



# **Department of Veterans Affairs Office of Inspector General**

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## **Combined Assessment Program Review of the VA Regional Office Milwaukee, Wisconsin**

## **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 14–18, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office (VARO) Milwaukee, WI. The regional office is part of the Veterans Benefits Administration (VBA) Central 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 approximately 275 regional office employees.

### **Results of Review**

This CAP review focused on 12 areas. The regional office complied with selected standards in the following nine areas:

- Accounts Receivable
- Automated Information Systems
- Security
- Benefits Delivery Network Security
- Director's Performance Standards
- Fiduciary and Field Examinations
- Government Purchase Card Program
- Locked Files
- Retroactive Payments
- Vocational Rehabilitation and Employment

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

- Improve the processing of compensation and pension (C&P) payment adjustments for hospitalized veterans.
- Reduce benefit payments for incarcerated veterans timely.
- Improve the processing of Benefits Delivery Network (BDN) system messages.

The report was prepared under the direction of Mr. Freddie Howell, Jr., Director, and Mr. Mark Collins, Audit Manager, Chicago Audit Operations Division.

## **Central Area and VA Regional Office Director Comments**

The Central Area and Regional Office Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7-11, 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:)*

Jon A. Wooditch  
Acting Inspector General

## Introduction

### Regional Office Profile

**Organization.** The regional office provides C&P, vocational rehabilitation and employment (VR&E), and burial benefits to eligible veterans, dependents, and survivors residing in Wisconsin. Part-time veterans' services representatives (VSRs) are assigned to VA medical centers (VAMCs) in Madison, Milwaukee, and Tomah, WI. In addition, the regional office processes claims for VR&E benefits through out-based offices located in Eau Claire, Green Bay, Madison, and Waukesha, WI. The regional office is also associated with homeless veterans organizations located in Milwaukee, Tomah, and King, WI.

In December 2001, the regional office was chosen to be one of three locations for a Pension Maintenance Center (PMC), which is responsible for processing and adjusting pension cases.

VA's Loan Guaranty program for veterans residing in Wisconsin is administered by the Regional Loan Center located in St. Paul, MN. Education benefits are provided by the Regional Education Processing Center located in St. Louis, MO. The Central Area Human Resources Center located in Detroit, MI, provides human resources management support.

**Resources.** The regional office had a fiscal year (FY) 2004 operating budget of about \$18.5 million and a staffing level of 262 full-time equivalent employees.

**Workload.** The regional office serves a veteran population of about 478,000 in the state of Wisconsin. In FY 2004, the regional office authorized and paid about \$487 million in C&P benefits to 63,911 beneficiaries. During FY 2004, the regional office had about 1,360 participants in the VR&E program and provided fiduciary oversight for 1,667 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 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 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 2002, 2003, 2004, and 2005 through January 2005 and was performed in accordance with OIG standard operating procedures for CAP reviews. The review covered the following 12 activities:

Accounts Receivable	Hospital Adjustments
Automated Information Systems	Incarcerated Veterans
Security	Locked Files
Benefits Delivery Network Security	Retroactive Payments
Director's Performance Standards	System Messages
Fiduciary and Field Examinations	Vocational Rehabilitation and
Government Purchase Card Program	Employment

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3-7). For these activities, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are taken.

## Results of Review

### Opportunities for Improvement

#### **Hospital Adjustments – Processing Benefit Adjustments for Hospitalized Veterans Needed To Be Improved**

**Condition Needing Improvement.** Veterans Service Center (VSC) and PMC staff did not properly adjust 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 adjusting payments to veterans who were hospitalized at Government expense for extended periods resulted in both overpayments and underpayments. At our request VAMCs Milwaukee, Tomah, and Madison, WI, and Iron Mountain, MI provided data identifying 356 veterans who had been hospitalized for 90 days or more at Government expense as of February 1, 2005. The VA Austin Automation Center also provided a list identifying an additional 136 veterans who had been hospitalized for 90 days or more and had been discharged between October 1, 2002, and February 1, 2005.

We compared the lists to BDN master records and found that 105 (21 percent) of the 492 veterans' claims files needed to be reviewed during our onsite visit. Forty-seven (45 percent) of the 105 veterans were hospitalized or were in nursing homes at VA expense for more than 90 days and should have had their C&P awards adjusted by a total amount of \$373,590. Forty-three veterans received overpayments totaling \$367,239, and 4 veterans were underpaid a total of \$6,351.

Identifying Hospitalized Veterans. VSC and PMC staff did not consistently identify hospitalized veterans whose C&P awards required adjusting. Each month VSC staff are required to review 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 and PMC staff should promptly adjust veterans' C&P benefits where appropriate. VSC staff did not make the required hospital adjustments for 23 veterans receiving compensation benefits:

- Seven cases should have had adjustments totaling \$56,971. The claims files contained AMIE reports or other evidence of hospitalization, but VSC staff did not use them to make necessary adjustments. According to the Senior VSR, VSC staff took no action on these cases because they overlooked the notices of hospitalization or erroneously concluded that no action was necessary.



- Nine cases that required adjustments totaling \$82,963, did not include AMIE reports or other evidence of hospitalization in the claims files and were not adjusted. The Senior VSR attributed this to contract nursing homes not having the capability to update the AMIE reports system when veterans were under their care.
- Seven cases required adjustments totaling \$175,404, but were not adjusted for other reasons including hospitalizations not indicated on the AMIE reports, VSRs entering incorrect coding in rating data, and VSR staff not being notified when a discharged veteran was transferred to a nursing home.

There were also seven compensation overpayments that were outside VARO Milwaukee's jurisdiction. The regional office did not have national CAPRI<sup>1</sup> access, which prevented staff from accessing data for veterans whose files were located at other regional offices. VARO Detroit had jurisdiction for two cases with overpayments totaling \$9,450. VARO Fargo had jurisdiction for two cases with overpayments totaling \$7,826. VAROs Chicago, Des Moines, and Lincoln had jurisdiction for one case each with overpayments of \$6,572, \$3,354, and \$10,753, respectively. These cases should be referred to the appropriate regional offices to adjust the benefits.

The PMC did not make required hospital adjustments for 17 veterans receiving pension benefits:

- In 11 cases that required adjustments totaling \$9,271, claims files contained AMIE reports or other evidence of hospitalization that PMC staff did not use to make necessary adjustments. According to the Senior VSR, no action was taken on these files because notices of hospitalization were overlooked.
- Six cases that required adjustments totaling \$11,026, did not include AMIE reports or other evidence of hospitalization and were not adjusted. As with the nine compensation cases discussed above, the Senior VSR and the Assistant Veterans Service Manager stated the reasons for not having an AMIE report in the files included contract nursing homes not being able to update AMIE and the possibility that the medical centers were not always updating AMIE when veterans were hospitalized for more than 90 days.

**Recommended Improvement Action 1.** We recommended that the Area Director ensure that the Regional Office Director requires VSC and PMC staff to: (a) adjust C&P benefits for the 47 veterans identified by our review and initiate collection actions where necessary, (b) forward AMIE reports to the appropriate regional offices of jurisdiction, and (c) review AMIE reports and other evidence, such as hospital admission report, to identify hospitalized veterans whose C&P awards require adjustment.

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<sup>1</sup> CAPRI (Compensation and Pension Records Interchange) is an interface program for AMIE that provides online access to medical data and reduces the administrative burden of sharing demographic data between VBA and the Veterans Health Administration.

The Central Area and Regional Office Directors agreed with the findings and recommendations and reported that action has been taken to adjust the benefits of the 47 veterans identified and to recover overpayments. AMIE reports have been forwarded to the appropriate regional offices of jurisdiction. Refresher training on hospital adjustment procedures and the proper handling of hospital reports has been conducted. The PMC will track AMIE messages received from the regional offices, and a VSR on the correspondence and data input team will review all AMIE messages. The PMC will emphasize the need for the timely submission of AMIE reports to the regional offices. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

### **Incarcerated Veterans – Benefit Payments for Incarcerated Veterans Needed To Be Adjusted Timely**

**Condition Needing Improvement.** Regional office staff needed to improve the timeliness of benefit payment reviews and adjustments for incarcerated veterans. Federal law requires that VA reduce compensation payments to incarcerated veterans or beneficiaries effective the 61<sup>st</sup> day following a felony conviction and discontinue pension payments effective the 61<sup>st</sup> day following either a felony or a misdemeanor conviction. Local policy requires that compensation and pension benefits be reduced or terminated 97 days after an incarceration notice is received.

Based on Social Security Administration and Bureau of Prisons computer matches received by the regional office from July 2004 through December 2004, there were 277 incarcerated veterans or beneficiaries. From a judgment sample of 35 incarcerated veterans entitled to C&P benefits, there were 9 pension cases that were not processed timely. Because of the delay in processing these veterans' cases, five of the nine cases resulted in overpayments totaling \$17,858. For example:

- In one instance the regional office received notice on December 12, 2003, that a veteran receiving a pension had been incarcerated since May 23, 2003. His pension should have been terminated no later than March 18, 2004, 97 days after the date of notification. However, PMC staff did not terminate his payments until December 17, 2004, which resulted in an additional overpayment of \$5,768.
- In another instance the regional office received notice on August 5, 2004, that a veteran receiving pension benefits had been incarcerated since June 8, 2004. Pension payments should have been terminated by November 12, 2004. However, PMC staff did not terminate payments until December 27, 2004, which resulted in an additional overpayment of \$2,443.

According to the Assistant PMC Manager, a large workload affected the PMC's ability to ensure the timely processing of incarcerated veteran cases. She indicated that measures were being taken to ensure the expeditious handling of these cases in the future.

**Recommended Improvement Action 2.** We recommended that the Area Director ensure that the Regional Office Director requires PMC staff to timely process incarcerated veteran benefit adjustments.

The Central Area and Regional Office Directors agreed with the findings and recommendation and reported that the PMC has taken action to adjust the nine pension cases and recover the overpayments. Refresher training has been conducted, the PMC has established a tracking log for Bureau of Prisons match messages, and supervisors are monitoring timeliness. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

### **System Messages – Processing of Benefits Delivery Network System Messages Needed To Be Improved**

**Condition Needing Improvement.** BDN system messages were not processed timely, and veterans' awards were not properly adjusted. The BDN system generates various system and diary messages indicating that adjustments of veterans' benefits or corrections to BDN records are necessary. VBA policy requires regional offices to take initial action on system messages within 5 days of receipt. If no action is necessary, VBA policy requires system messages to be annotated, dated, and initialed.

We reviewed a judgment sample of 50 BDN system messages that were generated in October and November 2004 and discussed 25 questionable cases with the Assistant Chiefs of VSC and the PMC. PMC staff failed to properly or timely process system messages that resulted in two underpayments totaling \$14,512. PMC staff did not act on messages informing them that veterans whose pensions had been terminated may have been entitled to service-connected compensation.

**Recommended Improvement Action 3.** We recommended that the Area Director ensure that the Regional Office Director requires that: (a) PMC staff correct the pensions of the veterans who were underpaid and (b) PMC staff timely process BDN messages.

The Central Area and Regional Office Directors agreed with the findings and recommendations and reported that the three underpayments were adjusted and that PMC coaches were monitoring the timely processing of BDN messages. The implementation plans are acceptable, and we will follow up on planned actions until they are completed.

## **Central Area Director Comments**

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 5, 2005  
**From:** Central Area Director  
**Subject:** CAP Review of the VA Regional Office Milwaukee, WI  
**To:** Assistant Inspector General for Auditing (52)

We concur with the Milwaukee Regional Office's comments and corrective actions.

If you have any questions, please contact me at (918) 781-7900.

*(original signed by:)*

WILLIAM D. FILLMAN, JR.

## **Regional Office Director Comments**

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 1, 2005  
**From:** Regional Office Director  
**Subject:** CAP Review of the VA Regional Office Milwaukee, WI  
**To:** Director, Central Area

Enclosed is the Milwaukee Regional Office response to the Combined Assessment Program (CAP) Review Draft Report. I concur with the recommendations. Attached is our response concerning specific recommendations.

I appreciate the analysis and cooperation provided by the audit team. Their findings, along with our corrective actions, provides an opportunity to improve our operations.

Should you have any questions regarding our reply, please contact me at: 414-902-5001.

*(original signed by:)*

JON A. BAKER

## Regional Office Director Comments

### Regional Office Director 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:

**Recommended Improvement Action 1.** We recommend that the Area Director ensure that the Regional Office Director requires VSC and PMC staff to: (a) adjust C&P benefits for the 47 veterans identified by our review and initiate collection actions where necessary.

Concur **Target Completion Date:** 7/21/05

Appropriate action has been taken on the 47 veterans identified. Recovery of overpayments is in progress.

(b) forward AMIE reports to the appropriate regional offices of jurisdiction.

Concur **Target Completion Date:** Completed

AMIE reports have been forwarded to the appropriate regional offices of jurisdiction for the seven compensation overpayments that were outside VARO Milwaukee's jurisdiction.

and (c) review AMIE reports and other evidence, such as hospital admission reports, to identify hospitalized veterans whose C&P awards require adjustment.

Concur **Target Completion Date:** 7/21/05

Hospital adjustment refresher training has been conducted on the procedures for reducing C&P benefits for veterans hospitalized at government expense.

Refresher training has been conducted on the acquisition and referral of hospital reports.

## Regional Office Director Comments

The PMC has established a tracking system for AMIE messages received from the 11 regional offices under their jurisdiction to ensure we receive the required monthly AMIE reports from these stations.

A VSR in the Triage Team will review all AMIE messages.

The PMC will emphasize the need for timely submissions of AMIE reports at the Service Center Managers Conference scheduled for July 21, 2005.

**Recommended Improvement Action 2.** We recommend that the Central Area Director ensure that the Regional Office Director requires the PMC staff to timely process incarcerated veteran benefits adjustments.

Concur **Target Completion Date:** Completed

The Pension Maintenance Center has taken the necessary action to adjust the nine pension cases that should have been adjusted due to incarceration. Overpayment recovery is in progress.

Refresher training was conducted to ensure these cases are processed timely.

The PMC has established a tracking log for Bureau of Prisons match messages. Supervisors are monitoring timeliness on a weekly basis.

**Recommended Improvement Action 3.** We recommend that the Central Area Director ensure that the Regional Office Director requires that PMC staff timely process BDN messages and correct the pensions of veterans who were underpaid.

Concur **Target Completion Date:** Completed

The three cases involving underpayments were adjusted appropriately.

## **Regional Office Director Comments**

PMC coaches monitor timely processing of overpayment and underpayment BDN messages through weekly team pending workload reports.



**Appendix C**

## **Monetary Benefits in Accordance with IG Act Amendments**

<b><u>Recommendation</u></b>	<b><u>Explanation of Benefit(s)</u></b>	<b><u>Better Use of Funds</u></b>
1	Adjust benefit payments to veterans hospitalized at Government expense for extended periods.	\$373,590
2	Recoup payments made to incarcerated veterans where adjustments were not timely processed.	17,858
3	Correct underpayments resulting from system messages not properly or timely processed.	14,512
Total		\$405,960

**Appendix D**

**OIG Contact and Staff Acknowledgments**

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OIG Contact	Freddie Howell, Jr. (708) 202-2670
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Acknowledgments	John Brooks Larry Chinn Mark Collins Ken Dennis Mary Ann Fitzgerald Kevin Gibbons Ray Jurkiewicz Cynnde Nielsen Cherie Palmer Jennifer Roberts Bill Wells Ora Young
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