Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Denver, Colorado

Report No. 02-01766-171 **September 30, 2002**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the period May 13–24, 2002, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of VA Regional Office (VARO) Denver, CO. The purpose of the review was to evaluate selected regional office operations, focusing on benefits claims processing, loan guaranty operations, and financial and administrative controls.

The VARO provides Compensation and Pension (C&P), Vocational Rehabilitation and Employment (VR&E), and burial benefits to eligible veterans, dependents, and survivors residing in Colorado and Wyoming. The VARO also operates a Veterans Benefits Administration (VBA) Regional Loan Center (RLC) with VA Loan Guaranty program jurisdiction for nine Western States.

Results of Review

VARO benefits delivery, loan guaranty, and financial and administrative activities were generally operating satisfactorily, and management controls were generally effective. To improve operations, the VARO needed to:

- Improve the quality and timeliness of C&P claims development and properly process hospital award adjustments and system messages.
- Strengthen controls on large retroactive C&P payments by completing third-signature authorizations and improving the Director's reviews of these payments.
- Strengthen Government Purchase Card program management controls.
- Explore alternatives for reassigning information security officer (ISO) duties and improve tests of the continuity of operations plan (COOP).
- Promptly process VR&E applications and improve the monitoring of case status.
- Improve follow-up supplemental servicing for defaulted guaranteed loans and correctly establish interest cutoff dates.

Regional Office Director Comments

The Director agreed with the findings and provided acceptable implementation plans for all of the issues except for the suggestion to explore alternatives for reassigning information security duties. (See Appendix B, pages 14–19, for the full text of the Director's comments.) However, in August 2002 VBA reported to the OIG that more specific guidelines concerning staff requirements for ISO positions will be issued to VAROs, which is an acceptable implementation plan for this issue.

(original signed by)
RICHARD J. GRIFFIN
Inspector General

Introduction

Regional Office Profile

Organization and Programs. VARO Denver provides C&P, VR&E, and burial benefits to eligible veterans, dependents, and survivors residing in Colorado and Wyoming. The VARO operates outbased offices at Fort Carson, CO and at VA medical centers (VAMCs) Denver, CO and Cheyenne and Sheridan, WY. The estimated veteran population in Colorado and Wyoming is 469,000.

In Fiscal Year (FY) 2001, the VARO authorized payment of about $431.9 million in C&P benefits to about 55,000 beneficiaries. As of September 2001, the VARO had 1,329 participants in the VR&E program, which provides evaluations, counseling, education and training programs, and other services to service-disabled veterans with employment impairments. The VARO also provided fiduciary oversight for 1,395 incompetent veterans and beneficiaries.

The VARO operates one of nine VBA Regional Loan Centers that administer VA's Loan Guaranty program. The RLC has loan approval and management responsibilities for nine Western States: Alaska, Colorado, Idaho, Montana, New Mexico, Oregon, Utah, Washington, and Wyoming. The RLC also operates the Loan Guaranty property management (PM) and construction and valuation (C&V) activities for Colorado, Wyoming, and Montana.

In FY 2001, the RLC guaranteed 33,132 home loans with principal values totaling $4.7 billion. In the first 6 months of FY 2002 the RLC received 8,901 notices of loan default and made 9,785 supplemental servicing contacts with veteran-borrowers in default. In FY 2001, the RLC paid loan guaranty claims to lenders for 2,458 terminated loans, acquired 245 properties, spent $1.6 million for property repairs, maintenance, and marketing, and sold 142 properties. As of May 2002, the RLC had 202 properties available for sale in inventory.

Resources. In FY 2001, the VARO's general operating expenditures totaled $17.4 million. The FY 2002 budget is $17.2 million. FY 2001 staffing totaled 273 full-time equivalent employees (FTEE), and FY 2002 staffing as of May 2002 was 259 FTEE.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefit services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected medical center and regional office operations, focusing on patient care, quality management, benefits delivery, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected benefits claims processing, loan guaranty, and financial and administrative activities to evaluate the effectiveness of benefits delivery and general management controls. Benefits delivery is the process of ensuring that veterans' claims and requests for benefits or services are processed promptly and accurately. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we interviewed managers and employees; reviewed benefits, financial, and administrative records; and inspected work areas. The review covered the following 14 activities:

Agent Cashier	Construction and Valuation
Automated Information System (AIS) Security	Fiduciary & Field Examination (F&FE)
Benefits Delivery Network (BDN) Controls	Government Purchase Card Program
C&P Claims Processing	Loan Administration
C&P Large Retroactive Payment Controls	Loan Production (LP)
C&P Hospitalization Adjustments	Property Management
C&P System Message Processing	Vocational Rehabilitation and Employment

We did not provide fraud and integrity awareness training to VARO employees during this CAP review because we had provided this training in October 2001 when we visited the VARO to perform work on the OIG's Special Review of VA Compensation and Pension One-Time Payments and Related Security Controls. About 170 employees attended the October training.

The review covered VARO operations for FY 2001 and FY 2002 through May 2002 and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations and suggestions for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VARO management until corrective actions are completed.

Results of Review

Organizational Strengths

VARO management had created an environment that supported performance improvement. The administrative, fiduciary, financial, loan guaranty, and BDN security activities reviewed were generally operating satisfactorily, and management controls were generally effective.

Fiduciary and Field Examination Operations Were Effective. The F&FE unit had established effective controls to ensure that initial appointment and follow-up fiduciary-beneficiary field examinations were completed promptly. For FY 2002 through March 2002, the F&FE unit completed 99 percent of field examinations on time, which exceeded the Balanced Scorecard national target of 88 percent. In addition, about April 2001 the new F&FE supervisor had identified past due fiduciary accountings as a significant problem. She initiated rigorous follow-up with fiduciaries who were delinquent in submitting the required accountings. As a result of these efforts, the number of past due accountings was significantly reduced from 96 in April 2001 to only 13 in April 2002.

VA-Acquired Properties Were Well Managed. The RLC Property Management section had established effective controls to oversee management broker activities for securing, maintaining, repairing, and reselling VA-acquired properties. The PM section generally assigned properties to management brokers within 2 days of title notifications. Management brokers usually completed property inspections and market appraisals within 15 days of assignment. The PM section also ensured that only necessary repairs were authorized and that the properties were effectively marketed for resale.

Guaranteed Loan Underwriting and Property Appraisals Were Effectively Reviewed. The RLC Loan Production unit effectively monitored lender underwriting for VA-guaranteed loans by conducting required monthly post-audit reviews of prior approval and automatic approval loans. Borrower applications and lender underwriting were thoroughly analyzed for loans that had gone into default within the first 6 months of the loan term. The LP unit was also meeting timeliness standards for issuing Loan Guaranty Certificates. The RLC's Construction and Valuation section had established effective controls to verify fee appraiser qualifications and to review the quality of appraisal reports submitted by fee appraisers. C&V staff were conducting the required number of field reviews to validate fee appraisals, and they took appropriate follow-up actions on appraisals with deficiencies.

BDN Security Requirements Had Been Implemented. Our review confirmed that the VARO had implemented BDN security requirements that have been emphasized in VBA internal control guidance since May 2001. The VARO was requiring employees to use strong passwords to access the BDN system. The VARO had restricted the assignment of the C&P authorization command to GS-11 employees or higher. In addition, we confirmed that VARO management had taken the corrective actions certified in April 2002 to address BDN security deficiencies identified in the March 2002 OIG report, Special Review of VA Compensation and Pension One-Time Payments and Related Security Controls.

Opportunities for Improvement

C&P Claims Processing – Claims Development and Award Adjustment Processing Should Be Improved

Conditions Needing Improvement. The VARO needed to improve the development of C&P claims and the processing of system messages and hospital adjustments. In recent years, claims processing timeliness has been a major challenge for all VA regional offices. For the current FY, the VARO's claims processing performance indicators have shown mixed results. For example, for the 7-month period October 1, 2001–May 10, 2002, the total number of C&P claims pending decreased from 9,604 to 8,529, an 11 percent reduction, but the number of claims pending over 180 days increased from 3,403 to 3,528, a 4 percent increase. Rating cases pending decreased from 7,928 to 7,538, a 5 percent decrease, while rating cases pending more than 180 days increased from 3,267 to 3,452, a 6 percent increase. The average processing time for original pension and dependency and indemnity compensation claims decreased, but the processing time for original and reopened disability compensation claims increased.

Claims Processing. To evaluate VARO claims processing procedures, we reviewed a random sample of 80 C&P claims shown as in process during the period October 2000–February 2001. We identified 110 instances of avoidable delay in 58 (73 percent) of the 80 claims. (Many of the 58 cases had delays in more than 1 phase of claims processing.) The combined average delay in the 58 cases was 136 days, or about 4.5 months. As shown in the following table, most of the days of delay (69 percent) occurred in the claims development phase:

Table 1. Avoidable Delays by Claims Processing Phase

Phase	No. Delays	Days of Delay	Percent of Total Days of Delay	Average Delay
Establishment	21	588 days	7.5%	28 days
Development	44	5,439 days	69.1%	124 days
Rating	35	1,676 days	21.3%	48 days
Authorization	10	169 days	2.1%	17 days
Combined	110	7,872 days	100%	136 days

In the claims development phase, Veterans Service Center (VSC) staff should determine what additional evidence is needed to complete the adjudication of the claim and then request the required information from the claimant or other appropriate sources. The following examples illustrate how development errors contributed to delays in completing the processing of claims:

- On September 25, 2000, a veteran filed a claim for increased disability compensation. On January 5, 2001, VSC staff began claims development. On January 29, VSC staff sent a letter to the veteran requesting information, but the list of items requested was incomplete. On May 8, after the veteran had submitted the requested information, the VSC sent another letter requesting additional information. On October 3, the VSC requested a necessary VA medical examination. On November 29, 2001, the final award was processed. The total

avoidable delay in this case was 347 days, all of which occurred in the claims development phase.

- On November 14, 2000, a veteran filed a claim for pension benefits. Initially, VSC staff made a procedural error by categorizing the claim as a compensation claim. On January 17, 2001, the VSC corrected this error. However, claim development did not begin until March 13, when the VSC requested that the veteran be scheduled for a VA medical examination. At the same time, the VSC made another procedural error by requesting service medical records, which were not needed for this pension claim. On April 9, the VARO received the medical examination results, and on May 13, the claim was ready for rating (60 days after the development letter was sent to the veteran). There were 76 days of avoidable delay in the development phase. (In addition to this 76 days of delay, there were 162 additional days of delay in the rating and authorization phases, for a total of 238 days of delay on this claim.)

VSC managers attributed claims processing problems to three circumstances: (1) a shortage of fully trained veterans service representatives (VSRs) and rating veterans service representatives (RVSRs) needed to meet the increase in C&P workload, (2) the time and effort involved in hiring and training new VSRs and RSVRs over the last 2 years, and (3) the major interruption in routine processing activities during 2001 to conduct the large scale review of claims that was required to ensure compliance with the Veterans Claims Assistance Act. In March 2002, the VARO reorganized the VSC, creating new teams that will specialize in claims development and appeals. VSC management indicated that the VARO had begun to realize the benefits of the hiring and training efforts of the past 2 years. In addition, the VSC had implemented individual performance measures to identify and correct performance problems. However, to be sure that these efforts are effective in improving the quality of claims development and overall claims processing timeliness, VSC management needed to closely monitor VSC claims workload and performance measurement data.

BDN System-Generated Diary and Error Messages. C&P system messages were not properly processed. The BDN system generates various system diary and error messages that may affect benefits payments. When the VARO receives these messages, VSC staff should review the issues and complete the appropriate processing actions. VSC staff should establish system diary control in the Work in Progress (WIPP) system within 7 calendar days of receipt of the messages. Delays in processing system messages can result in overpayments or underpayments to beneficiaries. To evaluate system message processing, we reviewed a sample of 35 messages that had been generated during the 5-month period September 2000–January 2001. Of the 35 messages, 16 (46 percent) had not been properly processed.

- For 12 messages (34 percent), the required actions had not been completed (8 messages had been filed in the claims folders with no actions taken). After our review, VSC staff completed the appropriate review and development actions for the 12 messages. No overpayments or underpayments resulted for these cases.

- For 4 messages (11 percent), the appropriate review actions had been completed, but VSC staff had not properly cleared the end product controls in the WIPP system and had not received work measurement credit for the actions.

Hospital Adjustments. C&P benefits were not properly reduced for some hospitalized veterans. When certain veterans receiving C&P benefits are hospitalized at VA expense, VAROs must reduce the payment amounts. To determine if the VARO was properly processing hospital adjustments, we reviewed a judgment sample of 15 cases in which veterans had been discharged from VA-paid hospitalizations during the period October 2001–March 2002. Benefits payments had not been reduced in 2 of the 15 cases (13 percent), which resulted in overpayments totaling $27,500:

- In March 2000, an incompetent veteran with no dependents was hospitalized at VA expense and remained hospitalized at the time of our review in May 2002. In May 2000, the VARO had given the veteran due process notice of the pending benefits reduction. However, no award action to reduce benefits was done after the due process period ended in July 2000, even though there were several review notes in the claims folder indicating that award action was needed. Following our review, the VARO prepared another due process notification. The estimated overpayment resulting from the delay in reducing benefits was $6,600.

- In February 2001, an incompetent veteran with no dependents was hospitalized at a VAMC. The claims folder did not contain documentation of a notification of this hospitalization until after the veteran was discharged in February 2002. At this time, VSC staff completed a rating to confirm the veteran's disability and competency status, but took no action to provide him due process or to develop income and estate information. Following our review, the VARO took development action. The estimated overpayment was $20,900.

Recommended Improvement Action 1. We recommended that the VARO Director ensure that: (a) VSC managers closely monitor the effectiveness of recent initiatives to improve the quality and timeliness of claims development and (b) VSC staff receive training aimed at improving the development of claims and the processing of system messages and hospital adjustments. The Director agreed and reported that VSC managers were using all available tools to monitor claims development quality and timeliness. As of August 2002, the oldest claim pending development was 82 days old, which is an improvement from May 2002 when the oldest claim pending development was 270 days old. By September 30, 2002, the VARO's goal will be to begin initial development of claims within 7 days of receipt. The number of claims pending had been reduced from a high of 9,488 in January 2002 to 6,488 in August 2002.

The Director also reported that continuous informal training was being provided to VSC staff. Information is being provided on practices to help staff develop claims more quickly and with greater accuracy. By September 1, 2002, training to improve performance on BDN system messages and hospital adjustments will have been conducted. The improvement actions are acceptable, and we will follow up on the completion of planned actions.

C&P Retroactive Payment Controls – Third-Signature Authorizations and Director's Review Procedures Should Be Improved

Conditions Needing Improvement. Some improvement was needed in VARO controls for large retroactive C&P benefits payments. VBA requires a supervisory third review for large payments ($25,000 or more since April 2001 and $15,000 before then) and for payments for retroactive periods exceeding 2 years. In addition, since September 2001 VARO Directors or Assistant Directors have been required to review claims folder documentation to verify the validity of all payments of $25,000 or more.

To evaluate VARO retroactive payment controls, we reviewed a judgment sample of 80 payments with a combined value of $2.3 million. The sample included 40 payments of $10,000–$24,999 selected from VBA Target Payment History data for the 12-month period October 2000–September 2001 and 40 payments of $25,000 or more subject to the Director's review requirement during the 3-month period January–March 2002. Of the 80 payments reviewed, 55 were subject to the third-signature review, and 25 of the payments were not because they were either less than $15,000 or were for retroactive periods of less than 2 years. Our review of the claims folders confirmed that all 80 payments were based on valid awards and claims evidence. However, we identified the following control deficiencies that should be addressed.

Third-Signature Reviews. VSC supervisors are supposed to document their review and approval of the large retroactive payments by signing and dating the award transaction printouts in the claims folders. For 8 of the 55 payments (15 percent) subject to the third-signature review, the reviews had not been done, and for 28 payments (51 percent) the reviews had not been dated.

Director's Verification Reviews. The Director and Assistant Director were completing their required verification reviews within 15 days of the payment notifications. However, 4 of the 40 payments did not have a third-signature review, and there was no documentation that the Director or Assistant Director had referred these cases to the VSC Manager for further review as required. In addition, the reports submitted to VBA for completed Director's reviews did not identify the instances of missing third-signature reviews or explain why the reviews were missing.

Suggested Improvement Actions. We suggested that the VARO Director ensure that: (a) VSC staff are reminded of the importance of the third-signature review requirements, (b) cases identified in the Director's review with missing third-signature reviews are referred to the VSC Manager for further review, and (c) the Director's review reports to VBA identify and explain instances of missing third-signature reviews. The Director agreed and reported that as of August 2002 VSC staff had been reminded of the importance of third-signature review requirements and that for missing third-signature cases the VSC manager was requiring the responsible employees to provide written explanations of the reasons for the deficiencies. All cases reviewed by the Director that do not have the third signatures were being routinely returned to the VSC Manager. The Director's reports to VBA will identify and explain instances of missing third-signature reviews. The implementation actions are acceptable, and we consider the issues resolved.

Government Purchase Card Program – Controls Should Be Strengthened

Conditions Needing Improvement. The VARO needed to improve some controls over the use of Government purchase cards. During the 12-month period April 2001–March 2002, 34 cardholders made 2,565 purchases totaling $1.8 million. Cardholders and approving officials exceeded timeliness standards for reconciling and certifying purchase card transactions. Purchase card accounts had been promptly cancelled for cardholders who had terminated employment, and monthly quality reviews of purchases were properly conducted. Our review of a judgment sample of 20 purchase card transactions found that the purchases were made for valid VA purposes. However, purchase card program controls needed to be strengthened in four areas:

- **Duties Not Separated.** Some key purchase card program control duties were not properly separated among different individuals. The purchase card program coordinator was an approving official for 18 cardholders, and the alternate purchase card coordinator was both a cardholder and an approving official, which are inappropriate combinations of duties.

- **Inadequate Training.** Interviews with the purchase card program coordinator and five cardholders confirmed that training for purchase card participants consisted of informal, undocumented briefings that did not provide them with adequate information on the full scope of purchase card responsibilities and procedures.

- **Cardholders without Warrants.** Five of the seven cardholders with single purchase limits exceeding the $2,500 micro-purchase threshold did not have the required contracting warrants.

- **Split Purchases.** For 10 of the 20 purchase transactions reviewed, individual cardholders had made multiple purchases from the same vendor on the same day. For 6 of the 10 transactions, the cardholders had split the purchases in order to keep the transaction amounts below their $2,500 purchase limits. Purchases expected to exceed the $2,500 micro-purchase limit should be made by a cardholder with the appropriate purchasing and contracting warrant. Generally, the cardholder should attempt to obtain quotes from at least three sources in order to obtain the items at the most advantageous terms to the Government.

Suggested Improvement Actions. We suggested that the VARO Director ensure that: (a) purchase card control duties are properly separated, (b) all cardholders with single purchase limits exceeding $2,500 are trained and warranted as contracting officers, and (c) cardholders and approving officials receive formal, documented training on purchase card responsibilities and procedures.

The Director agreed and reported that as of August 2002 the separation of duties will be performed pending VBA directives expected to be issued in the next few months. Cardholders with single purchase limits exceeding $2,500 were directed to complete training classes that would entitle them to the appropriate warrants. Two employees have completed the required training and will retain their purchase authority. Employees who have not completed the training have had their purchase limits reduced to $2,500 pending completion of training. Formal

classroom training was provided to all cardholders in May and June 2002. Also, since the CAP review, all cardholders have completed the GSA Smart Pay Purchase Card course. The implementation actions are acceptable, and we consider the issues resolved.

Automated Information System Security – Security Duties Should Be Reassigned and Continuity of Operations Tests Strengthened

Conditions Needing Improvement. We evaluated VARO automated information system security to determine if controls adequately protected information system resources from unauthorized access, disclosure, modification, destruction, or misuse. Most required elements of an information security program were in place. Physical security of the computer room and equipment was adequate, and systems were supported by an uninterrupted power supply that was periodically tested. Alternative processing sites had been designated, and critical data was routinely backed up and stored at a secure off-site location. A comprehensive continuity of operations plan outlining disaster recovery and contingency procedures had been developed, and essential staff and functions had been identified and periodically reviewed. However, we identified two issues that required management attention.

Tests of Continuity of Operations Plan. VA and VBA information security directives require that operational tests of disaster recovery and continuity of operations plans be periodically conducted, but they do not specify what type of tests should be performed, such as full or partial system shutdown or other requirements. In January 2002, the VARO conducted a limited assessment of the COOP that consisted of the ISO, alternate ISO, and the Chief of Support Services performing a "tabletop" review of various elements of the COOP. The assessment did not include any live, operational tests such as a full or partial shut down of automated systems. In our opinion, this type of assessment does not adequately test VARO capabilities to resume operations following a disaster or other major system interruption. VARO officials expressed concern about the adverse impact on VARO production and operations if a major system shutdown was required to test the COOP. However, the VARO could possibly address this concern by conducting tests after normal business hours or on weekends to minimize disruptions to regular operations.

Information Security Officer Duties. VA and VBA information security directives have required that information security duties be assigned to individuals who do not have management or operational responsibilities for the AIS. However, ISO duties were assigned to the Assistant Chief of Support Services, and the Chief of Information Resources Management (IRM) was the alternate ISO. Both of these individuals had operational responsibility for the VARO's information systems.

These same issues were identified as AIS security vulnerabilities in a recent CAP review at another VARO. In his response to that CAP review report, the VARO Director indicated that he needed further clarification and direction from VBA before taking corrective actions. Accordingly, the OIG referred the issues to VBA for resolution.

Suggested Improvement Actions. We suggested that the VARO Director: (a) obtain clarification from VBA on requirements for conducting acceptable and effective operational tests of AIS continuity of operations plans and (b) explore alternatives for reassigning ISO duties to staff without operational AIS responsibilities. The Director agreed to seek clarification from VBA for conducting tests of continuity of operations plans. In an August 9, 2002, memorandum to the OIG addressing AIS security issues identified during a recent CAP review, VBA stated that live tests of VARO contingency plans will be required and that clarifying instructions will be provided to VAROs.

The Director did not agree to explore alternatives for reassigning ISO duties, stating that that it would be difficult to implement at this time because of staffing and training limitations but would implement the suggestion if the staffing situation changed or if mandated by VBA. In the August 9 memorandum, VBA acknowledged the difficulties in achieving the preferred separation of duties. VBA described a recent change in security guidelines that allowed security duties to be assigned to IRM staff if the alternative is appointing someone without the necessary skills and knowledge. However, after meeting with OIG staff VBA agreed to issue more specific guidelines on staff requirements for ISO positions to VAROs. Based on VBA's plans to provide additional guidance to VAROs on these AIS security vulnerabilities, we consider the issues resolved.

Vocational Rehabilitation and Employment – Processing of Applications and Monitoring of Case Status Should Be Improved

Conditions Needing Improvement. The VR&E Service needed to improve the timeliness of processing veteran applications for vocational rehabilitation benefits and the monitoring of case status. For the period October 2001–March 2002, VR&E's average time to complete entitlement determinations was 69 days, which was in excess of the FY 2002 Balanced Scorecard timeliness target of 66 days. In addition, processing time had increased from the March 2001 average of 59 days. To evaluate VR&E claims processing and case management activities, we reviewed the counseling, evaluation/planning, and rehabilitation (CER) folders for a judgment sample of 15 cases (5 cases each in the application, evaluation, and training phases as of March 2002). We identified deficiencies in the following areas:

- For 8 of the 15 cases (53 percent), entitlement determinations were not completed within the 66-day target. Processing time for these eight cases ranged from 78 days to 210 days. In five of the eight cases, the CER files did not contain documentation of any VR&E contacts with the veterans, such as to acknowledge receipt of an application or to explain the reason for the extended processing delay.

- For 6 of the 15 cases (40 percent), incorrect dates of receipt of claim had been entered into the BDN system. The dates entered were from 15 to 117 days later than the actual dates of claim. The use of these incorrect, later dates understated the time VR&E staff actually took to process the veterans' applications and complete entitlement determinations.

- For 3 of the 15 cases (20 percent), the veterans' program phases or status were not accurately recorded in the BDN system. For one case, BDN showed the veteran as being in the evaluation and planning phase but he was actually in the application phase. For two cases, BDN showed the veterans as being in the evaluation and planning phase, but evaluation actions had been completed and the cases closed out for 163 days and 30 days respectively.

VR&E supervisors and case managers should make more effective use of available BDN reports and other databases to ensure that key data elements have been accurately entered into the claims processing systems and to identify and follow up on processing delays and other case management issues. In addition, more timely and accurate data input on phase dates and status will make system data more useful in monitoring VR&E program operations.

Suggested Improvement Actions. We suggested that the VARO Director ensure that: (a) VR&E applications are processed timely, (b) program status and phase dates are promptly and accurately entered into the automated systems, and (c) case management contacts are conducted with program participants as appropriate and documented in case files. The Director agreed and reported that as of August 2002 all VR&E applications are being routed directly to the VR&E Service to better control application processing and timeliness. Veterans' files will be better documented to explain delays. By September 30, 2002, three comprehensive 2-hour refresher training sessions will be provided to VR&E staff on the importance of comprehensive case documentation. VR&E has encountered some technical problems in merging data in BDN and the new VR&E case management database system that is currently being implemented. Although VR&E staff have been reconciling data in the two systems, cases were occasionally missed. By September 30, 2002, VR&E managers will train staff on the importance of updating both systems at the same time. The data in both systems will be monitored monthly to ensure timely and accurate case status updates. There should be fewer problems when the new system is fully operational. The implementation actions are acceptable, and we consider the issues resolved.

Loan Administration – Consistent Follow-Up Supplemental Servicing Should Be Performed and Interest Cutoff Dates Correctly Established

Conditions Needing Improvement. The RLC Loan Administration activity needed to make appropriate follow-up supplemental servicing contacts with veteran-borrowers in default and to correctly establish interest cutoff dates for insoluble loan defaults. To evaluate Loan Administration servicing and claims processing activities for VA-guaranteed loans, we reviewed a judgment sample of 30 defaulted loans that had been terminated during the 6-month period October 2001–March 2002 (10 foreclosed loans, 10 compromise sales, and 10 refunded loans). Loan Administration staff actively monitored lender servicing and termination activities and accurately processed lender claims. Compromise sale determinations were properly supported by benefit-cost analyses and property appraisals. Refunded loan approvals were supported by documentation showing that the veteran-borrowers wanted to retain and occupy the properties and had the financial ability to resume regular loan payments. However, for 3 of the 10 foreclosed loans reviewed, we identified problems in follow-up supplemental servicing and interest cutoff procedures.

Follow-Up Supplemental Servicing. After a lender notifies the RLC of a default, Loan Administration staff should make supplemental servicing contacts with the veteran-borrower to determine the reason for default, to assist the borrower in retaining ownership of the property, and to obtain information to protect VA's financial interest as guarantor of the loan. For 1 of the 10 foreclosed loans, there was no follow-up supplemental servicing. After the initial attempt to contact the borrower was unsuccessful, there were no follow-up attempts to personally contact the borrower during the 3-month period between the notice of the default and the notification of intent to foreclose on the loan.

Interest Cutoff Dates. When a loan in default is determined to be insoluble, Loan Administration staff should establish an interest cutoff date to limit VA's liability to the lender under the loan guaranty. VA notification to the lender of interest cutoff establishes the date after which VA will no longer be responsible for additional loan losses or costs incurred by the lender. For 2 of the 10 foreclosed loans, the interest cutoff dates were miscalculated, which unnecessarily increased VA costs under the loan guaranties by a total of $1,478. In both cases, an extra month of loan interest was allowed on the lenders' claims because the cutoff dates had been based on seven missed payments instead of six payments. (Loan defaults are usually considered insoluble when the borrower has missed six monthly payments.)

In April 2002, a VA Financial Systems Quality Assurance Services review of RLC operations identified similar problems in supplemental servicing and interest cutoff procedures. RLC management had begun corrective actions to require Loan Administration staff to make monthly servicing contacts for all unresolved defaulted loans and to improve supervisory monitoring of servicing activities. In addition, to ensure that VA's liability to lenders is kept within reasonable limits, refresher training on interest cutoff requirements should be provided to Loan Administration staff responsible for monitoring defaulted loans and processing lender claims.

Suggested Improvement Actions. We suggested that the VARO Director ensure that Loan Administration staff: (a) consistently perform supplemental servicing for defaulted loans and (b) receive training on correctly computing interest cutoff dates for lender claims. The Director agreed in part, stating that the VARO had not been able to complete the ideal number of follow-up calls on all defaulted loans but had completed all required servicing. However, the RLC will work to increase the number of follow-up contacts in future servicing. In addition, the Loan Administration has taken action to correct interest cutoff date errors, which apparently began in late 2001, and appropriate cutoff dates are now being used. Team leaders are monitoring performance to identify deficiencies. The improvement actions are acceptable, and we consider the issues resolved.

Appendix A

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of VA Regional Office, Denver, Colorado

Report Number: 02-01766-171

Recommendation	Explanation of Benefit	Better Use of Funds
1b	Provide training to improve the processing of C&P hospital adjustments.	$27,500
	Total	$27,500

Appendix B

Regional Office Director Comments

Department of Veterans Affairs

Memorandum

Date: August 15, 2002

From: Director (339/00)

Subj: Draft Report: Combined Assessment Program Review, VA Regional Office, Denver, CO (Project No. 2002-01766-R8-0101)

To: Assistant Inspector General for Auditing (52)

The written responses to the OIG Combined Assessment Program Review of VARO Denver, Colorado, are attached.

If we may be of further assistance, please call BJ Scott at (303) 914-5800.

Sincerely yours,

(Original signed by)
C. L. Smith

Appendix B

Regional Office Director's Comments to Office of Inspector General's Draft Report 02-01766-R8-0101 August 2, 2002

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

OIG Recommendation.

OIG Recommended Improvement Action 1. We recommend that the VARO Director ensure that: (a) VSC managers closely monitor the effect of recent initiatives to improve the quality and timeliness of claim development processing, and (b) VSC staff receive training aimed at improving claims development, and system message and hospital adjustment processing.

Response.

a. We agree.

VSC managers have been closely monitoring the timeliness and quality of our claim development processing, using all available tools.

The OIG review included claims filed in 2000 and 2001. We have made great progress in the timeliness of claim development processing since that time period. Our oldest claim pending development at this time is 82 days old, an improvement from 270 days 3 months earlier. Our goal is to reduce pending initial development to 7 days by September 30, 2002.

From a high of 9,488 claims pending in January 2002, we now have 6,760 pending. We expect the improvement to continue. Improvement is attributed to the intense training we conducted for new VSRs and RVSRs during the last 6 months of 2001.

b. We agree, in part.

Additional formal development training is not necessary at this time; however informal training is continuous and ongoing. Issues are discussed as they arise. Training topics are generated by VSRs, RVSRs, and coaches of other teams, and, through review of errors found on formal and informal quality reviews. Team members are kept informed of practices that will improve their ability to develop claims more quickly and with greater accuracy.

We agree with the errors cited regarding BDN System-generated diary and error messages and hospital adjustments. We will conduct training to improve our performance in this area prior to September 1, 2002.

Appendix B

OIG Suggestions.

Suggested Improvement Action 1. We suggest that the VARO Director ensure that: (a) VSC staff are reminded of the importance of the third-signature review requirements, (b) cases identified in the Director's review with missing third-signature reviews are referred to the VSC for further review, and (c) the Director's review reports to VBA identify and explain instances of missing third-signature reviews.

Response.

a. We agree.

VSC staff has been reminded of the importance of third-signature review requirements. In addition, for all cases where the third signature is not obtained, the VSCM requires a written explanation from the responsible employee (the authorizer) of the reasons for the deficiency.

b. All cases reviewed by the Director or designee that do not have a third signature are routinely returned to the Veterans Service Center manager.

c. We Agree.

Suggested Improvement Action 2. We suggest that the VARO Director ensure that: (a) purchase card control duties are properly separated, (b) all cardholders with single purchase limits exceeding $2,500 are properly trained and warranted as contracting officers, and (c) cardholders and approving officials receive formal, documented training on purchase card responsibilities and procedures.

Response.

a. Agreement Pending.

The separation of duties will be performed based on directives from Headquarters, which we have been told will be received in the next few months.

b. We agree.

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Each cardholder with a single purchase limit exceeding $2,500 was directed to complete the appropriate training class that will entitle them to a warrant allowing single item purchases greater than $2,500. Two employees have completed appropriate training and will retain their purchase authority. Certificates documenting the training are on file. Employees who have not completed their training had their limit reduced to $2,500 pending completion of the training.

c. We agree.

Formal, classroom training was provided to all cardholders on May 23, and June 6, 2002. All cardholders have also completed the GSA Smart Pay Purchase Card course since the CAP review. Certificates are of record to document this training.

Suggested Improvement Action 3. We suggest that the VARO Director: (a) explore alternatives for reassigning ISO duties to staff without operational AIS responsibilities and (b) obtain clarification from VBA on requirements for conducting acceptable and effective operational tests of AIS continuity of operations plans.

a. We disagree.

While we understand the reasons for the IG recommendation, it would be difficult for us to implement it at this time because of staffing and training limitations.

Per M20-4, Part II dated April 4, 2002 (VBA IRM Handbook, No. 5.00.02 HB-1, "VBA Information Systems, General Security and Organization"), "In those cases where the alternative to appointing an ISO from the IRM staff is appointing an individual who does not have the knowledge and skills to effectively perform the ISO duties, the preferred solution is to appoint an ISO from the IRM staff. The VBA acknowledges and accepts the risk arising from these potential conflict of interest situations." If our staffing situation changes, or if mandated by VBA, we will implement the above suggestion.

b. We agree.

We will request additional guidance from VBA on the requirements for conducting acceptable and effective operational tests of AIS continuity of operations plans.

Suggested Improvement Action 4. We suggest that the VARO Director ensure that: (a) VR&E applications are processed timely, (b) program status and phase dates are promptly and accurately entered into the automated systems, and (c) case management contacts are conducted with program participants as appropriate and documented in case files.

a. We agree.

Delays should be kept to a minimum. There are a number of unavoidable delays, including cases where disability has not been established, or the application was completed at a pre-discharge site and the veteran is in transit to his chosen state of residence.

The veteran's file will be better documented explaining these delays. We will provide three, 2-hour refresher training sessions to VR&E staff on the importance of comprehensive case documentation. Training will be completed by September 30, 2002.

b. We agree.

We will closely monitor applications to ensure that the date stamped on the application form is the date entered into the automated system.

We found that some application forms were not received directly into the division, causing a delay. VR&E now receives all VA Form 1900s in the division to control better the processing and timeliness of applications.

c. We agree.

We have encountered some technical problems in the merging of two major databases, BDN and CWINRS because a counselor must place data into both systems. We reconcile the systems, but occasionally miss a case. The synchronization of the systems has not been as reliable as hoped. Once the merger is complete, there should be fewer problems. The OIG auditors used only a BDN data sample to assess case status, which may have given a false picture of actual performance

We will monitor monthly the CWINRS and BDN databases to ensure accurate and timely case status updates. In addition, Denver VR&E managers will train staff by September 30, 2002 on the importance of updating both the CWINRS and BDN databases simultaneously.

Suggested Improvement Action 5. We suggest that the VARO Director ensure that Loan Administration staff: (a) consistently perform supplemental servicing for defaulted loans and (b) receive training on correctly computing interest cutoff dates for lender claims.

a. We agree in part.

While we agree Denver has not been able to complete an ideal number of follow-up calls on all defaulted loans, we believe that we have completed all required servicing. We will continue to work to increase the number of follow-up actions in our future servicing.

b. We agree.

The majority of our errors fell into two categories, late establishments, and incorrect adjustments. We have taken steps to correct and monitor both types of errors.

Late Establishments. While we were taking follow up action monthly, the auditors pointed out that we were using an incorrect cutoff date. We were unaware of this error, which began in late 2001. We immediately corrected this error and began using appropriated cutoff dates.

A second establishment error was failure by some employees to recognize when a default is insoluble. We provided all of our Servicing personnel two additional hours of training on this topic on April 17, 2002. Team leaders are monitoring performance to detect deficiencies.

Improper Adjustments. Improper adjustments were a result of the need for additional training, which was provided on April 17, 2002. In addition, all cutoff adjustments are reviewed by the Team Leader before a bid is released to the lender.

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Appendix C

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Appendix C

This report will be available in the near future on the VA Office of Audit Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.