



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Indianapolis, Indiana

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 week of March 8–12, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office (VARO) Indianapolis, IN. The regional office is part of the Veterans Benefits Administration (VBA) Eastern Area. The purpose of the review was to evaluate selected regional office operations, focusing on benefits claims processing and financial and administrative controls. During the review, we also provided fraud and integrity awareness training for 51 regional office employees.

Results of Review

The CAP review covered 11 areas. The regional office complied with selected standards in the following areas:

- Fiduciary and Field Examinations
- Retroactive Payments
- System Messages

Based on our review of these three areas, the following organizational strengths were identified:

- Fiduciary and field examinations were timely.
- Retroactive payments procedures were effective.

We identified eight areas that needed additional management attention. To improve operations, the following recommendations were made:

- Adjust compensation and pension (C&P) payments to hospitalized veterans and identify hospitalized veterans receiving C&P benefits to determine the appropriateness of their awards.
- Strengthen controls over the use of Government purchase cards and convenience checks.
- Review accounts receivable for potential fraud referrals to the OIG.
- Improve processing and management of Vocational Rehabilitation and Employment (VR&E) cases.
- Revise the automated information systems (AIS) contingency plan to include all essential elements.

Suggestions for improvement were made in the following areas:

- Improve management performance to meet national goals.
- Strengthen controls over Benefits Delivery Network (BDN) security.
- Improve the reconciliation of locked files.

This report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Mark Collins, CAP Review Coordinator, Chicago Audit Operations Division.

Regional Office Director Comments

The Regional Office Director agreed with the CAP review findings, recommendations, and suggestions, and provided acceptable improvement plans. (See Appendix A, pages 12-16 for the full text of the Director's comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Regional Office Profile

Organization and Programs. VARO Indianapolis provides C&P, VR&E, and burial benefits to eligible veterans, dependents, and survivors residing in Indiana. The regional office operates out-based offices in VA medical centers (VAMCs) located in Fort Wayne, Marion, and Indianapolis, IN.

VA's Loan Guaranty program for veterans residing in Indiana is administered by the Regional Loan Center located at VARO Cleveland, OH. Education benefits are administered by the Regional Education Processing Center located at VARO St. Louis, MO. Human Resources Management support is provided by the Eastern Area Human Resources Center located at VARO Baltimore, MD.

Resources. The regional office had a Fiscal Year (FY) 2003 operating budget of about \$10.6 million and a staffing level of 140 full-time equivalent employees.

Workload. The regional office serves a veteran population of about 565,000 in the state of Indiana. In FY 2003, the regional office authorized and paid about \$375 million in C&P benefits to about 59,900 beneficiaries. During FY 2003, the regional office had about 1,600 participants in the VR&E program and provided fiduciary oversight for about 1,300 incompetent veterans and other beneficiaries.

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 benefits services. The objectives of the CAP review program are to:

- Conduct recurring evaluations of selected health care facility 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 requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected benefits claims processing and financial and administrative activities to evaluate the effectiveness of benefits delivery and 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 inspected work areas; interviewed managers and employees; and reviewed benefits, financial, and administrative records. The review covered regional office operations for FYs 2001, 2002, 2003, and 2004 through February 2004, and was performed in accordance with OIG standard operating procedures for CAP reviews. The review covered the following activities:

Accounts Receivable	Hospital Adjustments
Automated Information Systems	Locked Files
Security	Management Performance
Benefits Delivery Network Security	Retroactive Payments
Fiduciary and Field Examinations	System Messages
Government Purchase Cards and	Vocational Rehabilitation and
Convenience Checks	Employment

Activities that were particularly effective or otherwise noteworthy are recognized in the Organizational Strengths section of the report (page 3). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4–11). 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 regional office management until corrective actions are completed. For the activities not discussed in the Organizational Strengths or Opportunities for Improvement sections, there were no reportable deficiencies.

During the review, we also presented two fraud and integrity awareness briefings to regional office employees. The briefings, attended by 51 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Organizational Strengths

Field Examinations Were Timely. Initial and periodic follow-up examinations are required for beneficiaries who are paid through a designated fiduciary. Fiduciary and Field Examination (F&FE) staff are required to complete initial appointment field examinations within 45 days of receipt of the requests and follow-up field examinations within 120 days of the scheduled dates. We reviewed 20 principal guardianship folders involving 10 initial appointments and 10 follow-up field examinations. F&FE staff timely completed all 20 examinations.

Procedures for Reviewing Retroactive Payments Were Effective. Veterans Service Center (VSC) staff effectively implemented controls to ensure that payments of less than \$25,000 were in accordance with VBA policy. VBA policy also requires that Regional Office Directors review payments of \$25,000 or more to ensure payments are appropriate and that related internal controls are operating effectively. We reviewed 84 C&P payments of \$25,000 or more issued during the 3-month period November 1, 2003, through January 31, 2004, and found that the Regional Office Director or Assistant Director had reviewed all payments.

Opportunities for Improvement

Hospital Adjustments – The Processing of Benefit Adjustments for Hospitalized Veterans Needed To Be Improved

Condition Needing Improvement. VSC staff did not properly reduce C&P payments for veterans hospitalized for extended periods at Government expense as required by Federal law. Payments to veterans receiving aid and attendance allowances in addition to their regular disability C&P benefits must be reduced to the lower housebound rate if they are hospitalized at Government expense for periods exceeding a calendar month.

Overpayments and Underpayments. Not properly reducing payments to veterans who were hospitalized at Government expense for extended periods resulted in both overpayments and underpayments. At our request, the VA Northern Indiana Health Care System provided data identifying 240 veterans who had been hospitalized for 90 days or more at Government expense as of January 2004. We compared the data with the records located in BDN and found that 32 of the veterans' claims files needed further review.

Sixteen of the 32 hospitalized veterans should have had their C&P awards adjusted. Fourteen veterans received overpayments totaling \$291,184, while two veterans were underpaid a total of \$35,662. VARO Indianapolis had jurisdiction for six cases with overpayments totaling \$209,019 and one case with an underpayment of \$35,196. The VA Pension Maintenance Center (PMC) in Milwaukee, WI had jurisdiction over seven cases with overpayments totaling \$46,918 and one case with an underpayment of \$466. VARO Cleveland had jurisdiction over one case with an overpayment of \$35,247. We referred the cases outside of VARO Indianapolis' jurisdiction to the PMC and to VARO Cleveland to adjust the benefits.

Identifying Hospitalized Veterans. VSC staff did not consistently identify hospitalized veterans whose C&P awards required adjusting. Each month the staff should review the admission reports from VA's Automated Medical Information Exchange (AMIE) system to identify veterans admitted to VA medical facilities or VA contract nursing homes. After reviewing the AMIE reports and the veterans' claims files, VSC staff should promptly adjust veterans' compensation benefits, if necessary. AMIE reports for pension cases should be forwarded to the PMC. The claims files contained AMIE reports in 4 of the 16 cases discussed above, which VSC staff should have used to make necessary adjustments. For the remaining 12 cases, the records contained no evidence that the veterans had been hospitalized.

Informing Offices of Jurisdiction. According to VSC staff, AMIE reports for pension cases are sent to the PMC during the first week of each month. Of the eight veterans who had pension awards for which the PMC had jurisdiction, five were hospitalized before the PMC began operations in October 2001. Therefore, the PMC would not have AMIE reports for these veterans. The remaining three veterans were hospitalized after the PMC began operations. However, PMC staff could not find AMIE reports for any of these veterans, and we could not determine whether the regional office had sent AMIE reports for them. In one compensation case, the AMIE report should have been forwarded to VARO Cleveland, which was the office of jurisdiction.

Recommended Improvement Action(s) 1. We recommended that the Regional Office Director ensure that VSC staff: (a) adjust compensation benefits for the veterans identified by our review and initiate collection actions where necessary, (b) review AMIE reports and identify hospitalized veterans whose C&P awards require adjustment, and (c) forward AMIE reports to the PMC or the appropriate regional offices of jurisdiction.

The Regional Office Director agreed with the findings and recommendations and reported that upon receipt of the cases identified by our review, VSC staff will adjust compensation benefits for the veterans and initiate collection actions where necessary. The regional office has taken steps to ensure the proper review of the admission reports from the AMIE system and to identify hospitalized veterans whose C&P awards require adjustment. The regional office is forwarding AMIE reports to the appropriate regional offices of jurisdiction. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Government Purchase Cards and Convenience Checks – Controls Needed To Be Strengthened

Condition Needing Improvement. VR&E management assigns a case manager to each veteran to assist in the successful completion of the veteran's rehabilitation program. The case manager is responsible for purchasing supplies that the veteran needs. To facilitate the procurement of supplies, each case manager is issued a Government purchase card. Case managers use convenience checks when vendors do not accept purchase cards. A cardholder is required to have a warrant to make purchases that exceed \$2,500. To obtain a warrant, the individual must receive required training in acquisition procedures. We identified two problems with purchase card and convenience check transactions.

Purchase Limits. We reviewed a judgment sample of 49 transactions out of 714 (134 convenience checks and 580 purchase cards) for the period July 1, 2003, to December 31, 2003. Our sample consisted of 20 convenience check and 29 purchase card transactions. One of 20 convenience check transactions (5 percent) totaling \$2,621, and 13 of 29

purchase card transactions (45 percent) totaling \$61,021, exceeded the single purchase limit of \$2,500. Cardholders made purchases ranging from \$2,515 to \$10,463 without the required training or warrants. This occurred because the Purchase Card Coordinator and the VR&E Officer were unaware of the training requirements and procedures necessary to obtain the warrants.

Split Purchases. VA policy prohibits splitting purchases to avoid exceeding the cardholder's authorized single purchase limit. We reviewed all 580 purchase card transactions in our 6-month sample period. Cardholders split 26 purchases (4.5 percent) totaling \$43,031 to avoid the single purchase limit of \$2,500. For example, one case manager purchased four computers from the same vendor, on the same day, for different veterans. The purchases totaled \$6,782. Documentation in the veterans' Counseling, Evaluation, and Rehabilitation (CER) folders showed the case manager knew that the computers were needed prior to the date of the purchase. A VR&E employee with a purchase limit greater than \$2,500 should have made a consolidated purchase of the computers.

Recommended Improvement Action(s) 2. We recommended that the VARO Director requires the VR&E Officer to ensure that: (a) purchase cardholders are properly trained and warranted and do not exceed their purchase authorities, and (b) controls are implemented to ensure purchases are made in accordance with VA policy to avoid split purchases.

The Regional Office Director agreed with the findings and recommendations and reported that action has been taken to ensure that all purchase cardholders are properly trained and warranted and do not exceed their purchase authorities. The regional office has implemented controls to ensure that purchases comply with VA policy to avoid split purchases. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Accounts Receivable – Potential Fraud Cases Needed To Be Reported

Condition Needing Improvement. Management needed to review C&P accounts receivable (ARs) and report potential fraud cases to the OIG Office of Investigations as required by VA policy. As of February 18, 2004, the regional office had 153 ARs over \$30,000, with a total value of \$8,115,180. From a judgment sample of 30 ARs, we identified 5 C&P cases, with a total value of \$440,018, that VARO staff should have reviewed and referred to the OIG Office of Investigations. All five cases involved dependency or income issues. To illustrate:

- One terminated Dependency and Indemnity Compensation (DIC) award had an AR of \$152,856. The widow failed to respond to a marital status questionnaire. However,

responding to a follow-up letter dated February 18, 1998, she reported that she had remarried in 1974. VSC staff stopped the award, which created an overpayment, and notified the Debt Management Center (DMC) in St. Paul, MN. Support Services staff subsequently received a message from the DMC notifying them of the potential fraud. Neither Support Services staff nor VSC staff referred the case to the OIG Office of Investigations.

- In another case involving an AR of \$47,693, a widow had received DIC benefits since June 1, 1975. VSC staff received information indicating that the widow had remarried on July 14, 1978. After determining that the widow was not entitled to DIC benefits, VSC staff stopped the award and retired the claims file but did not refer the case to the OIG Office of Investigations.

Recommended Improvement Action(s) 3. We recommended that the VARO Director report the five ARs identified to the OIG Office of Investigations and routinely review C&P ARs for potential fraud and possible referral to the OIG Office of Investigations.

The Regional Office Director agreed with the finding and recommendation and reported that the regional office will report the five ARs to the OIG Office of Investigations. The regional office has established a process to routinely review C&P ARs for potential fraud. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Vocational Rehabilitation and Employment – Processing of Claims and Case Management Needed To Be Improved

Condition Needing Improvement. To evaluate VR&E timeliness and accuracy of claims processing and case management activities, we reviewed a judgment sample of 31 veterans' CER folders. We identified deficiencies in the following areas:

Timeliness of Entitlement Determinations. In 5 of 31 (16 percent) cases, entitlement determinations were not completed within the VBA goal of 60 days. The *Balanced Scorecard*, VBA's standardized timeliness and workload measurements, reported an increase in VR&E's average time to complete entitlement determinations from 56.6 days in January 2003 to 63.6 days in January 2004. According to the VR&E Officer, this was attributable to the loss of three experienced counselors. To decrease processing times, the VR&E Officer had implemented an innovative training/orientation program in which new counselors were given uniform training as a group, rather than individual training.

Accuracy of Claim Dates. Fifteen of 31 (48 percent) cases had dates of claim in the BDN that did not agree with documentation in the CER folders or the WINRS¹ system, a local database system that feeds case data into BDN. Dates entered ranged from 1 to 144 days after the actual dates stamped on the applications. Incorrect dates understated the time VR&E staff actually took to process the veterans' applications and complete entitlement determinations. VR&E staff attributed the inaccurate dates to interface problems between BDN and WINRS.

Classification of Training Status. In 4 of 31 (13 percent) cases, the training status of the veterans was misclassified. Two veterans were erroneously placed in interrupted status. Veterans should not be placed in this status unless VR&E staff can establish or estimate the dates the veterans can resume their approved programs. We found no documentation in the veterans' CER folders that VR&E staff could have used to establish or estimate training resumption dates. There were two other veterans who had been in evaluation and planning status for over 20 months. After the counselors' initial interviews, there was no documentation in the CER folders to show that VR&E staff had followed up with the veterans.

Inaccurate data in the BDN hampered VR&E staff's efforts to monitor veterans' progress. Delays in placing veterans not actively pursuing their programs in a discontinued status inflated VR&E workload and affected performance measurements.

Recommended Improvement Action(s) 4. We recommended that the VARO Director require the VR&E Officer to ensure that: (a) applications are processed timely, (b) dates of claim are accurately entered into BDN and WINRS, and (c) participants' training statuses are accurate and up-to-date.

The Regional Office Director agreed with the findings and recommendations and reported that action has been taken to ensure that applications are processed timely. The VR&E Officer has taken action to ensure that dates of claim entries are accurately entered into BDN and WINRS. Corrective measures have been taken and local reviews are in place to ensure that the participants' training statuses in the VR&E program are accurate. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

¹ WINRS is VR&E's electronic case management system. The acronym was derived from the five pilot test stations that tested the original program: Winston-Salem (NC); Indianapolis (IN); Newark (NJ); Roanoke (VA); and Seattle (WA).

Automated Information Systems Security – The Contingency Plan Needed To Be Revised

Condition Needing Improvement. AIS security controls were adequate in the areas of security awareness training, risk assessment, virus protection, password controls, backup and recovery of essential data, and computer room security. The regional office had an adequate overall security plan; however, management needed to revise the AIS contingency plan.

VA policy requires the development, periodic testing, and updating of contingency plans for all general support systems to help ensure the protection of essential automated data. The regional office's plan did not:

- Identify an off-site storage facility for critical backup files.
- Prioritize critical functions that should be brought back on-line during an AIS recovery.
- Include a telephone listing of key personnel.

Finally, the plan had not been approved by the Regional Office Director.

Recommended Improvement Action(s) 5. We recommended that the Regional Office Director take action to: (a) identify an off-site storage facility in the AIS contingency plan, (b) include critical functions in priority order in the contingency plan, (c) include a telephone listing of key personnel in the contingency plan, and (d) approve the contingency plan.

The Regional Office Director agreed with the findings and recommendations and reported that management has included the identity of an off-storage facility, the critical functions in priority order, and a telephone listing of key personnel in the contingency plan. The Director has approved the contingency plan. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Management Performance – Certain Areas Needed To Be Improved To Meet National Goals

Condition Needing Improvement. Regional office management complied with VBA policies regarding administration of benefits to veterans and their beneficiaries. Management closely monitored the accuracy, quality, and timeliness of benefits processing. Management also provided guidance and training to employees on ethics, conflict of interest, and employee behavior issues. C&P rating accuracy and completed

rating timeliness improved for the 12 month period that ended January 2004. However, the January 2004 *National Dashboard* report, which compared VARO performance to national goals, identified the following scores that needed improvement:

- The regional office's average rating pending time was 119.3 days compared to the national goal of 104.7 days.
- Regional office staff used 176.8 days to process ratings compared to the national goal of 144.4 days.
- Regional office staff achieved a rating accuracy of 84 percent compared to the national goal of 90 percent.
- Regional office staff achieved a fiduciary accuracy of 75 percent compared to the national goal of 88 percent.
- Regional office staff had 73 pending cases in remand status compared to the national goal of 48 pending cases.
- Regional office staff used 141.4 days to complete Notices of Disagreement compared to the national goal of 132.4 days.
- Regional office staff achieved a VR&E rehabilitation rate of 57.9 percent compared to the national goal of 67 percent.

Suggested Improvement Action(s) 1. We suggested that the Regional Office Director take action to meet all VBA goals established in the *National Dashboard* report.

The Regional Office Director agreed with the finding and suggestion and reported that they were implementing several strategies to meet the goals established in the *National Dashboard* report. The VBA Eastern Area Office has given them authority to hire an additional FTE to help meet the goals. The improvement plans are acceptable.

Benefits Delivery Network Security – Control over Access Commands Needed Strengthening.

Condition Needing Improvement. The assignment of BDN passwords and C&P authorization commands complied with VBA policy. The names and social security numbers of all employee-veterans with active C&P awards claim numbers were located in the BDN user file. The employees' sensitivity levels were appropriate and their files were electronically locked. However, management needed to ensure that BDN commands requested for employees were necessary for their job responsibilities.

Supervisors must review an employee's list of BDN commands and submit a new "Benefits Delivery Network Access Request" form (VAF 20-8824) when the employee's duties change. The BDN commands requested for 19 of 20 employees in our sample

were consistent with their job responsibilities. However, one VSC employee was authorized more commands than requested or needed.

Suggested Improvement Action(s) 2. We suggested that the Regional Office Director ensure that the VSC manager reviews and authorizes appropriate commands for the employee identified and that employees are only authorized commands that are necessary for their job responsibilities.

The Regional Office Director agreed with the finding and suggestion and reported that the VSC manager has recently performed a review to address this issue. The review will be routinely performed. The improvement plan is acceptable.

Locked Files – The Semiannual Audit of Locked Files Needed To Be Performed

Condition Needing Improvement. Regional office staff had properly transferred claims files for VARO Indianapolis employee-veterans with active awards to VARO Louisville, the regional office of jurisdiction. Staff had secured keys to the locked file cabinets containing sensitive claims files. Individuals working with sensitive files were required to sign out the files and return them by close-of-business the same day. However, there was one area in which the security of sensitive claims files could be improved.

VBA policy requires staff to complete a semiannual audit and reconciliation of sensitive files to ensure that they are securely maintained at the proper location. The Information Security Officer (ISO) and the VSC manager are required to ensure that all sensitive files are properly secured physically and electronically. Although VSC staff had performed the semiannual audits of sensitive files, they had not coordinated with the ISO to reconcile the physically locked files to the electronically locked files.

Suggested Improvement Action(s) 3. We suggested that the VARO Director ensure that the VSC manager and ISO reconcile the physically locked files to the electronically locked files.

The Regional Office Director agreed with the finding and suggestion and reported that the VSC manager and the ISO would routinely perform a reconciliation of the locked files. The improvement plan is acceptable.

Regional Office Director's Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 18, 2004

From: Jeffrey Alger

Subject: VA Regional Office Indianapolis, Indiana

To: Freddie Howell, Jr., Director, Chicago Audit Operations Division

Enclosed is the Indianapolis Regional Office response to the Combined Assessment Program Review Draft Report. The Indianapolis Regional Office concurs with the recommendations and suggested improvement actions noted in the report.

We appreciate the analysis provided by the audit team. Their findings and our corrective actions will improve benefits and service delivery at this regional office. If you have any questions or concerns, please feel free to contact me at (317) 226-7880.

(original signed by:)

JEFFREY M. ALGER, Director

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. We recommend that the Regional Office Director ensure that VSC staff:

- a) Adjust compensation benefits for the veterans identified by our review and initiate collection actions where necessary.

Concur **Target Completion Date:** October 29, 2004

Upon receipt of the cases identified by the OIG, the VSC will adjust compensation benefits for the veterans identified and initiate collection actions where necessary.

- b) Review AMIE reports and identify hospitalized veterans whose C&P awards require adjustment.

Concur **Target Completion Date:** August 18, 2004

The Regional Office has taken steps to ensure the proper review of the admission reports from the AMIE system and to identify hospitalized veterans whose C&P awards require adjustment.

- c) Forward AMIE reports to the PMC or other regional offices for veterans under their jurisdiction.

Concur **Target Completion Date:** August 18, 2004

The Regional Office is forwarding AMIE reports to the proper office of jurisdiction.

Recommended Improvement Action(s) 2. We recommend that the VARO Director requires the VR&E Officer to ensure that:

- a) Purchase cardholders are properly trained and warranted, and do not exceed their purchase authorities.

Concur **Target Completion Date:** August 18, 2004

We have ensured that all purchase cardholders are properly trained, warranted and do not exceed their purchase authorities.

- b) Controls are implemented to ensure purchases are in accordance with VA policy to avoid split purchases.

Concur **Target Completion Date:** August 18, 2004

The Regional Office has put proper controls in place to ensure purchases are in accordance with VA policy to avoid split purchases.

Recommended Improvement Action(s) 3. We recommend that the VARO Director report the five ARs identified to the OIG Office of Investigations and routinely review C&P ARs for potential fraud and possible referral to the OIG Office of Investigations.

Concur **Target Completion Date:** October 29, 2004

Upon receipt of the five (5) ARs, the Regional Office will report them to the proper OIG Office of Investigations. The Regional Office has taken action and has a process in place to routinely review C&P ARs for potential fraud.

Recommended Improvement Action(s) 4. We recommend that the VARO Director require the VR&E Officer to ensure that:

- a) Applications are processed timely.

Concur **Target Completion Date:** August 18, 2004

The Regional Office has ensured that applications are processed timely.

- b) Dates of claim are accurately entered into BDN and WINRS.

Concur **Target Completion Date:** August 18, 2004

The VR&E Officer has taken action and has ensured that dates of claim are accurately entered into BDN and WINRS.

- c) Participants' training statuses are accurate and up-to-date.

Concur **Target Completion Date:** August 18, 2004

Corrective measures have been taken and local reviews are in place ensure the proper training status of participants in the VE&E program.

Recommended Improvement Action(s) 5. We recommend that the Regional Office Director take action to:

- a) Identify an off-site storage facility in the AIS contingency plan.

Concur **Target Completion Date:** August 18, 2004

We have identified an off-site storage facility in the contingency plan.

- b) Include critical functions in priority order in the contingency plan.

Concur **Target Completion Date:** August 18, 2004

Critical functions, in priority order, have been incorporated into the contingency plan.

- c) Include a telephone listing of key personnel in the contingency plan.

Concur **Target Completion Date:** August 18, 2004

This information has been incorporated into the contingency plan.

- d) Approve the contingency plan.

Concur **Target Completion Date:** August 18, 2004

The Regional Office Director has approved the contingency plan.

OIG Suggestion(s)

Suggested Improvement Action(s) 1. We suggest that the Regional Office Director take action to meet all goals established by the *National Dashboard* report.

Concur **Target Completion Date:** Date

The Regional Office has implemented several strategies that address meeting the goals established and documented on the National Dashboard report. We have been given authority by the Area Office to hire additional FTE. This FTE will enhance our opportunity to meet our goals.

Suggested Improvement Action(s) 2. We suggest that the Regional Office Director ensure that the VSC manager reviews and authorizes appropriate commands for the employee identified, and that employees are only authorized commands that are necessary for their job responsibilities.

Concur **Target Completion Date:** August 18, 2004

A recent review performed by the VSCM has addressed this issue. The review will be routinely performed throughout the year.

Suggested Improvement Action(s) 3. We suggest that the VARO Director ensure that the VSC manager and the ISO reconcile the physically locked files to the electronically locked files.

Concur **Target Completion Date:** August 18, 2004

The Regional Office has instituted a countermeasure to ensure that the VSM and the ISO routinely perform a reconciliation of the locked files.

Monetary Benefits in Accordance with IG Act Amendments

<u>Recommendation</u>	<u>Explanation of Benefit(s)</u>	<u>Better Use of Funds</u>
1	Adjust payments to veterans hospitalized for a period exceeding a calendar month at Government expense and recoup inappropriate payments (\$291,184 - \$35,662).	\$255,522
2	Referring potential fraud cases could result in recoupment of inappropriate payments.	<u>440,018</u>
	Total	\$695,540

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell, Jr., (708) 202-2670
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	Larry Chinn
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Report Distribution

VA Distribution

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