Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Providence, Rhode Island

Report No. 04-00731-110

March 24, 2005

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.
- 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.

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the weeks of July 26 and August 16, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office (VARO) Providence, Rhode Island. 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 2 fraud and integrity awareness briefings to 40 regional office employees.

Results of Review

This CAP review covered 16 areas. The regional office complied with selected standards in the following 9 areas:

- Accounts Receivable
- Automated Information Systems Security
- Benefits Delivery Network (BDN) Security
- Compensation and Pension (C&P) Benefits for Veterans Over 85
- C&P Claims Processing Timeliness
- C&P Long-Running Awards
- C&P System Message Processing
- Government Purchase Card Program
- Large Retroactive C&P Payment Controls

We identified seven areas that needed additional management attention. To improve operations, the following recommendations were made to both the Eastern Area Director and the VARO Providence Director:

- Improve controls over future C&P examinations.
- Improve oversight of fiduciaries responsible for managing the accounts of two veterans with estate values totaling approximately $766,000.
- Strengthen management controls over the Vocational Rehabilitation and Employment (VR&E) program to ensure program services are delivered timely and program decisions are well-supported.
- Improve the storage and reconciliation of sensitive and locked files.
- Promptly adjust benefit payments to veterans hospitalized at Government expense for extended periods.

In addition, the following recommendations were made to the Eastern Area Director:

- Ensure Regional Processing Office (RPO) personnel at VARO Buffalo notify applicable regional offices when Chapter 35 benefits are awarded so that regional offices may adjust corresponding C&P awards.
- Ensure Pension Management Center (PMC) personnel at VARO Philadelphia take appropriate action on notifications of incarcerations.

This report was prepared under the direction of Mr. Thomas L. Cargill, Jr., Director, and Mr. Nick Dahl, CAP Review Coordinator, Bedford Audit Operations Division.

Eastern Area Director and VARO Providence Director Comments

The Eastern Area and VARO Providence Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 16-22 for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions until they are completed.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Facility Profile

Organization and Programs. The regional office provides compensation, initial pension eligibility determinations, and survivor benefits, along with VR&E services to eligible veterans, dependents, and survivors residing in Rhode Island and southeastern Massachusetts. The veteran population in the regional office's jurisdiction is approximately 171,000. Approximately 22,000 veterans and survivors are in receipt of C&P benefits and over 500 veterans are receiving VR&E services. Annual benefit expenditures are in excess of $279 million.

The Regional Loan Center, located at VARO Manchester, provides loan guaranty services to veterans residing in Rhode Island and southeastern Massachusetts. The RPO, located at VARO Buffalo, administers education benefits to those veterans residing in the regional office's jurisdiction.

Resources. In Fiscal Year (FY) 2004, the regional office's general operating expenses were nearly $3.9 million, and staffing at the end of FY 2004 was 49.6 full-time equivalent 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 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 CAP review, we inspected work areas; interviewed managers and employees; and reviewed beneficiary files and financial and administrative records. The review covered selected aspects of the following areas:

- Accounts Receivable
- Automated Information Systems Security
- BDN Security
- Claims Folder Security
- C&P Benefits for School Aged Children
- C&P Benefits for Veterans Over 85
- C&P Claims Processing Timeliness
- C&P Future Examinations
- C&P Hospital Adjustments
- C&P Long-Running Awards
- C&P Payments to Incarcerated Veterans
- C&P System Message Processing
- Fiduciary and Field Examinations
- Government Purchase Card Program
- Large Retroactive C&P Payment Controls
- VR&E Program

The review covered facility operations for FYs 2003 and 2004 through August 2004 and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

During the review, we also provided fraud and integrity awareness training attended by 40 regional office employees. The briefings covered procedures for reporting suspected criminal activities to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Opportunities for Improvement

Compensation and Pension Future Examinations – Controls Needed To Be Established To Prevent Benefit Overpayments

Condition Needing Improvement. Veterans receiving 100 percent service-connected compensation for disabilities subject to reduction were not scheduled for required future VA medical examinations, resulting in overpayments to four veterans totaling about $800,000.

Veterans with certain disabilities that may be of a temporary nature are granted 100 percent service-connection while undergoing treatments for those disabling diseases and conditions. The majority of the disabilities result from orthopedic conditions, which require knee surgery, joint replacement, or other similar treatments. However, the regional office's rating board can grant 100 percent service-connection for veterans who are undergoing treatments for cancer or who have had heart surgery if the conditions were either incurred in service or were secondary to exposure to Agent Orange. In all cases, these conditions require future VA medical examinations in order to determine if the veterans' medical treatments have been completed and if the 100 percent compensation awards are still warranted.

In order to ensure that the required future VA medical examination takes place, the rating specialist records a future examination date on the rating decision. When the veteran service representative (VSR) inputs the award into BDN, the future examination date should be entered into the BDN 301 screen. Prior to the date of the future examination, BDN generates a VA Form 21-2507a, Request for VA Examination. Once this form is generated, the veteran's claims folder is pulled from the file bank and both the form and the claims folder are sent to the rating board for review and scheduling of the examination. Following the completion of the VA medical examination, the rating board reviews the evidence of record and if the veteran is still receiving treatment for his or her medical condition, the 100 percent evaluation is continued and another examination is scheduled. If the veteran's medical condition no longer requires treatment, the rating specialist will reduce the 100 percent evaluation and assign the appropriate service-connection rating for any remaining conditions or treatments.

We reviewed a sample of 25 compensation cases where the veterans were receiving 100 percent service-connected compensation for disabilities potentially subject to reduction. These 25 cases were selected from a population of 31 cases where the veterans were receiving 100 percent compensation based on certain cancer diagnoses. In the 25 cases we reviewed, the veterans were receiving $708,660 annually. Our review revealed that VSC personnel did not consistently ensure future VA medical examinations

were scheduled and conducted. We questioned VSC management whether future examinations should have been scheduled and conducted to determine if veterans were still receiving treatments in 19 of the 25 cases reviewed. VSC management agreed that examinations should have been scheduled and conducted in 13 of these cases. In the 6 cases where VSC management did not believe future examinations were required, we agreed with their conclusions and reasons for not scheduling future examinations.

In 10 of the 13 cases where future examinations should have been scheduled, the examinations were not scheduled either because a VSR failed to enter a date for an examination in BDN or a rating specialist failed to note the need for an examination on the rating decision. When future examinations are not scheduled, the 100 percent evaluation could run indefinitely. In these 10 cases, the veterans are receiving $335,372 annually. In the other three cases, with annual awards totaling $90,504, rating specialists annotated the need for examinations and VSRs entered the dates of the examinations in BDN; however, when BDN generated VA Form 21-2507a, VSC personnel marked them as no action needed and examinations were not scheduled. The rating for one of these three veterans had been in place for over 20 years. We estimate that this 52-year old veteran has been overpaid by about $350,000[1] since an examination to determine whether he was still receiving treatment for lung cancer was improperly cancelled in 1984, and he continues to be overpaid by about $20,000 annually. Once an evaluation has been in place for 20 years, the 100 percent evaluation is protected by Federal law and can not be reduced.

In the 12 cases VSC management agreed required further actions[2] (13 cases less the 1 where the rating is protected), VSC personnel took action after our site visit to determine whether the veterans were still receiving treatments. As of January 2005, examinations had been conducted in all cases. In 3 of 12 cases, veterans were assigned permanent and total 100 percent evaluations after examination evidence was evaluated and in 6 cases ratings were continued at 100 percent, but future examinations have been scheduled to ensure the veterans' conditions require continued treatments. In the three remaining cases, VSC personnel have reduced benefits in one case and proposed reducing benefits in two cases. Details on these cases follow.

- A 41-year old veteran was no longer receiving treatment for leukemia, and the 100 percent evaluation should have been reduced to 0 percent. We estimate the veteran was overpaid at least $350,000 since 1990. Had this error not been found, we estimate this veteran would have been overpaid an additional $995,000 based on his life expectancy of 77 years.
- A 59-year old veteran was no longer receiving treatment for prostate cancer, and the 100 percent rating for this condition should have been reduced to 10 percent. (The

[1] The veteran has been paid at the 100 percent rate but should have been paid at the 60 percent rate.
[2] Rating decisions in these 12 cases were issued between March 1990 and June 2003, including 10 issued since March 2001. Examinations should have been scheduled 6 to 12 months after the rating decisions were issued.

veteran's combined rating should be reduced from 100 percent to 30 percent.) We estimate this veteran was overpaid approximately $50,000 since 2003. Had this error not been found, we estimate this veteran would have been overpaid an additional $485,000 based on his life expectancy of 80 years.

- A 57-year old veteran was no longer receiving treatment for prostate cancer, and the 100 percent rating for this condition should have been reduced to 0 percent. (The veteran's combined rating should be reduced from 100 percent to 50 percent.) We estimate this veteran was overpaid approximately $50,000 since 2002. Had this error not been found, we estimate this veteran would have been overpaid an additional $460,000 based on his life expectancy of 80 years.

Failure to schedule and conduct future VA examinations for veterans receiving 100 percent service-connected compensation for disabilities subject to reduction places VA funds that could be put to better use at risk. In our review, we identified cases where compensation benefits should have been reduced because the veterans no longer required treatments for their cancer conditions. Veterans have been overpaid approximately $800,000 in four cases. VSC management has initiated action to reduce payments to three of these veterans, thereby potentially avoiding additional overpayments of $1.9 million based on their life expectancies.[3]

Recommended Improvement Action 1. We recommended the Area Director ensures the Regional Office Director requires VSC management to: (a) make appropriate award adjustments for the cases involving evaluations that should be reduced, (b) ensure VSRs input future examination dates into BDN, and (c) conduct refresher training for rating specialists to ensure disabilities subject to reduction are reduced when appropriate.

The Eastern Area and VARO Providence Directors agreed with the finding and recommendations and reported that benefits have been reduced in one case and reductions proposed in two others. VSC management will continue to focus on the need for VSRs to input future examination dates into BDN and has provided refresher training on disabilities subject to reduction. We should note that the Director informed us this issue had not been discovered to be in error by local or national quality reviews conducted at her regional office, and she believed that current processes were sufficient to ensure appropriate control over this area. We disagree. An emphasis needs to be placed on reviewing and correcting the condition we identified to ensure other unsupported payments will not be made. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

[3] One of the veteran's ratings is protected by Federal law because it has been in place for over 20 years. As the rating is protected, we did not project the anticipated additional overpayment in this case.

Fiduciary and Field Examination Unit – Closer Oversight of Fiduciaries Is Needed

Condition Needing Improvement. To improve oversight of two fiduciary accounts valued at about $766,000, regional office management needed to determine whether investments made by a relative serving as a fiduciary are appropriate in one case and whether a Federal fiduciary should be appointed in another case. The Fiduciary and Field Examination (F&FE) unit is responsible for protecting the interests of incompetent or minor beneficiaries by appointing fiduciaries when necessary to manage the beneficiaries' funds and for monitoring the fiduciaries' activities. One method of monitoring fiduciaries' activities is to require the fiduciaries to submit annual accountings listing the beneficiaries' assets, income, and expenses.

We reviewed the records of nine beneficiaries, with estate values totaling about $3.1 million, whose funds were managed by fiduciaries. Management attention is needed in two of the nine fiduciary cases.

- Regional office management needed to improve oversight of investments made by a fiduciary. A state court appointed the stepsister of a deceased Vietnam era veteran to serve as fiduciary for the veteran's adult child. This beneficiary was born in 1969 and is diagnosed with dementia. As of December 31, 2003, the beneficiary's estate was valued at about $226,000. As of July 2004, the beneficiary was receiving VA benefits of about $8,000 annually. The fiduciary had approximately 95 percent of the estate's value invested in a variable annuity. For the 12-year period ending December 31, 2003, the beneficiary's annuity account experienced an annualized negative rate of return since inception of 6.3 percent. Additionally, the fiduciary had opened an unrelated brokerage account in 1999 and invested approximately $34,000 in stocks and options. The brokerage statement described the customer's risk tolerance as aggressive and investment objective as speculation. In 2001, the beneficiary experienced a loss of approximately $28,000 (82 percent) from the sale of stock in this account.

  VA policy states that fiduciaries will invest income or estate derived from VA benefits only in legal instruments which have safety, assured income, and stability of principal, and that are readily convertible for the requirements of the beneficiary. The investments discussed above do not appear to meet the intent of VA criteria. VA policy requires VARO management to take immediate action to protect the beneficiary's estate when it has notice of imprudent investments. We believe the F&FE Unit's oversight of this case was inadequate and that the Regional Office Director should consult with the VA Regional Counsel to determine if the investments made by this fiduciary meet VA criteria. If it is determined that the investments do not meet VA criteria, action should be taken to ensure the fiduciary invests the beneficiary's VA-derived assets in investment vehicles that meet VA criteria.

- Regional office management needed to consider the appointment of a Federal fiduciary. A court-appointed attorney serves as the fiduciary for a veteran who was born in 1919 and is 100 percent service connected for schizophrenia. The attorney was appointed as fiduciary in 2001. The latest available information shows that as of May 2001, the veteran's estate was valued at approximately $540,000. As of July 2004, the veteran was receiving VA benefits of about $27,000 annually. At the time of our review, the fiduciary had failed to submit any of the three required annual accountings to either the state court or the regional office. Without complete and timely accountings, F&FE personnel cannot effectively monitor the fiduciary's activities or determine whether the veteran's estate is at risk.

  We believe regional office management, in conjunction with the VA Regional Counsel, needs to determine whether the appointment of a Federal fiduciary in place of the court-appointed fiduciary is warranted in this case. Appointing a Federal fiduciary would be advantageous because it allows the regional office more control over the fiduciary. If a Federal fiduciary fails to properly execute his or her duties, VA can administratively remove the fiduciary and appoint a new one without involving the VA Regional Counsel or the court.

Recommended Improvement Action 2. We recommended the Area Director ensures the Regional Office Director consults with the VA Regional Counsel to: (a) determine whether a fiduciary's investments are appropriate in one case, (b) take action to correct the situation if it is determined that the fiduciary's investments do not meet VA criteria, (c) institute appropriate controls to ensure timely action is taken when inappropriate investments are identified in the future, and (d) determine whether a Federal fiduciary should be appointed for the case identified.

The Eastern Area and VARO Providence Directors agreed with the finding and recommendations and reported that VA Regional Counsel has been consulted and the necessary field examination has been scheduled for the first case we identified to review past investments and ensure the propriety of future investments. Training on the propriety of fiduciary investments has been conducted and investments will be monitored. Regional office management decided to retain the court-appointed guardian in the second case identified, but is working to obtain the delinquent accountings. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Vocational Rehabilitation and Employment – Program Oversight Needed Improvement

Condition Needing Improvement. We evaluated management controls to ensure VR&E program services were delivered timely and program decisions were well supported. We concluded that VR&E management did not ensure that VR&E case managers: effectively managed and monitored veterans' cases; completed needs

assessments for veterans pursuing Independent Living (IL) plans; or developed sound self-employment plans prior to approving purchases for those pursuing self-employment.

The VR&E program assists certain service-connected veterans to obtain and retain gainful employment. Veterans are entitled to vocational rehabilitation benefits if they have a service-connected disability rated at 20 percent or more and an employment handicap. Entitlement is also applicable if the veteran has a disability rated at 10 percent and a serious employment handicap. An employment handicap is an impairment of a veteran's ability to prepare for, obtain, or retain employment consistent with his or her abilities, aptitudes, and interests. Veterans participating in the VR&E program are assigned case managers who oversee their cases and assist them through the different program phases.

Case managers use two separate automated systems, the Chapter 31 Case Status System and the Corporate WINRS[4] System, to manage their case workload and produce management reports. Case managers assign each participant to a specific case status as they progress through the rehabilitation process. Generally, veterans pursuing higher education or other training should move sequentially from applicant status through evaluation and planning status, rehabilitation to the point of employability status, employment services status, and rehabilitated status. If a veteran completes his or her training program and obtains gainful employment, the veteran is classified as rehabilitated. Veterans who temporarily stop their training programs but plan to restart in the near future are placed in interrupted status, while veterans who leave the program without being classified as rehabilitated are placed in discontinued status.

To evaluate the effectiveness of VR&E case management, we reviewed a sample of 36 cases, including 14 active, 17 rehabilitated, and 5 discontinued cases. We identified three issues requiring management attention.

Monitoring and Managing Veterans' Case Progress. Case managers are responsible for keeping in contact with program participants and assisting them as they attempt to successfully meet their program goals. We found that in 17 of 36 cases reviewed, the case managers responsible for overseeing the veterans' progress had not adequately retained control of the cases. The following are examples where the case managers did not retain appropriate control of the cases:

- A case manager placed a veteran's case into rehabilitation to the point of employability status on June 4, 2001. The case remained in this status until June 30, 2003, 757 days later, when it was moved into interrupted status. It remained in this status until August 2, 2004, 400 days later, when it was moved into discontinued status. There was limited contact by the case manager with the veteran

[4] Corporate WINRS is VR&E's electronic case management system. The acronym was derived from the first letter of the names of the five stations that tested the system: Winston-Salem, NC; Indianapolis, IN; Newark, NJ; Roanoke, VA; and Seattle, WA.

when the veteran was first placed in rehabilitation to the point of employability status. Contact ceased while he was in this program phase and there was no evidence the case manager contacted this veteran while he was in interrupted status. There was no evidence in his Counseling, Evaluation, and Rehabilitation (CER) folder indicating he planned to resume his training in the near future, which would justify placing his case in interrupted status. We believe this veteran's case should have been discontinued at an earlier date.

- A case manager placed a veteran's case into evaluation and planning status on March 31, 2003. The case remained in this status until June 28, 2004, 456 days later, when the case manager inappropriately placed it into interrupted status. Thirty-seven days later, during our review, the case was placed into discontinued status. There was no evidence the case manager contacted this veteran while his case was in evaluation and planning status. Remaining in an initial phase of the program for such a lengthy time indicates the veteran was not working toward meeting his program goals. We believe this case should also have been discontinued at an earlier date.

When case managers do not keep in contact with program participants and maintain control of their cases, they are not assisting the veterans in meeting their rehabilitation goals and they do not know when a case should be put into interrupted status or classified as discontinued. Delays in placing the cases of veterans who are not actively pursuing their programs into discontinued status inflate the VR&E workload and may skew performance measures.

VR&E personnel have access to the monthly "COIN TAR 6013" report that lists all active cases, sorted by case manager and case status. The report also shows how many days each case has been in its current status. VR&E management was not adequately using this report to monitor case management and ensure participants' needs were being met.

Completing Needs Assessments for Independent Living Participants. Veterans who are having a difficult time functioning independently in family, community, or employment matters may qualify for vocational or rehabilitation services that are available under the Independent Living (IL) program. The goal of the IL program is to help veterans become more independent in their daily living and improve their quality of life. When a case manager determines that a veteran is unable to attain a vocational or educational goal, he or she has the option of allowing the veteran to pursue an IL plan. An IL plan usually involves purchasing goods or providing services with a goal of increasing the veteran's independence in daily living and quality of life. Prior to approving an IL plan, the case manager should complete a thorough needs assessment clearly identifying the goods and services needed to meet the veteran's goals.

We reviewed nine cases (five active and four rehabilitated cases) where the veterans were pursuing or had pursued IL plans. We questioned the justifications for purchases made in

8 of 9 cases. In these eight cases, we found the veterans' CER folders did not include needs assessments. Review of the CER folders associated with these cases revealed that the veterans were apparently placed in the IL program as a way to rationalize purchasing them computers. In 8 of 9 cases, including 7 of the 8 lacking completed needs assessments, the only purchases were computers and computer-related training. The average age of these veterans when they applied for VR&E benefits was 65, and the length of time each was in the program was less than 2 years. Review of these veterans' CER folders revealed minimal contact between the veterans and the case managers. The cases that were closed as rehabilitated were classified as such because case managers determined the veterans had developed at least basic computer skills which enhanced their independence.

Without completed needs assessments, it was not clear whether case managers' decisions and purchases made on behalf of the veterans were appropriate or if the classification of cases as rehabilitated was appropriate. We also could not ascertain how and why the purchase of computers and computer-related training was determined to be the actions necessary to improve the veterans' independence in daily living and quality of life.

Developing Self-Employment Plans. Rehabilitation of a veteran may be achieved through self-employment in a small business if the veteran's access to the normal channels for suitable employment in the public or private sector is limited because of his or her disability, or other circumstances if the veteran's situation warrant consideration of self-employment as an option. Before a self-employment plan can be approved, the veteran must complete a comprehensive business plan and VR&E personnel must conduct a thorough feasibility study. The required plan and study should be documented in the CER folder and include details such as an analysis of the economic viability of the proposed small business; a cost analysis specifying the amount and type of assistance to be provided by VA; and a marketing plan.

In August 2003, a case manager approved a rehabilitation plan, with a goal of "maintaining business in landscape maintenance," for a veteran with a 30 percent service-connected rating for multiple sclerosis. This plan replaced the veteran's previous rehabilitation plan, dated January 2000, which had a goal of obtaining an Associates degree in Computer Information Systems. Review of this veteran's CER folder revealed that neither a business plan nor a feasibility study had been completed and that the veteran was operating a landscaping business before the case manager approved the veteran's rehabilitation plan. Between October 1, 2003, and June 24, 2004, VR&E personnel spent at least $16,023 on equipment to support the veteran's ongoing business. This included spending $4,688 on a cargo trailer, $2,499 on a lawnmower, and $2,399 on a snow thrower. Without a completed business plan and feasibility study, we could not determine how the case manager justified approving the self-employment plan and the related purchases.

Recommended Improvement Action 3. We recommended the Area Director ensures the Regional Office Director requires VR&E personnel to: (a) actively manage and monitor cases to ensure timely services are provided to program participants and cases are properly classified, (b) complete and document needs assessments that identify the needs of veterans before approving IL plans, and (c) ensure appropriate business plans and feasibility studies are completed for those pursuing self-employment plans.

The Eastern Area and VARO Providence Directors agreed with the finding and recommendation and reported that a systematic monthly case management monitoring process has been instituted, an IL protocol developed by VR&E Service is being used, and refresher training on self-employment plans has been provided. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Security of Sensitive Records – Management Controls Needed Improvement

Condition Needing Improvement. Management controls over employee claims folders needed improvement. VBA policy requires that these sensitive hardcopy records be secured in locked files with access limited to division chiefs and designated alternates, and sensitive electronic records be secured through the Common Security User Manager (CSUM) application. Sensitive records must be secured at the designated regional offices of jurisdiction. VARO Providence serves as the office of jurisdiction for VARO White River Junction. The claims folders for employees of the co-located regional office and medical center in White River Junction should be stored in locked files at VARO Providence.[5]

To ensure that sensitive records are securely maintained at the proper location, VBA policy requires that regional office personnel conduct semiannual audits of sensitive records. These audits should include inventories of locked files, comparisons of CSUM electronically secured file listings with inventories of locked files, and reconciliations of the inventory listings with the office of jurisdiction's listings.

We evaluated the identification and handling of sensitive records and found the following deficiencies requiring management attention:

- Regional office personnel could not provide documentation of semiannual audits of sensitive records. After our request for copies of semiannual audits, the Information Security Officer initiated a semiannual audit, which was not complete as of October 2004.

[5] Until December 31, 2003, the White River Junction facility was a VA medical and regional office center. On January 1, 2004, the regional office and medical center became separate, but still co-located, facilities. Personnel involved with security of locked files at VARO Providence and White River Junction agreed that the claims folders of both regional office and medical center employees should be secured in locked files.

- Regional office personnel had not secured in locked files the claims folders of 127 employees from the co-located regional office and medical center in White River Junction. While the regional office had possession of these folders, their efforts to identify and secure the folders were hampered because the list of sensitive records provided by VARO White River Junction was not up-to-date.

Recommended Improvement Action 4. We recommended the Area Director ensures: (a) regional offices under the jurisdiction of the Eastern Area periodically provide the applicable regional offices of jurisdiction up-to-date and accurate lists of sensitive records; and (b) the Regional Office Director takes action to conduct and document semiannual audits of sensitive records, and secure the claims folders of all White River Junction regional office and medical center employees.

The Eastern Area and VARO Providence Directors agreed with the finding and recommendations. The Eastern Area Director reported that his office will monitor annual Network Support Center reports to ensure regional offices provide applicable regional offices of jurisdiction up-to-date and accurate lists of sensitive records. The VARO Providence Director reported that the regional office's Information Security Officer (ISO) has conducted and documented a semiannual audit of sensitive records and will continue to conduct them as required. Steps have been initiated to ensure the claims folders of all White River Junction regional office and medical center employees will be secured at VARO Providence. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Compensation and Pension Hospitalization Adjustments – Payments To Veterans Hospitalized at Government Expense Needed To Be Reduced

Condition Needing Improvement. VSC personnel did not properly reduce C&P payments to certain veterans who were hospitalized for extended periods of time at Government expense. In certain situations, Federal law requires the reduction of C&P payments to hospitalized veterans. For example, payments to veterans who are entitled to an aid and attendance allowance in addition to their regular disability pension or compensation benefits generally must be reduced to the lower housebound rate if the veterans are hospitalized at Government expense for periods exceeding a full calendar month.

At our request, the VA Providence Medical Center and the VA Boston Health Care System identified 49 veterans who had been continuously hospitalized at Government expense for 90 days or more as of July 16, 2004. We compared the information provided by the medical facilities with C&P system records for the 49 veterans and identified 5 veterans (10 percent) whose C&P payments had not been reduced, as required. As of

October 2004, these veterans were overpaid $43,285 while hospitalized at Government expense. C&P payments to 4 of the 5 veterans (with overpayments totaling $36,703) had not been reduced because VSC personnel did not take appropriate actions when hospitalization notifications were received from the medical facilities. The other case (with an overpayment of $6,582) originally required adjustment action by a different Eastern Area regional office, but is now under the jurisdiction of VARO Providence.

Recommended Improvement Action 5. We recommended the Area Director ensures the Regional Office Director takes action to: (a) reduce C&P payments as appropriate for the veterans we identified who were hospitalized at Government expense for extended periods, and (b) provide refresher training for VSC personnel at least annually concerning required reductions of C&P payments to hospitalized veterans.

The Eastern Area and VARO Providence Directors agreed with the finding and recommendations and reported that payments for the veterans identified have been adjusted and refresher training will be provided annually. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Compensation and Pension Claims Processing – Duplicate Benefit Payments for Children Attending School Needed To Be Reduced

Condition Needing Improvement. VSC personnel did not reduce C&P payments to veterans when the veterans were receiving additional compensation for school-aged children and the children were also receiving Dependents' Education Assistance (Chapter 35) benefits. Dependents of veterans who receive compensation for a permanent 100 percent disability, or who died while on active duty or of a service-connected disability, are eligible to receive Chapter 35 benefits. VA regulations require VSC staff to discontinue the veterans' additional compensation for school-aged children when the school-aged children receive Chapter 35 benefits. When a Chapter 35 benefit is processed, the Education Division of one of the four RPOs[6] is required to coordinate with the regional office having jurisdiction over the veteran's claim file to ensure concurrent payments of additional compensation for school-aged children and Chapter 35 benefits are not issued.

We identified 2 of 29 veterans receiving 100 percent compensation benefits with additional benefits for school-aged children while the children were also receiving Chapter 35 benefits. The two veterans were overpaid a total of $6,746, as of October 2004. In both cases, benefit payments had not been reduced for the veterans because RPO personnel at VARO Buffalo did not notify VARO Providence VSC personnel about Chapter 35 benefits being paid to the dependents.

[6] The four RPOs are located at VAROs in Atlanta, GA; Buffalo, NY; St. Louis, MO; and Muskogee, OK.

Recommended Improvement Action 6. We recommended the Area Director ensures that: (a) RPO personnel at VARO Buffalo notify the applicable regional office when Chapter 35 benefits are awarded, and (b) the Regional Office Director requires VSC personnel to reduce the C&P payments for the two veterans we identified.

The Eastern Area and VARO Providence Directors agreed with the findings and recommendations. The Eastern Area Director reported that his office has verified that comprehensive procedures for notification are in place at the RPO and that management controls are also in place to ensure regional offices are promptly notified when Chapter 35 benefits are awarded. The VARO Providence Director reported that payments for the veterans identified have been adjusted. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Compensation and Pension Payments To Incarcerated Veterans – Procedures for Terminating Pension Benefit Payments Needed Improvement

Condition Needing Improvement. VBA staff needed to improve the processing of notifications of veterans incarcerated in Federal, state, or local penal institutions in excess of 60 days. VA policy requires reducing compensation benefits to the 10 percent rate for conviction of a felony and terminating pension payments for conviction of a felony or misdemeanor.

To identify veterans who have been incarcerated, VBA provides regional offices the monthly results of database cross matches between the C&P Master Record File and the Federal Bureau of Prisons; along with the Social Security Administration and state prisons. VSC personnel are responsible for reviewing the claims folders of veterans receiving compensation benefits and for taking appropriate actions to reduce their benefits when necessary. VSC personnel forward the incarceration notices for veterans receiving pension benefits to applicable PMC[7] personnel, who review the claims folders and terminate benefits when necessary. PMC personnel at VARO Philadelphia are responsible for making adjustments to pension benefits of veterans residing in Rhode Island and Massachusetts.

In reviewing the claims folders of 26 veterans on the regional office's lists of incarcerated veterans from December 1, 2003, through July 31, 2004, we identified 4 veterans who were receiving pension benefits. While the claims folders included evidence that VSC personnel had notified the PMC regarding the incarceration of these four veterans, there was no evidence that PMC personnel had taken action in three of four cases. If PMC personnel had reviewed these cases upon receiving the notices of incarceration, they would have found the need to terminate the pension benefits for one of the three veterans.

[7] PMCs are responsible for processing all activity related to pension cases. The three VBA PMCs are located at VAROs in Philadelphia, PA; Milwaukee, WI; and St. Paul, MN.

Because timely action was not taken by PMC personnel, the incarcerated veteran was overpaid $961 as of October 31, 2004. This veteran is scheduled to remain incarcerated until December 25, 2005. As a result, he could be overpaid an additional $11,377 (13.8 additional months times $824 monthly benefit) if no action is taken. The other two cases did not require award adjustments because the periods of incarceration were each less than 60 days.

Recommended Improvement Action 7. We recommended the Area Director ensures that: (a) PMC personnel at VARO Philadelphia take action to terminate the pension benefits paid to the veteran we identified, and (b) PMC personnel at VARO Philadelphia take appropriate and timely action when receiving notifications of incarceration from regional office personnel.

The Eastern Area Director agreed with the finding and recommendations and reported that pension benefits were reduced in the case we identified and that PMC personnel at VARO Philadelphia are taking action to control and timely process notices of incarceration. The improvement plans are acceptable, and we will follow up on the completion of planned actions.

Appendix A

Eastern Area Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 24, 2005

From: Director, Eastern Area Office (20F1)

Subject: **Combined Assessment Program Review of the VA Regional Office Providence, Rhode Island**

To: Director, Bedford Audit Operations Division (52BN)

I appreciate the thorough assessment and the feedback provided by your audit team in the Providence Combined Assessment Program Review which took place at the Providence Regional Office (RO) during the weeks of July 26 and August 16, 2004.

I concur with the Office of Inspector General's recommendations and monetary benefits estimates from the Combined Assessment Program report. I am attaching the response from the Providence Regional Office which addresses the five areas your audit team identified as requiring regional office management attention. Those areas are:

1. Improve controls over future Compensation & Pension examinations.

2. Improve oversight of fiduciaries responsible for managing the accounts of two veterans with estate values totaling approximately $766,000.

3. Strengthen management controls over the Vocational Rehabilitation and Employment (VR&E) program to ensure program services are delivered timely and program decisions are well-supported.

4. Improve the storage and reconciliation of sensitive and locked files.

5. Promptly adjust benefit payments to veterans hospitalized at Government expense for extended periods.

I concur with the Providence response to your recommended improvement actions and believe that the corrective actions undertaken by the Providence RO are sufficient to address your findings.

In addition, I concur with the following recommendations and have taken the following actions:

1. Under Improvement Action 4, you recommended that I ensure regional offices under my jurisdiction periodically provide the applicable regional offices of jurisdiction up-to-date and accurate lists of sensitive records. Adjudication Procedures (M21-1-MR Part III, Subpart II, Chapter 4, Section A, 4.a) and the VBA IT Handbook (No. 5.00.02 HB2, 1.08) require a semiannual audit of both sensitive file holdings and locked file holdings and that reciprocal audits with sister stations also occur. Our Network Support Centers (NSC) conduct yearly site visits as a mechanism to ensure station compliance with these policies. The Area Office is provided a copy of the NSC findings and we note any identified deficiencies and ensure corrective actions are taken. We will continue to monitor these reports for deficiencies. I consider my actions on this recommendation closed.

2. Under Improvement Action 6 you recommend that I ensure Regional Processing Office (RPO) personnel at VARO Buffalo notify applicable regional offices when Chapter 35 benefits are awarded so that regional offices may adjust corresponding C&P awards. In an effort to ensure that the RPO in Buffalo promptly notifies regional offices when Chapter 35 benefits have been awarded, my office contacted the Director in Buffalo and verified that comprehensive procedures for notification are in place and that management controls are also in place to ensure regional offices are promptly notified. I can provide a copy of both the email describing the procedures and

controls if requested. I consider my actions on this recommendation closed.

3. Under Improvement Action 7 you recommend that I ensure Pension Management Center (PMC) personnel at VARO Philadelphia take appropriate action to terminate payments to incarcerated veterans. There were four cases involving incarcerated veterans that came up for review during the OIG investigation. Providence was able to review three of the four cases to determine that no adjustment was required. The fourth case required an adjustment which was completed in November 2004. My staff contacted the Philadelphia RO to discuss their procedures when notification of incarceration is received from regional office personnel. When the PMC receives notification, it is reviewed and the appropriate action is taken to control and timely process the incarceration notification. I consider my action on this recommendation closed. I consider my actions on this recommendation closed.

Implementation of the audit team's recommendations along with continued oversight at both the Regional Office Director and Area Director's level will strengthen management controls and improve operations at the Providence RO. I thank you again for your time reviewing the RO operations in Providence and your recommendations for improvement.

If you have any questions, please contact me at (734) 930-5800.

(original signed by:)

James A. Whitson

Appendix B

Regional Office Director Comments

VARO Providence Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommend the Area Director ensures the Regional Office Director requires VSC to: (a) make appropriate award adjustments for the cases involving evaluations that should be reduced, (b) ensure VSRs input future examination dates into BDN, and (c) conduct refresher training for rating specialists to ensure disabilities subject to reduction are reduced when appropriate.

Concur **Target Completion Date: April 2005**

Many of the cases reviewed under this finding were prepared years ago, some over 20 years prior to the time of the review. The most recent case reviewed was prepared over one year prior to the review. While we do agree with the findings of most of the cases, we do not agree that this is a current problem.

Of the original 31 cases in the IG population, we agreed that review was appropriate in 13 of the cases. Because one veteran has a protected evaluation, the total number of veterans' claims for which we agree a review would be appropriate is 12.

(a) Of these 12 veterans' claims reviewed, we have completed action on 10, continuing the 100% evaluation in 9 cases. Of these 9, 3 veterans have been assigned "permanent and total" 100% disability, requiring no future reviews. The 6 other veterans continued at 100% all have review examinations scheduled at appropriate intervals to evaluate the current level of disability.

Of the remaining 3 veterans' claims questioned, we have completed action on 1 veteran, reducing his benefits from 100% to 0% (combined evaluation) effective 4/1/2005 per 38 CFR 3.105e. We have evaluated available medical evidence and are proposing reduction of benefits for the other 2 veterans. As required, due process notification has been provided to these veterans. In the event no further evidence is submitted to support the continued evaluations, these 2 veterans will have their

benefits reduced from 100% to 30% (combined evaluation); and 100% to 50% (combined evaluation).

(b) While this element is an item already considered under both local and national accuracy reviews, we will continue to focus on this element in all future reviews. It should be noted that this issue has not been discovered to be in error in any recent reviews and we believe our current processes are sufficient to ensure appropriate control over this area.

(c) We have conducted refresher training regarding disabilities subject to reduction. Again, a current, systemic problem has not been detected in this area in any local or national reviews of recently decided claims. Therefore, we believe our training in this area is adequate. We will continue to focus on this area in all future reviews, and should we determine a problem does exist, we will re-evaluate our training needs.

Recommended Improvement Action 2. We recommend the Area Director ensures the Regional Office Director consults with the VA Regional Counsel to (a) determine whether a fiduciary's investments are appropriate in one cases, (b) take action to correct the situation if it is determined that the fiduciary's investments do not meet VA criteria, (c) institute appropriate controls to ensure timely action is taken when inappropriate investments are identified in the future, and (d) determine whether a Federal fiduciary should be appointed in the case identified.

Concur **Target Completion Date: April 2005**

(a & b) Consultation with Regional Counsel has been accomplished as recommended and necessary field examination has been scheduled to review past investments and ensure the propriety of future investments.

(c) Training on the propriety of fiduciary investment strategies for VA beneficiary assets has been conducted and the matter will continue to be monitored by local and national quality review samples.

(d) We are working to secure from the current guardian annual accounts of those assets for which he has been responsible since his appointment. Due to the size of the estate and amount of VA income involved, a court appointed guardian remains in the best interests of the beneficiary and the VA according to guidance provided in M21-1MR, Part XI, Chapter 2, Sections C8 and E29g.

Recommended Improvement Action 3. We recommend the Area Director ensures the Regional Office Director requires VR&E personnel to: (a) actively manage and monitor cases to ensure timely services are provided to program participants and cases are properly classified, (b) complete and document needs assessments that identify the needs of veterans before approving IL plans, and (c) ensure appropriate business plans and feasibility studies are completed for those pursuing self-employment plans.

Concur **Target Completion Date: Completed**

(a) We have made great strides in improving the level of oversight and documentation of service provisions to the veterans in the VR&E program. The cases reviewed under this finding were disproportionately under the case management of one individual who has since left the Providence staff. We have instituted a much more systematic monthly case management monitoring process which we believe will ensure our veterans receive timely and consistent services to which they are entitled.

(b) We have begun using an Independent Living protocol developed by VA Central Office VR&E Service. We believe our use of this tool will ensure our IL plans are documented appropriately.

(c) We have conducted refresher training regarding self-employment plans. In recent years, we have done few of these types of plans, and will ensure that future cases follow appropriate documentation guidelines. VR&E Service is developing a Self Employment protocol that will provide us the tools and structure to appropriately develop these types of cases. This protocol will be fully implemented upon receipt.

Recommended Improvement Action 4. We recommend the Area Director ensures: (a) regional offices under the jurisdiction of the Eastern Area periodically provide the applicable regional offices of jurisdiction up-to-date and accurate lists of sensitive records, and the Regional Office Director takes action to: (b) conduct and document semiannual audits of sensitive records and (c) ensures the claims folders of all White River Junction regional office and medical center employees.

Concur **Target Completion Date: January 31, 2005**

(b) The Information Security Officer has formally documented the most recent locked file reviews. This will continue to be done regularly as required.

(c) The Providence ISO has prepared appropriate VA Forms 20-0334a for all appropriate White River Junction employees and has sent those to the WRJ ISO for review and signature. Once all forms and files are provided to Providence, they will be placed in locked files as required.

Recommended Improvement Action 5. We recommend the Area Director ensures the Regional Office Director takes action to: (a) reduce C&P payments as appropriate for the veterans identified who were hospitalized at Government expense for extended periods and (b) provide refresher training for VSC personnel at least annually concerning required reductions of C&P payments to hospitalized veterans.

Concur **Target Completion Date: Completed**

(a) The five veterans' records identified have been properly adjusted.

(b) We have conducted training annually on this topic and have recently prepared a Systematic Analysis of Operations regarding these types of adjustments. We will continue to monitor these cases through our local quality and workload management review processes.

Recommended Improvement Action 6. We recommend the Area Director ensures that (a) RPO personnel at VARO Buffalo notify the applicable regional office when Chapter 35 benefits are awarded and (b) the Regional Office Director requires VSC personnel to reduce C&P payments for the two veterans identified.

Concur **Target Completion Date: Completed**

(b) Benefits have been adjusted for the two veterans identified.

Recommended Improvement Action 7. We recommend the Area Director ensure that (a) PMC personnel take action to terminate the pension benefits paid to the veteran identified and (b) the personnel at the PMC under the jurisdiction of the Eastern Area take appropriate action when receiving notifications of incarcerations from regional office personnel.

No Providence Regional Office response required.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Compensation payments to 100 percent service-connected veterans with disabilities subject to reductions should be reduced and will create overpayments totaling $450,000. Over the lifetime of these claims, an estimated $1.9 million in unsupported payments will be avoided.	$2,350,000
3	VR&E purchases for a veteran pursuing self-employment were not properly justified.	16,023
5	Payments to certain veterans who were hospitalized at Government expense for extended periods should be reduced.	43,285
6	Payments to two veterans receiving school child benefits while the children were receiving Chapter 35 benefits should be stopped.	6,746
7	Payments to an incarcerated veteran receiving pension benefits should be stopped.	12,338
	Total	$2,428,392

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Nicholas Dahl, (781) 687-3141
Acknowledgments	Stephen Bracci Matthew Kidd James McCarthy Amy Mosman

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
General Counsel
Director, Eastern Area (20F1)
Director, VARO Providence (304/00)
Director, VARO Buffalo (307/00)
Director, VARO Philadelphia (310/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on VA, HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Lincoln Chafee, Edward Kennedy, John Kerry, Jack Reed
U.S. House of Representatives: Bill Delahunt, Barney Frank, Patrick Kennedy, Jim Langevin, James P. McGovern

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.