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Report to the Acting Inspector General, Department of Veterans Affairs

July 1989

INSPECTORS GENERAL

Compliance With Professional Standards by the VA Office of Inspector General

GAO/AFMD-89-76

GAO

United States
General Accounting Office
Washington, D.C. 20548

Accounting and Financial
Management Division

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July 3, 1989

The Honorable Renald P. Morani
Acting Inspector General
Department of Veterans Affairs

Dear Mr. Morani:

This report presents the results of our review of the Department of Veterans Affairs' (VA) Office fo Inspector General (OIG). This is the seventh in our series of quality assessment reviews of federal inspectors general. (See appendix I for a complete listing of the previous reviews.) Statutory offices of inspectors general play an important role in preventing and detecting fraud and abuse and in promoting economy, efficiency, and effectiveness in federal programs and operations. The government relies on OIGs to determine whether federal funds are handled properly and agencies are economically and efficiently achieving the purposes for which their programs were authorized and funded. Because the OIGs' work is so important, we initiated our series of reviews to assess its quality.

The objectives of our review were to determine whether the VA OIG (1) performed its work in accordance with generally accepted government auditing standards and other professional standards and (2) conducted investigations in accordance with standards adopted by the President's Council on Integrity and Efficiency (PCIE). Compliance with these standards provides users of OIG reports with greater assurance that the work was performed adequately and that the results of the work can be relied on for decision-making and oversight purposes. We also reviewed the OIG's audit and investigative coverage of VA's operations, the accuracy of two OIG semiannual reports to the Congress, and the OIG's impact on VA.

We found that the OIG satisfactorily complied with the 12 audit and 11 investigation standards we tested. We also found that the OIG has established effective quality controls to help ensure its compliance with standards. When we did identify the need for quality control improvements in referencing[1] and following up on minor audit report findings, the OIG clarified its policies to strengthen both these areas. Our review of the OIG's coverage of VA's operations, accomplishments reported in the

[1]Referencing is the process by which an experienced auditor with no involvement on an assignment compares a report's statements of fact and numbers with working papers to ensure their accuracy.

OIG's semiannual reports, and benefits received by VA from the OIG's efforts indicate that the OIG is having a significant impact on VA's operations.

Background

The Inspector General Act of 1978, as amended, and other legislation established an OIG in the Department of Veterans Affairs (formerly the Veterans Administration) and other departments and agencies. The President, with the advice and consent of the Senate, appoints the inspector general (IG) who directs the office. The IG is under the general supervision of, and reports to, the Secretary of Veterans Affairs. The current Deputy Inspector General, Renald P. Morani, is now serving as the Acting Inspector General. He replaced Frank S. Sato, who resigned in January 1988 after serving as IG since July 1981.

The OIG's mission is to prevent, detect, and reduce fraud, waste, and abuse and promote economy, efficiency, and effectiveness through audits and investigations of the Department's programs and operations. The OIG performs its mission through three major offices, each headed by an assistant inspector general. They are the Office of Auditing, the Office of Investigations, and the Office of Policy, Planning, and Resources. In addition to its central office, the OIG has eight regional offices and a field data processing center.

In fiscal year 1987, the OIG had 380 employees and a budget of approximately $19 million to oversee the administration of VA's budget of about $27 billion and the activities of around 250,000 VA employees. During this period, VA operated 172 medical centers, 229 outpatient clinics, and 117 nursing homes. Through 58 regional offices, VA also administers programs for veterans and their survivors. These programs provide compensation and pension payments, education assistance payments, burial benefits, guaranteed and insured home loans, and life insurance.

The Office of Auditing provides coverage of VA primarily through performance audits of VA's many centers for medical services and benefits to veterans. The OIG generally reviews each VA facility every 3 years. These reviews include the major functions of each VA facility, such as medical services, facility planning, and benefits payments. The OIG also provides coverage in areas of the delivery of medical care, loan guarantees, disability payment controls, and procurement. While the OIG does not usually perform financial audits, it plans to audit aspects of VA's financial statements in 1989.

The Office of Investigations provides coverage of VA primarily through reactive investigations of allegations or complaints brought to the OIG's attention. However, the OIG also undertakes proactive investigations in certain VA programs, such as the multibillion dollar home loan guaranty program. At times, the OIG's investigations involve coordination with the Federal Bureau of Investigation and the OIG of the Department of Housing and Urban Development.

The Office of Policy, Planning, and Resources is responsible for quality assurance reviews of the OIG's operations; postaudit quality reviews; operation of the fraud hotline; oversight of the agency's health care quality assurance activities; and matters relating to policy, planning, and resources.

Objectives, Scope, and Methodology

The objectives of our review were to determine whether the VA OIG was performing its work in accordance with professional standards, including (1) the Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, revised in 1981,[2] (2) the PCIE Quality Standards for Federal Offices of Inspector General, (3) the PCIE Quality Standards for Investigations, and (4) the Office of Management and Budget (OMB) Circular A-73, "Audit of Federal Operations and Programs." In addition, we evaluated the OIG coverage of VA's operations; the documentation and presentation of two OIG semiannual reports to the Congress for the periods ending September 30, 1987, and March 31, 1988; and the OIG's impact on VA.

These standards are guiding principles which must be applied with professional judgment in individual circumstances. While compliance with standards helps ensure quality work, judgments about compliance cannot be rigidly made. During our review, we used the term "standard" to refer to either an individual standard or, in some cases, a combination of similar standards or OMB directives. (See appendix II for a summary of the standards used in our review and their sources.)

Our review approach for this report is essentially the same as the one we used in our earlier quality assessment reviews. For a detailed discussion on how we developed this review approach, refer to our report on

[2]The Comptroller General's standards were again revised in 1988 and the revisions became effective January 1, 1989. Since the revised standards were not effective until our review was almost completed, we used the 1981 version of the standards during this review.

the Department of Commerce OIG.[3] We assessed compliance with standards by (1) evaluating the OIG's controls, written policies, and procedures for ensuring adherence to the standards, (2) reviewing a sample of audit and investigation reports and supporting documents for recently completed assignments, and (3) reviewing, testing, and evaluating other evidence of OIG compliance with the standards.

We chose a judgmental sample of 14 audits and 18 closed investigations completed between April 1 and September 30, 1987. We consulted with OIG officials to ensure that our sample would fairly reflect the size and diversity of the OIG's work. Since we did not redo any of the audits or investigations, we cannot conclude whether any OIG reports contained invalid findings, conclusions, or recommendations.

During our review, we met periodically with the Acting IG and his staff to discuss our assessment results, as well as suggestions on other management practices which we thought the OIG should consider adopting. In addition, we provided the Acting IG and his staff, including those directly involved in the assignments, with a detailed briefing on our findings.

We performed our work at OIG headquarters in Washington, D.C.; regional OIG offices for audit in Boston, Chicago, and Seattle; and regional OIG offices for investigations in Washington, D.C., Kansas City, and Atlanta. Our review was performed between January 1988 and February 1989 and was conducted in accordance with generally accepted government auditing standards. The OIG provided written comments on a draft of this report. These comments are included in full in appendix III.

Overall Compliance With Standards

We found that the VA OIG satisfactorily complied with the 12 audit and 11 investigation standards tested. We also found that the policies and procedures developed by the OIG establish effective quality controls which help ensure compliance with standards. However, we did identify two areas where the OIG could enhance its quality controls by clarifying its policies on (1) referencing and (2) the follow-up of minor report findings.

[3]Compliance With Professional Standards by the Commerce Inspector General (GAO/AFMD-85-57, August 12, 1985).

In a separate review, we examined allegations that the former IG lacked independence in his decisions related to nine audit reports not included in this review.[4] We found no conclusive evidence to substantiate those allegations. We did not assess these nine audits' compliance with any other professional standards nor did we take a position as to whether the former IG made correct decisions regarding these audits.

In February 1987, the OIG established a report-referencing policy requiring that audit report statements be verified with the audit working papers. During our review we found that (1) four audit reports had minor report statements which were not adequately supported in the working papers, (2) not all significant report statements were cross-indexed to supporting working papers, and (3) eight reports had minor reporting errors, such as mistakes in the rounding and addition of numbers. To illustrate, one report statement without adequate support stated that the audit findings were verified in consultation with agency officials. Our review disclosed that report findings were adequately supported by other documented evidence, but that consultations with the agency officials were not documented.

These minor omissions and errors, along with report statements that lacked cross-indexing, indicate that not all report statements were referenced. OIG staff told us that full referencing was not always done and that, in some cases, it was done after the report had been issued. While these minor problems did not affect the outcome of the reports, they could divert attention from or cast doubt on the substance of the report.

The OIG agreed with our assessment and, in April 1989, revised its policies to require that all report statements and figures be cross-indexed and referenced before the report is issued. In addition, the OIG has added a staff editor position to the Office of Auditing to assist in the review and editing of audit reports.

We also found that the OIG generally followed up on prior audit report recommendations to determine the status of VA's implementation and documented the results of its follow-up efforts. However, the OIG was not always documenting its follow-up on minor internal control deficiencies from prior reports. OIG officials told us that the follow-up efforts to

[4]Inspectors General: Allegations About the Independence of the Former VA Inspector General (GAO/AFMD-89-46, March 17, 1989).

determine the status of these minor deficiencies were usually documented only if the deficiency continued and would be reported in subsequent audits. We believe that documenting the follow-up of these minor findings from prior audits would assure audit management that the work was performed and that the findings were examined for significant or material changes in the current audit. The OIG agreed with our assessment and revised its policies to require this documentation in April 1989.

Impact of the OIG on VA Operations

Based on our review, of (1) the OIG's coverage of VA's operations, (2) the accomplishments reported in the OIG's semiannual reports, and (3) the benefits that the VA is receiving from the OIG's work, we believe that the OIG has had a significant impact on VA's operations.

As we have discussed, the OIG generally provides audit coverage of VA facilities every 3 years. In addition, the OIG provides coverage in such major programs as medical care, compensation, and benefits. Overall, the OIG conducted audits and investigations in areas of VA's operations which accounted for approximately 97 percent of the total fiscal year 1987 VA budget.

The OIG plans to increase the depth of its nationwide coverage of VA issues and programs through four headquarters divisions which it has established in the Office of Auditing. These divisions are responsible for issues in (1) health care affairs, (2) veterans' benefits, (3) procurement and financial management, and (4) automated data processing operational systems and technical support. They will evaluate VA program or management problems identified by the auditors at the field facility level and recommend efficiency and effectiveness improvements in VA's nationwide programs. While the OIG currently reviews some areas of VA's nationwide programs, it believes that the addition of program divisions will increase its audit coverage of VA's programs. In an ongoing review, we are examining the OIG's staffing levels and will include our results in a separate report.

At the VA OIG, we reviewed the documentation and presentation of information in two semiannual reports for the periods ending September 30, 1987, and March 31, 1988. For these periods, the OIG reported approximately $854 million and $636 million respectively in potential recoveries and cost efficiencies from audit recommendations and $2.6 million and $4 million, respectively, in fines, penalties, and settlements from investigations. In addition, the OIG reported a total of 242 convictions

and 120 administrative sanctions for these periods. Our review of these reports and their supporting documentation indicates that the OIG accurately reported its potential monetary benefits and investigative accomplishments.

For fiscal year 1987, the OIG reported potential recoveries and efficiencies of about $1.2 billion. Compared with the OIG's funding of about $19 million for fiscal year 1987, these monetary accomplishments represent a potential return of approximately $63 for every $1 spent on the OIG's operations.

Based on our review of the OIG's audit and investigative work, we believe the VA is benefiting from the OIG's efforts. For example, in selected states, the OIG matched the earnings reported by VA beneficiaries, whose entitlements are based on reported income and employability, to state wage files and other employment records to verify their employment status and reported earnings. These matches identified instances of unreported earnings which resulted in more than $44 million in VA overpayments. Because this computer matching was so effective, VA's Chief Benefits Director agreed to incorporate it in the Department's internal controls systems to verify the accuracy of pensions and certain compensation payments. The technique is already being phased into VA's operations.

In another example, the OIG identified 93 VA physicians with records of license sanctions or other disciplinary actions related to their medical practice. The OIG found that VA was unaware of many of these actions because its internal controls did not require disclosure. In response to the audit, VA revised its policies to require fuller disclosure of questionable medical practices related to VA physicians.

Conclusions

The Office of Inspector General, Department of Veterans Affairs, satisfactorily complied with all professional audit and investigation standards tested. The OIG has established effective quality controls which help to ensure its compliance with standards. In those areas where we found that improvements could be made, the report-referencing process and the follow-up of minor internal control findings, the OIG clarified and strengthened its policies. We believe these improvements will enhance the OIG's adherence to standards. Based on our review of the OIG's coverage of VA's operations, the OIG's semiannual reports, and the benefits that VA is receiving from the OIG's work, we believe that the OIG is having a significant impact on VA.

Agency Comments

In his May 26, 1989, response to our draft report, the Acting Inspector General of VA expressed his appreciation for both the formal and informal suggestions we made to further enhance the OIG's quality control system. He stated that the OIG had accepted the majority of our suggestions during the review and had made the necessary policy changes.

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary, Department of Veterans Affairs. We are also sending copies to various congressional committees and to other interested parties. This report was prepared under the direction of John J. Adair, Director, Audit Oversight and Policy. Major contributors are listed in appendix IV.

Sincerely yours,

Brian P. Crowley
Acting Assistant
Comptroller General

Contents

Tables

Abbreviations

IG	Inspector General
OIG	Office of Inspector General
OMB	Office of Management and Budget
PCIE	President's Council on Integrity and Efficiency
VA	Department of Veterans Affairs

Previously Issued Quality Assessment Reviews

Compliance With Professional Standards by the Commerce Inspector General (GAO/AFMD-85-57, August 12, 1985).

Inspectors General: Compliance With Professional Standards by the Agriculture Inspector General (GAO/AFMD-86-41, September 30, 1986).

Inspectors General: Compliance With Professional Standards by the EPA Inspector General (GAO/AFMD-86-43, September 30, 1986).

Inspectors General: Compliance With Professional Standards by the GSA Inspector General (GAO/AFMD-87-22, July 20, 1987).

Inspectors General: Compliance With Professional Standards by the Transportation Inspector General (GAO/AFMD-87-28, August 10, 1987).

Inspectors General: Compliance With Professional Standards by the HHS Inspector General (GAO/AFMD-88-36, September 29, 1988).

Standards Used in VA OIG Review

Table II.1: Audit Standards Used for Assessing the VA OIG Audit Function

Category	Comptroller General audit standard[a]	Other standard
Staff qualifications	Qualification	
Independence	Independence Scope impairments	
Individual job planning	Planning	
Annual audit planning	No standard	Planning[b,c]
Supervision	Supervision Due professional care	
Legal and regulatory requirements	Legal and regulatory requirements	
Internal controls	Internal controls Auditing computer-based systems Due professional care	
Evidence	Evidence Working papers Due professional care	
Fraud, abuse, and illegal acts	Fraud, abuse, and illegal acts	
Reporting	Reporting	
Audit follow-up	Due professional care	
Quality assurance	No standard	Quality assurance[c]

[a]Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions.

[b]OMB Circular A-73, "Audit of Federal Operations and Programs."

[c]PCIE Quality Standards for Federal Offices of Inspector General.

Table II.2: Investigation Standards Used for Assessing the VA OIG Investigation Function

Category	Quality standard[a]	Investigation standard[b]
Staff qualifications	Assuring staff qualifications	Qualifications
Independence	Maintaining independence	Independence
Planning	Planning	Planning
Due professional care	No standard	Due professional care Execution
Directing and controlling	Directing and controlling	No standard
Coordination	Coordinating	No standard
Reporting	Reporting	Reporting
Preserving confidentiality	Preserving confidentiality	No standard
Screening allegations	Receiving, controlling, and screening allegations	Information management
Information management	No standard	Information management
Quality assurance	Maintaining quality assurance	No standard

[a]PCIE Quality Standards for Federal Offices of Inspector General.

[b]PCIE Quality Professional Standards for Investigations.

Comments From the Department of Veterans Affairs

Office of Inspector General

Washington DC 20420

Veterans Administration

MAY 26 [illegible]

In Reply Refer To:

Mr. Brian P. Crowley
Acting Assistant Comptroller
General
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Crowley:

We appreciate the opportunity to review and comment on the May 1989 General Accounting Office (GAO) draft report titled "Compliance With Professional Standards by the VA Office of Inspector General."

We were especially pleased the GAO assessment reflected that the VA Office of Inspector General (OIG) satisfactorily complied with all 23 audit and investigative professional standards tested; the OIG has had a significant impact on VA's operations; and the OIG is accurately reporting its potential monetary benefits and investigative accomplishments. GAO's independent assessment confirms for us that our system of management controls are working and are helping achieve our goal of providing quality audit and investigative service to the VA to enhance the delivery of benefits and services to our Nations veterans.

Quality assessments of Offices of Inspectors General are difficult and sensitive undertakings at best. We would like to compliment the GAO for their professional approach to the quality assessment as well as the special review on our independence. Throughout these reviews, the GAO staff offered both formal and informal suggestions for further enhancing our quality control system. We accepted the majority of their suggestions and made the necessary policy changes. We believe the quality assessment, as well as the special review, served a useful and beneficial purpose.

Sincerely,

RENALD P. MORANI
Acting Inspector General

"America is #1—Thanks to our Veterans"

Major Contributors to This Report

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