

# Department of Veterans Affairs Office of Inspector General

## Combined Assessment Program Review of the VA Regional Office Fort Harrison, Montana

# 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.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the **requirement** to refer suspected **criminal activity** to the OIG.

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 August 16–20, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office Fort Harrison, MT. The regional office is under the jurisdiction of the Salt Lake City VA Regional Office and is part of the Veterans Benefits Administration (VBA) Western Area. The purpose of the review was to evaluate selected regional office operations, focusing on benefits claims processing and financial and administrative controls. We also provided fraud and integrity awareness training to 35 regional office employees.

#### **Results of Review**

The CAP review covered seven regional office operational activities. We identified no significant deficiencies in two activities, both of which had noteworthy organizational strengths:

- Employee claim folders were properly secured.
- Controls on benefits for incarcerated veterans were effective.

We identified one area that needed management attention. To improve operations, the following recommendation was made:

• The VA Montana Health Care System, which administered the regional office's purchase card activities, needed to strengthen management controls for the Vocational Rehabilitation and Employment (VR&E) purchase card.

Suggestions for improvement were made in the following areas:

- Ensure that large retroactive payments are properly processed.
- Improve the timeliness of VR&E entitlement determinations and update case status data.
- Process system error messages properly and promptly.
- Promptly reduce benefit payments for veterans hospitalized at Government expense.

This report was prepared under the direction of Mr. David Sumrall, Director, Seattle Audit Operations Division, and Ms. Myra Taylor, CAP Review Coordinator, Seattle Audit Operations Division.

## Western Area, Regional Office, and VA Montana Health Care System Directors' Comments

The Western Area, Regional Office, and VA Montana Health Care System Directors agreed with the findings, recommendations, and suggestions and provided acceptable improvement plans. (See Appendixes A, B, and C, pages 9–16, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions.

(original signed by:)
RICHARD J. GRIFFIN
Inspector General

#### Introduction

#### **Regional Office Profile**

**Organization and Programs.** The regional office provides compensation and pension (C&P), VR&E, and burial benefits to eligible veterans, dependents, and survivors in Montana. The estimated veteran population served by the regional office is 106,080.

During Fiscal Year (FY) 2003, the regional office authorized about \$138.5 million in C&P payments for 12,883 beneficiaries. VR&E benefits totaling about \$8.5 million were paid to 531 beneficiaries. In addition, the regional office provided fiduciary oversight for 445 incompetent veterans and other beneficiaries.

**Resources.** In FY 2003, regional office operating expenditures were about \$3.4 million. As of June 2004, the regional office had 42 full-time employees.

#### **Objectives and Scope of the 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 benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected benefits claims processing, 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 for benefits and requests for 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 CAP review, we interviewed managers and employees, reviewed beneficiary files and financial and administrative records, and inspected work areas. The review covered the following seven activities:

Employee Claims Folder Security Government Purchase Card Program Hospital Adjustments Incarcerated Veterans Large Retroactive Payment Controls System Error Messages Vocational Rehabilitation and Employment The review covered regional office operations for FY 2003 and FY 2004 through July 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of this report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–8). For these activities, we make recommendations or suggestions. 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 VBA and regional office management until corrective actions are completed.

#### **Results of Review**

### **Organizational Strengths**

Employee Claims Folders Were Properly Secured. Regional office management had implemented satisfactory controls over employee C&P claims folders and other sensitive claims folders. All claims folders for VA Regional Office Fort Harrison employees had been properly transferred to the VA Regional Office Seattle, and folders for VA Regional Office Boise were secured in locked cabinets at the VA Regional Office Fort Harrison. The regional office appropriately required new employees to complete VA Form 70-4535 (Notice of Employment, Transfer, or Separation of Veteran), on which the employees show their veteran status, whether they have applied for VA benefits, and whether they have relatives who are veterans. Benefits Delivery Network (BDN) records pertaining to the benefits claims of VA employees were electronically locked to prevent unauthorized access to these records. In addition, regional office employees performed required semiannual audits to verify the inventory and ensure the security of folders located in Fort Harrison.

Controls on C&P Benefits for Incarcerated Veterans Were Effective. VBA policy requires that Veterans Service Center (VSC) employees reduce C&P benefits for veterans incarcerated in Federal, state, or local penal institutions in excess of 60 days. Pension benefits are to be terminated and compensation benefits reduced for veterans convicted of felonies. The BDN staff provides regional offices with monthly listings of matches between the C&P Master Record File and the Social Security Administration's and Bureau of Prisons' state prisoner data. We reviewed the claims folders for 12 veterans who appeared on the monthly listings during the 6-month period January–June 2004. We found that the regional office had properly taken action in all 12 cases, reducing or terminating benefits when appropriate.

### **Opportunities for Improvement**

# Government Purchase Card Program – Controls Should Be Strengthened for VR&E Card

Conditions Needing Improvement. The regional office purchase card program is administered by the VA Montana Health Care System, and the health care system's Purchase Card Coordinator (PCC) is responsible for overseeing the regional office's use of the VR&E purchase card. The PCC needed to improve controls over the administration of purchase card usage in the VR&E program. During the 9-month period October 2003–June 2004, the VR&E purchase card was used to make 113 VR&E purchases totaling \$66,211. Our review of a judgment sample of 10 VR&E purchase card transactions found that the purchases were made for valid VA purposes. However, purchase card controls needed to be strengthened in three areas.

Non-Cardholder Purchases. Cardholders are not allowed to let others use their purchase cards. We found that the VR&E cardholder routinely allowed five other VR&E employees to make purchases with her card. Over the 9-month period, these employees used the card to make 108 separate supply purchases totaling \$64,436. The approving official was aware that these employees were inappropriately making purchases on the card but still certified the transactions.

<u>Unsupported Purchases</u>. We reviewed supporting documentation for our sample of 10 transactions. Three transactions did not have adequate supporting documentation, such as receipts. However, we did not find any indication that the purchases were inappropriate.

Monthly Reviews Were Not Performed. VA policy requires that the PCC conduct monthly reviews to monitor the timeliness of purchase card reconciliations and certifications. The PCC acknowledged that these reviews had not been performed for VR&E purchases in recent years. In addition, for all 10 sample transactions, the cardholder did not note the dates of her reconciliations on the billing statements. The reconciliation dates are necessary for the PCC to evaluate cardholder compliance with VA timeliness requirements.

**Recommended Improvement Action 1.** We recommended that the VA Montana Health Care System Director ensure that: (a) the VR&E cardholder and approving official receive refresher training on the policy that prohibits the sharing of cards, (b) all purchases are properly supported, and (c) the PCC reviews the timeliness of purchase card reconciliations and certifications.

The Director agreed and reported that additional VR&E cardholders will be authorized. The cardholders and the approving official will receive training on purchase card

responsibilities and procedures, including the prohibition of sharing cards and the proper documentation of purchases. In addition, the PCC will perform monthly reviews of all cardholder billing statements for timeliness. The target date for completing these actions is October 31, 2004. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

# Large Retroactive Payment Controls – Third-Signature Authorizations and Processing Procedures Should Be Improved

Conditions Needing Improvement. Some improvement was needed in regional office controls for retroactive C&P benefits payments. VBA requires that VSC staff, including a supervisor or a coach, review and authorize retroactive payments of less than \$25,000 for retroactive periods exceeding 2 years. For payments of \$25,000 or more, VBA requires a third supervisory review. In addition, regional office Directors or Assistant Directors are required to review claims folder documentation to verify the validity of all retroactive payments of \$25,000 or more.

To evaluate regional office retroactive payment controls, we reviewed a judgment sample of 60 payments with a combined value of \$3.1 million. The payments were selected from the BDN Target Payment History File for the periods FY 2003 and FY 2004 through July 2004. Of the 60 payments reviewed, 55 were subject to the third-signature review, and 5 were not because they were less than \$25,000. All 60 payments were valid. However, the following control deficiencies should be addressed.

<u>Third-Signature Reviews</u>. VSC supervisors are required to document their reviews and approvals of large retroactive payments by signing and dating the award transaction printouts in the claims folders. For 6 of the 55 payments (11 percent) subject to the third-signature review, the reviews were dated after the payments had been issued. In addition, a review had not been conducted for one payment, and for another payment a VSC employee who did not have third-signature authority had conducted the review.

<u>Award Processing and Payment Errors</u>. Award processing errors resulted in two underpayments and one overpayment.

- While processing two awards for a veteran, VSC employees left a dependent off the awards, resulting in a combined underpayment of \$4,231.
- An attorney's fee was not deducted from a payment to a veteran's beneficiary, resulting in an overpayment of \$13,043.

**Suggested Improvement Action 1.** We suggested that the Regional Office Director ensure that VSC staff: (a) are reminded of the importance of the third-signature review requirements, (b) establish controls to ensure accuracy of award payments, and (c) pursue recovery of the \$13,043 overpayment.

The Director agreed and reported that third-signature review requirements were emphasized to the VSC staff. In addition, controls had been added to ensure the accuracy of award payments and corrective actions had been taken on the overpayment and underpayments identified in the report. The improvement actions are acceptable, and we consider the issues resolved.

# **Vocational Rehabilitation and Employment – Entitlement Determinations Should Be Timely and Case Status Data Accurate**

**Conditions Needing Improvement.** VR&E management needed to improve the timeliness of entitlement determinations and the accuracy of reporting case status in the BDN system. To evaluate VR&E claims processing and case management activities, we reviewed a judgment sample of counseling, evaluation/planning, and rehabilitation folders for 25 veterans enrolled in the VR&E program.

<u>Timeliness of Entitlement Determinations</u>. The FY 2004 timeliness target for entitlement determinations was 60 days. For 9 of the 25 cases (36 percent), VR&E staff did not complete entitlement determinations within the 60-day target. Processing time for these 9 cases averaged 110 days (range = 61 to 196 days).

<u>BDN Accuracy</u>. VR&E staff assign each participating veteran to a specific case status at each stage of the rehabilitation process. Generally, veterans actively pursuing training should progress from application through the four stages of evaluation and planning, rehabilitation to employment, employment services, and rehabilitated status.

As of the date we selected our judgment sample, VR&E staff had not accurately reported the veterans' status in the BDN system for 16 of the 25 cases (64 percent). However, in preparation for the CAP review, the VR&E Service Officer performed a self-assessment of case status accuracy and made corrections to all 16 cases. Inaccurate case status data inflates VR&E workload and may skew performance measures. In addition, accurate case status data provides information useful for ensuring proper veteran progression through the VR&E program.

**Suggested Improvement Action 2.** We suggested that the Regional Office Director ensure that: (a) VR&E entitlement determinations are processed timely, and (b) case status is accurately reported in the BDN system.

The Director agreed with our suggestions and reported that procedures had been implemented to ensure entitlement determinations are processed timely and the case status reported in BDN is accurate.

# System Error Messages – Messages Should Be Properly and Promptly Processed

**Condition Needing Improvement.** VSC management should improve the processing of C&P system messages. The BDN system generates various system messages indicating that adjustments of benefits or corrections to BDN records are necessary. For example, the "SSA Death Mismatch" message is generated when a C&P master record matches a record on the Social Security Administration's death file. When VSC staff receive system messages, they should review them and take appropriate actions.

To evaluate system message processing, we reviewed a judgment sample of 30 messages generated during the 2-month period May–June 2004. Of the 30 messages, 23 were correctly processed. However, seven (23 percent) had not been properly processed:

- A \$121 overpayment occurred because VSC staff had not adjusted an award after notification that a veteran's dependent no longer attended school.
- A \$246 underpayment occurred because VSC staff had not properly completed a BDN transaction necessary to increase the veteran's award.
- VSC staff did not act on a message indicating that a veteran's BDN records needed to be adjusted to show the correct number of dependents. Because no action was taken on the message, it was generated six times over a 6-month period. (Payments were not affected.)
- For four system messages, VSC staff determined no actions were necessary. However, VBA policy still requires the staff to annotate, date, initial, or file these messages in the claims folders. This had not been done for the four messages.

**Suggested Improvement Action 3.** We suggested that the Regional Office Director ensure that VSC staff properly and promptly process C&P system messages.

The Director agreed and reported that as of August 2004, VSC staff had been given refresher training and that procedures in processing system error messages had been changed to ensure action is promptly taken. In addition, action has been taken on the erroneous payments identified during our review. The improvement actions are acceptable, and we consider the issues resolved.

# Hospital Adjustments – Benefit Payments for Hospitalized Veterans Should Be Promptly Reduced

**Condition Needing Improvement.** VSC management needed to improve the processing of hospital adjustments. In certain situations, the law requires the reduction of C&P payments for veterans hospitalized at Government expense for extended periods. As of July 2004, there were 67 veterans who had been hospitalized continuously for 90 days or more within the VA Montana Health Care System.

To determine if the regional office had properly processed hospital adjustments, we reviewed a sample of claims folders for 30 of the 67 hospitalized veterans. Of the 30 cases, 28 had been properly processed. However, two had not been properly processed, resulting in overpayments totaling \$3,485. These two overpayments occurred because VSC staff did not take proper action when notifications were received. In preparation for the CAP review, the VSC Manager had performed a self-assessment of hospital adjustments and had identified these two instances of overpayment. In July 2004, VSC management began the process for recovering the overpayments to these veterans.

**Suggested Improvement Action 4.** We suggested that the Regional Office Director ensure that VSC staff promptly process adjustments upon notification to prevent overpayments.

The Director agreed and reported that VSC staff will receive annual refresher training on the proper handling of hospital adjustments and that procedures had been revised to ensure all hospital adjustments are identified and handled promptly. In addition, action has been initiated to recover the overpayments. The target date for completing these actions is October 31, 2004. The implementation plans are acceptable, and we consider the issue resolved.

#### **Western Area Director Comments**

### Department of Veterans Affairs

#### Memorandum

**Date:** September 16, 2004

**From:** Diana M. Rubens, Western Area Director

Subject: Draft Report: Combined Assessment Program Review,

VA Regional Office Fort Harrison, Montana

**To:** David Sumrall, Director, Seattle Audit Operations

Division (52SE)

I reviewed the Draft Report of the CAP review for the VA Regional Office Fort Harrison. As the Western Area Director, I appreciate the feedback from the review. The station recently came under the jurisdiction of the Salt Lake City Regional Office so your insights are timely and appreciated.

Attached are the Regional Office's implementation plans for your recommendations and suggestions. We will work with the Regional Office to ensure all open remaining actionable plans are implemented by the set target date.

Again, thank you for your feedback. If you have any questions, please don't hesitate to call me at (602) 627-2746.

Thank you, (original signed by:)

Diana M. Rubens

Western Area Director

### **Regional Office Director Comments**

### Department of Veterans Affairs

#### Memorandum

Date: September 22, 2004

**From:** Director, VA Regional Office Salt Lake City, Utah

**Subject:** Combined Assessment Program (CAP) Review of the VA

Regional Office, Fort Harrison, Montana

**To:** Myra Taylor, VA Office of Inspector General (52SE)

Enclosed is the Salt Lake City VA Regional Office response to the CAP Review Draft Report for the VA Regional Office, Fort Harrison, Montana. The Salt Lake City Office concurs with the recommendation regarding the Government Purchase Card Program and concurs with the suggested improvement items for Fort Harrison. Attached are our comments and responses to the specific improvement actions resulting from the review. The comments and responses on the Government Purchase Card Program were submitted to us from the Montana Healthcare System Director and coordinated through their VISN for their review and concurrence.

We appreciate the professionalism and courtesy exhibited by the audit team members during their review, as well as the analysis provided by the team. This analysis and suggested improvement actions are invaluable in our continued efforts to provide the best possible benefits and services to our veterans.

Please feel free to contact me at (801) 326-2400 with any questions or concerns regarding our reply.

(original signed by:)

DOUGLAS WADSWORTH

Enclosure

### Regional Office Director's Comments to Office of Inspector General's Report

#### **Comments and Implementation Plan**

#### **OIG Suggestions**

1. C&P Large Retroactive Payment Controls – Third-Signature Authorizations and Processing Procedures Should Be Improved

**Suggested Improvement Action 1.** We suggest the Regional Office Director ensure the VSC staff: (a) are reminded of the importance of the third-signature review requirements, (b) establish controls to ensure accuracy of award payments, and (c) pursue recovery of the \$13,043 overpayment.

Concur with suggested improvement actions.

a. Veterans Service Center staff are reminded of the importance of third signature review requirements.

Planned Action: All Veterans Service Center employees have been reminded of the third signature review requirements. The third signature review process was implemented upon Salt Lake's remote management of Fort Harrison in January 2004. Upon the Fort Harrison VSC's review and coordination, payments greater than \$25,000 are faxed to the Director's Office for review, checklist coordination, signature, and then faxed back to Fort Harrison for final processing. (Action completed.)

b. Veterans Service Center staff establish controls to ensure accuracy of award payments.

<u>Planned Action:</u> Controls to ensure accuracy of award payments are now in place. Corrective actions have been taken on the cases identified in the report. Consideration has been given to specifically incorporate accuracy of third

signature authorization processing in local performance standards. (Action completed.)

### c. Veterans Service Center staff pursue recovery of the \$13,043 overpayment.

<u>Planned Action:</u> The Veterans Service Center staff is currently in the process of pursuing the recovery of the \$13,043 overpayment. This process began in August 2004. (Target completion date is October 31, 2004.)

# 2. Vocational Rehabilitation and Employment – Entitlement Determination Should Be Timely and Case Status Data Accurate

**Suggested Improvement Action 2.** We suggest the Regional Office Director ensure (a) VR&E entitlement determinations are processed timely and (b) case status is accurately reported in the BDN system.

Concur with suggested improvement actions.

### a. VR&E entitlement determinations are processed timely.

<u>Planned Action:</u> Monthly Coin Tar Reports will be reconciled each month by the counselors to be sure BDN and Winrs data are timely and accurate. The BDN info on the Coin Tar Report was not totally accurate to show actual days to close applicant status, thus the timeliness issue was showing old cases. Data in Winrs more accurately reflected the statuses. Counselors will report monthly changes in the coin tar reports to the VR&E Officer to maintain accurate data in both systems. (Action completed.)

#### b. Case status is accurately reported in the BDN system.

<u>Planned Action:</u> The BDN info on the Coin Tar Report was not totally accurate to show actual days to close applicant status, thus the timeliness issue was showing old cases. Data in Winrs more accurately reflected the case status. Monthly Coin Tar Reports will be reconciled each month by the counselors to be sure BDN data is accurate. (Action completed.)

### 3. System Error Messages – Messages Should Be Properly and Promptly Processed

**Suggested Improvement Action 3.** We suggest the Regional Office Director ensure the VSC staff properly and promptly process C&P system messages.

Concur with suggested improvement actions.

<u>Planned Action:</u> Corrective action has been taken on the cases identified in the report. Workflow processes have been changed to ensure proper action is promptly taken in processing C&P system messages. Refresher training was conducted in August 2004. (Action completed.)

### 4. Hospital Adjustments – Benefit Payments for Hospitalized Veterans Should Be Promptly Reduced

**Suggested Improvement Action 4.** We suggest the Regional Office Director ensure VSC staff promptly process adjustments upon notification to prevent overpayments.

Concur with suggested improvement actions.

<u>Planned Action:</u> Action has been initiated for recovery of the overpayments identified in the report. In addition the workflow process, which identifies potential hospital adjustments, has been further revised to insure all cases are identified and appropriate and timely action taken. Hospital Adjustment training has been added to annual refresher training for the VSC staff. (Target completion date is October 31, 2004.)

Appendix C

### **VA Montana Health Care System Director Comments**

### **Department of Veterans Affairs**

#### **Memorandum**

**Date:** September 13, 2004

From: Director, VA Montana HCS (436/00)

**Subject: VBA OIG CAP Review August 2004** 

**To:** Office of Inspector General (OIG)

Attached is VA Montana's response to the recent VBA OIG CAP review conducted the week of August 16, 2004. I concur with the findings on the credit card issues and we have taken corrective action to be completed by

September 30, 2004.

(original signed by:)

Joseph M. Underkofler

### VA Montana Health Care System Director's Comments to Office of Inspector General's Report

#### **Comments and Implementation Plan**

#### OIG Recommendation

1. Government Purchase Card Program – Controls Should Be Strengthened for VR&E Card

**Recommended Improvement Action 1.** We recommend the Montana Health Care System Director ensure: (a) the VR&E cardholder and approving official receive refresher training on the policy that prohibits the sharing of cards, (b) all purchases are properly supported, and (c) the PCC reviews the timeliness of purchase card reconciliations and certifications.

Concur with recommended improvement actions.

a. The VR&E cardholder and approving official receive refresher training on the policy that prohibits the sharing of cards.

The VA Montana Purchase Card **Planned Action:** Coordinator (PCC) has already requested and received VACO approval for issuing new cards to the field VRE employees to order various items as necessary for VR&E operations. The purchase cards are assigned to the VRE national fund. The Chief VR&E is providing a list of VR&E employees who will receive a new purchase card. The PCC will submit the request to Citibank who will setup and deliver the purchase cards to the PCC. The PCC will turn over the new cards once the PCC has trained the new card holders as well as the existing purchase card holder on the appropriate use of government purchase cards. The existing VR&E purchase card holder will also train the new purchase card holders on the use of the purchase card application in the VISTA system and the PCC will provide to the Approving Official refresher training that will include the prohibition of the sharing of cards. The Chief VR&E will provide IRM with the necessary

paperwork required to grant access to the purchase card holder applications in VISTA. (Target completion date is September 30th, 2004.)

#### b. All purchases are properly supported.

Planned Action: All VR&E purchase card holders will receive purchase card training that includes information concerning the proper use of and the required documentation for purchases made with a government purchase card. Card holders will receive a hard copy of all purchase card holder policies. Purchase card refresher training and government policy on purchase card use is currently posted on the VA Montana HCS web site. A recommendation will be made to VBA to post this material on the VBA web site. (Target completion date is October 31, 2004.)

### c. The PCC reviews the timeliness of purchase card reconciliations and certifications.

<u>Planned Action:</u> The PCC will review the timeliness of purchase card reconciliations and certifications on a monthly basis ensuring the program is in compliance with VA Handbook 7401.6 and VHA Handbook 1730.1. (Target completion date is October 31, 2004.)

VARO Response to Improvement Recommendation: We have stopped all VR&E employees from using the purchase card of the one VR&E cardholder. VR&E employees will be issued their own cards and receive training on the use of the cards, as stated in the planned action to item (a) above. Cards will be issued by September 30, 2004, and training will be completed by October 30, 2004.

#### Appendix D

# Monetary Benefits in Accordance with IG Act Amendments

<b>Suggestion</b>	Explanation of Benefit(s)	Better Use of Funds
1	Better use of funds by recovering an overpayment associated with an improperly processed retroactive payment.	\$13,043
4	Better use of funds by recovering overpayments associated with not reducing benefits for certain veterans who were hospitalized at Government expense for extended	
	periods.	3,485
	Total	\$16,528

#### Appendix E

### **OIG Contact and Staff Acknowledgments**

OIG Contact	David Sumrall (206) 220-6654
Acknowledgments	Myra Taylor Gary Humble Kevin Day Angie Fodor Melinda Toom

Appendix F

### **Report Distribution**

#### **VA Distribution**

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U. S. Senate: Max Baucus, Robert Bennett, Conrad R. Burns, Orrin Hatch

U. S. House of Representatives: Rob Bishop, Chris Cannon, Jim Matheson, Dennis Rehberg

This report will be available in the near future on the OIG's Web site at <a href="http://www.va.gov/oig/52/reports/mainlist.htm">http://www.va.gov/oig/52/reports/mainlist.htm</a>. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.