specialist has been removed and the case is being referred to the Department of Justice.

In investigations involving the Department of Memorial Affairs, the director of one national cemetery was involved in many irregularities including using government vehicles for personal business, having cemetery employees work on his privately owned

automobile, absenting himself from duty for extensive periods without taking annual leave, and verbally abusing subordinates. Removal action against the director has been initiated. At another cemetery, supervisory personnel showed poor judgment in their response to an accident that occurred during the course of an interment, and a cemetery caretaker exhibited unacceptable conduct in that he was disrespectful toward several decedents during interment. Actions to suspend the employees involved have been initiated.

Fifty-one investigations are currently in process, three of which involve allegations of retaliation against "whistle blowers." Thirteen additional investigations involving serious irregularities are awaiting assignment.

During the last reporting period, we reported the completion of 26 reactive investigations involving allegations of serious administrative or criminal irregularities. Some of the actions taken as a result of these investigations were completed during this reporting period. These actions include two employees removed, five reprimands issued, thirteen admonishments issued, and one demotion. The resignation of five additional employees either during or subsequent to investigation precluded further administrative actions against them. Other pertinent administrative actions were taken in these cases when indicated, and eight cases were referred to the Department of Justice.

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 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 116 laboratory cases consisting of 2,190 technical examinations. Forty-eight of these cases involved contested insurance claims amounting to \$371,968 in insurance coverage. Eight 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-one cases

involved home loans to veterans of which nineteen were found to contain one or more fraudulent loan documents. The VA loan liability amounted to \$411,905 in these cases. During the reporting period the Loan Guaranty Service terminated VA loan liability in two cases previously examined by the laboratory and recouped \$13,825.51 plus 7 percent interest. In another case, the laboratory findings were used to save approximately \$17,500 in acquisitions, management and resale costs. Action is pending on other laboratory cases. In ten cases involving medical records, x-rays or other documents submitted by claimants for benefits, the laboratory found five 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 twenty-seven cases, there were seventeen in which the laboratory found evidence of fraudulent documentation in hospitalization 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. Cases involving serious criminal irregularities are normally referred to the Department of Justice through local VA district counsels by the VA facilities requesting examinations.

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.

<u>Program</u>	<u>Referrals</u>	<u>Declinations</u>	<u>Prosecutions</u>	<u>Convictions</u>	<u>Dollars Recovered</u>
<u>Fraud</u>					
Education	85	74	6	3	\$ 23,227
Loan Guaranty	448	16	20	9	4,069
Compensation & Pension	65	54	8	2	29,723
Insurance	4	1	0	0	0
Medical	67	57	2	3	112
Contract	9	0	0	0	0
<u>Theft</u>	10	6	5	4	511
<u>All Other</u>	<u>26</u>	<u>13</u>	<u>0</u>	<u>0</u>	<u>3,879</u>
	703	221	41	21	\$ 61,521

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

CHAPTER V

VULNERABILITY ASSESSMENTS

The Risk Analysis Staff was established to assess vulnerabilities to fraud, waste and mismanagement of Agency programs, functions and activities. During this reporting period, analyses of loan guaranty investigations and hotline contacts, were completed. The staff continued to work on a government-wide computer match project and followed up on previous projects.

COMPUTER MATCH PROJECT

We previously reported that procedures were being developed for performing a computer match between the Office of Personnel Management Central Personnel Data File and VA Compensation, Pension and Education Master files. The purpose of the match is to identify Federal employees who are indebted to the VA or who have been paid benefits erroneously. If necessary, contact will be made with them directly at their place of employment and through their agencies, in an effort to collect these debts.

As of September 30, 1980, there were 546,973 accounts receivable in the Centralized Accounts Receivable System. These accounts receivable are valued at \$541.7 million, which represents over 80 percent of all accounts receivable. Education accounts resulting from overpayment of benefits amount to \$420.7 million. There was also an estimated \$22 million in education loan defaults. Compensation/Pension and Loan Guaranty accounts receivable as of September 30, 1980, total \$223 million. The Office of Personnel Management indicates that 46 percent of all federal employees have veteran status. The VA pays benefits in some form to at least 68 percent of all veterans. While it is not known what percentage of these recipients are Federal employees, it is estimated from previous VA experience that 10,000 to 12,000 cases may exist where employees from Federal agencies owe the VA money due to overpayment or erroneous payment of benefits.

Required notices have been prepared and sent to OMB and Congress, and Federal Register notices have been published in compliance with OMB Computer Matching Guidelines. We have received the data file computer tapes from OPM and are proceeding with matching.

INSPECTOR GENERAL'S FRAUD WATCH

In an effort to increase employee awareness of the potential for fraud, waste and abuse in VA programs, we initiated the first Inspector General's Fraud Watch. The Fraud Watch, a fact sheet to be issued periodically, will bring known program abuses and fraud schemes to the attention of our auditors, investigators, and other appropriate employees to provide assistance in detecting and preventing fraud, waste and abuse.

The first Fraud Watch summarizes the most common types of fraud schemes perpetrated in the Loan Guaranty Program. Investigations conducted by OIG Staff, DVB Regional Office personnel, and the FBI, have found that abuses generally fall into three categories: (i) fraud perpetrated by third parties, i.e., lenders, real estate brokers/ salespersons, credit agencies, fee appraisers, and builders or sellers; (ii) veteran or beneficiary fraud; and (iii) fraud by VA employees. Examples of how abuses may occur in each of these categories are highlighted. The internal controls which identify indicators that irregularities may exist are also highlighted, as well as the penalties, criminal and administrative, for those found responsible for the wrongdoing.

FOLLOW UP ON PRIOR PROJECTS

Part-Time Physician - Time Accounting. On May 5, 1980, the GAO granted approval of VA's request for part-time physicians to record and report their own time and attendance, using the new subsidiary time and attendance records previously suggested by us. The supporting administrative circular has been signed to become effective October 1, 1980. This new timekeeping and accountability method will be closely monitored in the ensuing months for its effectiveness.

Eligibility for Education Benefits. As a result of our earlier analysis, DVB initiated a computer project to identify veterans receiving Chapter 34 benefits although their records showed an Entered on Duty date later than December 31, 1976, the expiration date for Chapter 34 benefits. There were 612 claims found to be paid in error, involving erroneous payments of \$678,763. Stop payment actions were initiated to prevent further overpayments.

DVB also developed instructions and reporting procedures to review an additional 11,070 cases that were identified as questionable based on partial information. Ninety-four percent (10,467) of these cases have been reviewed to date. Some type of error was

found in 2,296 of these cases. There were 640 beneficiaries found to be ineligible for education benefits and \$1.4 million had been paid erroneously. Stop payment actions were initiated to prevent further overpayments.

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DEPARTMENT OF CHEMISTRY
5301 SOUTH CAMPUS DRIVE
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CHAPTER VI

INTERAGENCY ACTIVITIES

The Office of Inspector General participates in various activities to improve coordination and cooperation among Federal, state, and local agencies engaged in combating fraud, waste and abuse.

On July 2, 1980, OMB issued instructions for improving procurement practices in general and consulting service contracts in particular. OMB emphasized the Inspector General's involvement in the development of a consistent audit approach to consulting contracts, including preparation of a standard government-wide audit guide. Under the sponsorship of the Executive Group to Combat Fraud and Waste in Government, an interagency project team under the direction of the Office of Inspector General, HUD, was formed to develop the audit guide. The project team produced the audit guide, "Contracting for Consulting Services," which will be used by all Offices of Inspector General.

We participated in a brief survey with other Offices of Inspector General to determine the feasibility of an interagency effort to improve debarment and suspension procedures. The specific issue is whether contractors, grantees, and borrowers might be excluded from participating in Federal programs in one agency as a result of prior willful misconduct or poor performance resulting in suspension or debarment by another agency. Other agencies involved in this ongoing effort include the Departments of Agriculture, Housing and Urban Development, and Commerce, and the Small Business Administration.

An audit program has been developed to review controls over the VA Fee Basis Hometown Pharmacy Program. Health Care Finance Administration staff of the Department of Health and Human Services, responsible for controlling pharmaceutical reimbursements under medicaid, medicare, and public health programs, actively assisted our health programs audit staff in developing a method for determining if fee basis claims for reimbursement are valid and reasonable.

The Assistant Inspector General for Auditing is heading a task force of the Subcommittee on Training, Executive Group to Combat Fraud and Waste in Government, to develop a training profile and a plan to meet the short and long range basic training needs for Office of Inspector General entry level auditors. Two members of the Office of Audit staff served on a Subcommittee on Performance Appraisal project to develop standard criteria for Office of Inspector General auditors. The Subcommittee will soon begin developing similar criteria for investigators.

Our Office of Audit is also participating with OPM in a joint project to develop improved methods for staffing auditor and investigator positions within the Offices of Inspector General. Three avenues of approach have been agreed to: (i) develop a special staffing vehicle at the entry level for auditors and investigators, (ii) improve staffing cooperation and service between Offices of Inspector General and OPM's Washington Area Office staff, and (iii) establish special examining units. This project is a direct response to the expressed needs of the Offices of Inspector General for highly qualified auditors and investigators to meet Inspector General Act objectives to prevent fraud, waste and mismanagement in Federal government operations.

At the request of the Administrator of GSA, a member of our Office of Audit staff is serving with an interagency task group to develop an audit program to review Federal micrographics management. Upon completion of the audit program, we will conduct an audit of VA's micrographics management.

Our Office of Audit participated in two other interagency projects led by GSA: an audit of the Performance of IBM Equipment Leased or Purchased Under Contract, and a Survey of Furniture Procurement.

We are continuing to participate with the Office of Inspector General, Department of Housing and Urban Development, in a joint audit/investigation of loan guaranty programs in Puerto Rico.

Office of Audit staff members continue to serve on the Association of Government Accountants' Task Force on Proposed Standards for Executive Reports on Internal Control. The task force recently completed a guide for achieving compliance with the proposed Financial Integrity Act of 1980 entitled, "Executive Reporting on Internal Controls in Government." This guide was transmitted to the Comptroller General and OMB for consideration in the event the legislation is enacted.

A project to establish a working relationship with state audit groups is progressing satisfactorily. The project was designed to coordinate audit activities with state officials, to explore the possibility for joint audit efforts, and to contract with states for audits. Many of the states have agreed to cooperate. During this reporting period, we have signed contracts with three states for audits of VA contract and grant awards to state agencies.

Our Office of Investigation is participating in a pilot project with the Department of Labor and several other federal agencies to uncover recipients of fraudulent benefits under the Federal Employees Compensation Act of 1974 in the eight-state Atlanta Region.

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CHAPTER VII

REVIEW OF LEGISLATION AND REGULATIONS

NEW LEGISLATION AND REGULATIONS

We reviewed 28 proposed bills and 45 proposed regulations between April 1, 1980 and September 30, 1980. Comments and suggestions were submitted on 18 proposed bills and 5 proposed regulations. Some of the comments are as follows:

We supported proposed regulations regarding the establishment of a designated Agency Ethics Official whose duties are to prevent conflicts of interest on the part of employees. We are concerned, however, that the Inspector General's role in investigating conflict of interest matters is not recognized.

We supported the objectives of Department of Justice draft bill which would provide an administrative mechanism for the recovery of civil penalties and assessments for false claims involving Federal grants, contracts, and programs. This proposed bill set forth the right of offset against tax refunds due, which would allow for collection of small debts for which litigation costs would be prohibitive. We are extremely concerned with one aspect of this draft bill which will provide for the direct referral of potential corruption cases by the agency to the Department of Justice without the Inspector General's involvement. The Inspectors General are developing a coordinated position on this and other aspects of the bill.

We reviewed H.R. 7674, the proposed Consultant Reform Act of 1980 and the Senate version of the same bill. We expressed our concern that the Senate version seemed overly broad in identifying procurement activities subject to the Act.

The proposed Financial Integrity Act of 1980 was reviewed. Some changes were suggested that would allow the Inspectors General to select substantive allegations for audit and investigation rather than being mandated to look into all allegations received.

Proposed bills S.2402, S.2404 and S.2405 would change access to IRS tax return information. Under the proposal, the Inspectors General would not be authorized to present applications for access to tax returns directly to the appropriate Federal court for consideration. This could cause unnecessary delays in conduct of Inspectors General investigations and could require Inspectors General to prematurely refer investigations to U. S. Attorneys. This could also affect whether information received by U.S. Attorneys could be redisclosed to Inspectors General.

S. 2402 lists the information, treated as non-return information, that can be obtained by an Inspector General. We recommended that consideration be given to expanding this information to include gross income amounts, net income amounts and sources of income (e.g., wages and non-wage income). Because several veteran benefits are income dependent, this income information is necessary when determining the existence of benefit fraud and abuse by an individual. We proposed changes that would include the Inspector General as an official who might sign an application for a court order for the release of return information, clarification of redisclosure from U.S. Attorneys to our investigators in certain instances, and expansion of the "non-return" information which could be obtained by our personnel to evaluate possible fraud or abuse of income dependent benefit programs.

S. 503 is a proposed bill to amend the Privacy Act of 1974 to provide for the confidentiality of medical records. Our major concern with this proposed legislation was the separate treatment of audit and investigative functions which is inconsistent with the Inspector General Act of 1978. Under the proposed bill, Inspector General investigators, but not auditors, would be authorized to obtain confidential information. Further, the definition of "audit" was inconsistent with the Inspector General Act.

H.R. 5935, a bill to protect the privacy of medical information, was reviewed and opposed on the ground that it denied appropriate access to medical records needed to carry out responsibilities.

H.R. 6408, a bill to provide special loans for residential solar energy systems, was opposed because the proposed legislation would increase administrative costs without providing a benefit not already available under VA loan guaranty provisions.

EXISTING LEGISLATION AND REGULATIONS

Review of existing legislation and regulations occurs during an audit or investigation when the underlying causes for fraud, waste or mismanagement are traceable to these sources. The results of such reviews and related recommendations are discussed in preceding chapters of this report.

CONGRESSIONAL HEARINGS

During the past six months, we provided testimony at the following Congressional Hearings:

1. On April 23, 1980 the Senate Veterans Affairs Committee held hearings on VA Cardiac Pacemaker Policy.

2. On April 30, and May 1, 1980, hearings on year end spending were held before the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs.

3. On June 11, 1980 the Oversight of the Activities of the VA Inspector General were held before the Senate Veterans Affairs Committee.

4. On September 24, 1980, hearings were held on the Review of Procurement of Computer Equipment and Services by the VA in FY 1979. These hearings were held before the Subcommittee on Special Investigations, House Committee on Veterans Affairs.

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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 its inception, February 15, 1979 to September 30, 1980, there were 1140 hotline contacts, 906 from the VA hotline and 234 referrals from GAO.

Over 57 percent of the allegations were classified in the following 5 of the 18 established categories (1140 contacts resulted in 1592 allegations):

<u>Hotline Category</u>	<u>Number of Allegations</u>
Employee - Misuse of Position*	311
Wasteful Practices	186
Personnel	139
Employee Grievance	138
Poor Management	135

The allegations originated from 219 locations, as follows:

<u>Type of Facility</u>	<u>No. of Contacts</u>	<u>Percent</u>
VA Medical Centers	808	70
VA Regional Offices	227	20
VA Central Office	35	3
VA National Cemeteries	9	1
VA Outpatient Clinics	23	2
VA Data Processing Centers	8	1
Veterans Benefits Offices	2	-
Other	18	2
No Specific Location	17	1
TOTAL	<u>1147**</u>	<u>100</u>

* Formerly this category was labeled Employee Misconduct.

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

Eighty percent of all contacts have been closed as of September 30, 1980. Eighteen percent have been closed with no reply requested, i.e., they were considered non-hotline matters (employee grievance). Forty-one percent of the complaints were closed as unfounded, while twenty-one percent were closed as founded or partially founded.

In addition, 351 of the complaints were initially considered by us to be serious or substantive in nature. Of these, 232 have been closed, of which 90 were founded or partially founded; that is, all or part of the allegations were found to be true.

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, we did not identify any instances that are reportable under this section of the Act during the past six months.

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.

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ACCOUNTS RECEIVABLE

The Supplemental Appropriations and Rescission Bill, 1980 directs the Inspectors General to include in their semi-annual reports a summary of the total amounts due their agency or department, as well as amounts overdue, and amounts written off as uncollectible during the reporting period. The VA does not maintain centralized information on all overdue accounts and could not provide us with these statistics. The following statistics are as of September 30, 1980, and are shown to the nearest thousand.

Account Title	Receivables		Written Off
	Loans	Accounts	
Insurance & Indemnities	\$ 1,198	\$ 104	\$
Reopened Ins. Fund	39,578	10,103	
Service-Disabled Ins.	29,046	1,174	8
National Serv. Life Ins.	1,150,513	183,093	17
U.S. Gov. Life Ins.	44,289	8,701	
Vets. Special Life Ins.	68,728	13,300	
Compensation & Pension	8	68,656 (1)	
Major Construction		14,656	
Minor Construction		4,228	
Readjustment Benefits		436,595 (1)	6,962
Grants to Rep. of Philippines		260	
Gen. Operating Expenses		6,514	12
Med. Admin. & Misc. Expenses		576	
Medical Care		49,350	3,609
Med. & Prosthetics Research		3,396	3
Health Manpower Training		10,584	
Direct Loan	447,720	57,822	141
Loan Guaranty	1,417,198 (2)	26,702	2,404
Therapeutic & Rehabilitation		141	
Vocational Rehabilitation	423		6
Education Loan	61,934 (2)		3,317
Supply Fund		23,269	18
Post Vietnam Educ. Assistance		122	
General Post		1,979	
TOTALS	\$3,260,634	\$921,326	\$16,497

(1) In addition to the benefit overpayment receivables reported on page 1-2, this figure includes proceeds due from the Treasury for unavailable cancelled checks, unassociated amounts pending resolution, and accounts in process.

(2) Includes defaulted loan receivables.

AUDIT REPORTS COMPLETED
SECTION A - INTERNAL

HEALTH CARE PROGRAMS

VA Medical Center, Washington, DC
VA Medical Center, Los Angeles (Brentwood), CA
VA Medical Center, Erie, PA
VA Medical Center, Albuquerque, NM
VA Medical Center, Fort Howard, MD
VA Medical Center, Bay Pines, FL
VA Medical Center, Hot Springs, SD
VA Medical Center, Leavenworth, KS
VA Medical Center, Canandaigua, NY
VA Medical Center, Des Moines, IA
VA Medical Center, Sepulveda, CA
VA Medical Center, Clarksburg, WV
VA Medical Center, Lincoln, NE
VA Medical Center, Spokane, WA
VA Medical Center, Minneapolis, MN
VA Medical Center, American Lake (Tacoma), WA
VA Medical Center, University Drive, Pittsburgh, PA
VA Medical Center, Phoenix, AZ
VA Medical Center, Fort Lyon, CO
VA Medical Center, Grand Island, NE

HEALTH CARE PROGRAMS (Con't.)

VA Medical Center, Richmond, VA

VA Medical Center, Chicago (Lakeside), IL

VA Medical Center, Durham, NC

VA Medical Center, Bronx, NY

VA Medical Center, Grand Junction, CO

VA Medical Center, New York, NY

Edith Nourse Rogers Memorial Hospital, Bedford, MA

Olin E. Teague Veterans' Center, Temple, TX

VA Medical and Regional Office Center, Fargo, ND
(Audit of Medical Center)

VA Medical and Regional Office Center, White River Junction, VT
(Audit of Medical Center)

VA Medical Center, Reno, NV (Followup)

VA Medical Center, Northport, NY (Special Purpose Audit)

VA Medical Center, Salt Lake City, UT (Special Purpose Audit)

VA Domiciliary, White City, OR

VA Outpatient Clinic, Las Vegas (Henderson), NV

Pre-Installation Audit of Affiliation Assessment Project

Specialized Medical Programs/Sharing Agreements, VA Medical
Center, Decatur, GA

Review of VA Employees Receiving Treatment for Nonservice-
Connected Conditions

Summary of Audit Findings on Controls Over Quality of Patient Care

BENEFIT PROGRAMS

VA Medical and Regional Office Center, San Juan, PR (Regional Office audited)

VA Regional Office, Seattle, WA (Survey)

Financial Operations, VA Regional Office, Denver, CO

Education-Related Benefits and Overpayments, VA Regional Office, Roanoke, VA

Education Match Pay Processing, VA Data Processing Center, Hines, IL

Multiple Education Benefit Payments, VA Data Processing Center, Hines, IL

Centralized Accounting for Local Management (CALM) System Returned Checks and Payments, VA Data Processing Center, Austin, TX

Loan Guaranty, VA Center, Philadelphia, PA

MEMORIAL AFFAIRS PROGRAMS

VA National Cemetery, Dayton, OH

VA National Cemetery, Hot Springs, SD

VA National Cemetery, Fort Leavenworth, KS

VA National Cemetery, Fort Scott, KS

VA National Cemetery, Leavenworth, KS

VA National Cemetery, Bath, NY

VA Woodlawn National Cemetery, Elmira, NY

National Cemetery Area Office, Atlanta, GA, and Selected National Cemeteries

Department of Memorial Affairs Procurement Function, Monument Service

FUNCTIONAL AND SUPPORT ACTIVITIES

VA Supply Depot, Hines, IL

VA Marketing Center, Hines, IL

Survey of Replacement Medical Center Construction Projects

Review of VA's Construction Approval Steps, Central Office

Audit of Negotiations and Content of Selected Contracts Awarded by
VA Medical Center, Wadsworth, Los Angeles, CA for VA Medical
Center, Brentwood, Los Angeles, CA

Performance of IBM Equipment Leased or Purchased Under Contract
GS-00C-01522, Fiscal Year 1979

Maintenance Contracts (Summary Report)

Systems Application Inventory, VA Data Processing Center,
St. Paul, MN

Systems Application Inventory, VA Data Processing Center,
Hines, IL

Consultant and Attending Computer Application, VA Data Processing
Center, Hines, IL (Survey)

Agent Cashier Computer Application, VA Data Processing Center,
Hines, IL

Fiscal Reporting Application, VA Data Processing Center, Hines, IL

Systems Division, VA Data Processing Center, Philadelphia, PA

Annual Income Questionnaire, VA Data Processing Center, Hines, IL

Policies and Procedures for Acquiring Automated Data Processing (ADP)
Hardware and Software

Magnetic Media Procedures and Controls, VA Data Processing Center,
Austin, TX

Data Security, VA Data Processing Center, Austin, TX

Security Audit of Honeywell Clinical Laboratory System

TARGET - Modification 3 to the Honeywell Information System Contract

AUDIT REPORTS COMPLETED
SECTION B - EXTERNAL

Chelsea Veterans Home, Chelsea, MA, Laboratory Renovation,
Construction Grant

Rhode Island Veterans Home, Bristol, RI, 150-Bed Nursing
Home Care Facility, Construction Grant

Chelsea Veterans Home, Chelsea, MA, Remodel Hospital Central
Services and Patient Care Areas, Construction Grant

Iowa Veterans Home, Marshalltown, IA, 360-Bed Nursing Care
Facility, Construction Grant

Erie Soldiers and Sailors' Home, Erie, PA, New Nursing Care Wing,
Construction Grant

Chelsea Soldiers Home, Chelsea, MA, Renovations to Main Dormitory,
Construction Grant

Chelsea Soldiers Home, Chelsea, MA, Renovations to John Adams
Dormitory, Construction Grant

Wisconsin Veterans Home, King, WI, Fire Sprinkler System,
Construction Grant

Wisconsin Veterans Home, King, WI, Renovate Nursing Home Care
Facilities, Construction Grant

New Jersey Memorial Home for Disabled Soldiers, Menlo Park, NJ,
Financial and Compliance Audit

Bronx Community College, Bronx, NY, Manpower Grant 32-373

College of St. Francis, Joliet, IL, Manpower Grant 13-175

University of South Carolina, Columbia, SC, Manpower Grant 41-0001

University of Florida, Gainesville, FL, Manpower Grant 9-0202

University of Utah, Salt Lake City, UT, Review of Costs Incurred
Under Federal Grants and Contracts

University of Alabama, Birmingham, AL, Audit of Rates Used to
Charge Federal Programs for Computer Usage at the Rust Center

University of Minnesota, Minneapolis, MN, Audit of Costs Incurred
and Claimed Under Federally Sponsored Agreements

Yale University, New Haven, CT, Audit of Costs Transferred to Federal Grants and Contracts

George Washington University, Washington, DC, Review of Direct Costs Incurred Under Federal Research and Training Grants and Contracts

Northern Illinois University, Dekalb, IL, Audit of Costs Incurred Under Federally Funded Research and Training Grants and Contracts

University of California, Berkeley, Davis, Los Angeles, San Diego, and San Francisco, CA, Audit of Campus Computer Center Recharge Rates

University of California, Berkeley, CA, Followup Review of Recharge Center Accumulated Surpluses

University of California, Berkeley, CA, Review of Fringe Benefit Rates Applicable to Proposals of Federal Contracts and Grants

The Predischarge Education Program, Concordia College, Milwaukee, WI

The Predischarge Education Program, Unified School District #453, Leavenworth, KS

The Predischarge Education Program, Wahiawa Community School for Adults, Wahiawa, HI

State Approving Agency, Puerto Rico State Department of Education, San Juan, PR

Radiological & Nuclear Medical Professional Corporation, Scarce Medical Contract for Radiological Services, VAMC Des Moines, IA

Shepley, Bulfinch, Richardson and Abbott, Architectural and Engineering Services to Renovate Building, VAMC Lyons, NJ

Stearns-Rogers Architects, Ltd., Architectural and Engineering Services for Boiler Plant, VAMC Poplar Bluff, MO

University of California, Los Angeles, CA, Scarce Medical Contract for Anesthesiology with VAMC Wadsworth, CA

University of Kentucky, Scarce Medical Contract for Anesthesiology with VAMC Lexington, KY

University of Washington, Scarce Medical Contract for Orthopedic Services with VAMC Seattle, WA

Cahn Engineers, Inc., Drawings and Specifications for Project to Update Primary Distribution, VAMC Albany, NY

University of Washington, Scarce Medical Contract for Anesthesiology with VAMC Seattle, WA

L. W. "Red" Huddleston, Inc., Delay of Contract Claim, VAMC Tomah, WI

George Hyman Construction Co., Change Order Proposal, Therapeutic Pool, Replacement Hospital, VAMC Richmond, VA

Meyersbank Electric Co., Inc., Change Order Proposal to Modify Electrical Work for Replacement Hospital, VAMC Bronx, NY

County Construction Co., Inc., Outpatient Clinic Renovation and Admission Consolidation, VAMC Washington, DC

Stearns-Rogers Architects, Ltd., Boiler Plant Replacement Design Services, VAMC Grand Island, NE

Meyersbank Electric Co., Inc., Installation of Conduit and Wire Physiological Monitoring Equipment, VAMC Bronx, NY

Warner Electric, Inc., Modifications to Emergency Distribution Equipment, VAMC Long Beach, CA

Northwestern University Medical School, Scarce Medical Contract for Anesthesiology with VAMC Chicago (Lakeside), IL

Tutor & Saliba, Equitable Adjustment Claim, Air Condition Various Buildings, VAMC Sepulveda, CA

Meucci Engineering, Drawings, Specifications and Construction Period Services for Boiler Plant Replacement, VAMC Erie, PA

Bussard/Dikis Associates, Ltd., Working Drawings and Construction Period Services, VAMC Des Moines, IA

Texas A&M Research Foundation, Development and Evaluation of Advanced Automotive Equipment

Cline, Smull, Hamill, Quintier Associates, Building Analysis Drawings and Construction Period Services on Ward Renovation Project, VAMC Boise, ID

University of Missouri, Scarce Medical Contract for Radiology Service with Harry S. Truman Memorial Veterans Hospital, Columbia, MO

D. R. Michaels Company, Inc., Termination Claim, VAMC Boston, MA

Ivey's Plumbing & Electric Inc., Change Order Proposal, Air Conditioning Systems, Electrical Improvements and Emergency Generators, VAMC Lexington, KY

Loebl, Schlossman & Hackl, Architectural and Engineering Services for New Warehouse/Service Building, Edward Hines Jr. Medical Center, Hines, IL

Gerson/Overstreet Architects, Drawings, Specifications and Construction Period Services to Remodel Wards, VAMC Livermore, CA

Thomas, Harris, Ash and Mason, Working Drawings and Specifications, VAMC Wichita, KS

University of Texas Southwestern Medical School, Scarce Medical Contract for Anesthesiology Services with VAMC Dallas, TX

Beardsley and Beardsley, Wage Rate Determination for Safety and Fire Deficiencies Project, VAMC Syracuse, NY

Johnson, Johnson and Roy, Inc., Master Plan, Federal Region & National Cemetery Fort Custer, Battle Creek, MI

Mobility Engineering & Development, Inc., Final Audit of Costs Incurred

McKissack & McKissack, Architectural & Engineering Services for Renovation of Wards, VAMC Murfreesboro, TN

Gresham and Smith, Architectural and Engineering Services for Safety and Fire Deficiencies Project, VAMC Murfreesboro, TN

Max O. Urbahn Associates, Inc., Demolition and Site Development, VAMC Bronx, NY

Potomac Research, Inc., Final Audit of Contract for Six Computer Programmers at VADPC Hines, IL

University of California, San Francisco, CA, Scarce Medical Contract for Anesthesiology Service with VAMC San Francisco, CA

Center for Policy Research, New York City, NY, Final Audit of Costs Incurred

Carol Johnson Associates, Edwards and Kelsey, Inc., and Perry, Dean, Stahl & Rogers, Inc., Investigative Service including Preliminary Plans for the Committal Service Shelters and Columbaria Niches, Massachusetts National Cemetery, Bourne, MA

Harwood, K. Smith & Partners, Preliminary Plans, Addition and Renovation for Ambulatory Care Clinic and Education, VAMC Amarillo, TX

Williams & Tazewell, Perkins & Will, Utility Plant Redesign, VAMC Richmond, VA

Batteast Construction Co., Remodel Building, VAMC Marion, IN

W. C. Kruger & Company, Preliminary Plan Development, VAMC Albuquerque, NM

Odell Associates, Inc., Architectural and Engineering Services for Clinical Addition, VAMC Fayetteville, NC

Honeywell TARGET System Data Element, Dictionary Utility Enhancements

University of Alabama, Scarce Medical Contract for Radiology Services with VAMC Birmingham, AL

F. P. Lathrop Construction Co., Clinical Addition, Utility Improvements and Boiler Plant, VAMC Reno, NV

Williams & Associates, Inc., Test Soils and Concrete, VAMC Bay Pines, FL

Fletcher and Sons, Inc., Nursing Home Care Unit, VAMC Wilkes-Barre, PA

Howard R. Lane Associates, Architectural and Engineering Services for Remodeling Building, VAMC Brentwood, CA

Widom/Wein & Associates, Preliminary Architect/Engineering Plans for 60-Bed Nursing Home Units at VAMC Denver, CO, VAMC Fresno, CA, and VAMC Spokane, WA

Carl R. Blanchard Jr., Architects and The Minges Associates, Inc., Preliminary Design Contract for Air Conditioning, Patient Privacy and Support, VAMC Newington, CT

Capacete, Martin & Associates, Architectural and Engineering Services for Outpatient Clinic Expansion, VAMC & ROC San Juan, PR

Wachtel, Duklauer & Fein, Fire Sprinkler System Installation,
VAMC Bronx, NY

Universal Communications Systems, Change Order for Expansion of
Telephone Service Equipment, VAMC Bronx, NY

Vulcan Construction Company, Wage Rate Determination for Air
Conditioning and Ward Renovation, VAMC Knoxville, IA

Misso Services Corporation and Associates, VAX Systems Hardware
and Software

Misso Services Corporation and Associates, Nine Hardware to Systems

Misso Services Corporation and Associates, Nine Mine Computer Systems

Carlisle Associates/Wilbur Smith and Associates, Architectural and
Engineering Services for Building Renovation, VAMC Columbia, SC

Alex Munoz General Contractor, Inc., Relocation of Director's Suite,
VAMC Hines, IL

Bhandari Constructors & Consultants, Inc., Ward Bathroom Renovation,
VAMC Syracuse, NY

Mack Bean Construction, Patient Privacy, VAMC Erie, PA

Jim Takisaki, Inc., Relocation of Canteen, VAMC Tacoma (American
Lake), WA

F. E. Davis, Renovation for Patient Privacy, VAMC Salisbury, NC

Richardson Contracting Company, Correction of Life Safety Deficien-
cies, VAMC Prescott, AZ

Morse/Diesel, Inc., Construction Consultant Services, VAMC
Portland, OR

E. Henderson, Inc., Replace Windows and Repair Exterior Building,
VAMC Perry Point, MD

A. Jones Roofing Co., Re-Roofing Project, VAMC Memphis, TN

Custom Doors, Remodel Building, VAMC Salt Lake City, UT

Munoz General Contractors, Remodel Patients Bathrooms, VAMC
Chicago (Westside), IL

Heapy & Associates, Conceptual Design for Master Plan, VAMC
Dayton, OH

Holabird and Root, Preliminary Design for Outpatient Addition,
VAMC Chicago (Westside), IL

Glenn W. Brown Corporation, Reinsulate Ceilings, VAMC Canandaigua,
NY

Native American Construction, Inc., Roof Replacement, VAMC
Batavia, NY

Levin, Porter, Smith, Inc., Heapy and Associates, & THP Limited,
Clinical Expansion and Relocation, VAMC Cincinnati, OH

Velez Construction Company, Laboratory Construction, VAMC New
York, NY

Francis G. Vitetta Associates, Architectural and Engineering
Design for New Hospital, VAMC Camden, NJ

University of Minnesota, Scarce Medical Contract for Radiologist
Services with VAMC Minneapolis, MN

Drew's Construction Company, Correction of NFPA Deficiencies,
VAMC Nashville, TN

Gillum - Colaco, Hayakawa Associates & Hellmuth, Obata & Kassabaum,
Architectural and Engineering Services for Safety and Fire Defic-
iencies Project, VAMC St. Louis (Jefferson Barracks Division), MO

Lone Star Energy Co., Thermal Energy Services, Audie L. Murphy
Memorial Veterans Hospital, San Antonio, TX

Malor Construction Corporation, Renovation of Patient Toilets and
Washrooms, VAMC New York, NY

Drew's Construction Company, Vinyl Wall Covering, VAMC Nashville, TN

University of California, Los Angeles, CA, Hospice Evaluation

Southwest Research Institute, Environmental Control Devices Applied
to Vocational Rehabilitation of the Severely Handicapped, Audie L.
Murphy Memorial Veterans Hospital, San Antonio, TX

Northwestern University, Evanston, IL, Prosthetics Research

Blinded Veterans Association, Field Service Program

Neptune Thomas Associates, Working Drawings and Construction Period
Services for Fire and Safety Deficiencies, VAMC Sepulveda, CA

Mitre Corporation, Contract for Technical TARGET System

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