Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Boise, Idaho

Report No. 05-01816-184 **August 15, 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.

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Contents

Executive Summary

Introduction

During the period June 6–10, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office Boise, ID. The regional office is part of the Veterans Benefits Administration (VBA) Western Area. The purpose of the review was to evaluate selected regional office operations, focusing on benefits claims processing and financial and administrative controls. We also provided fraud and integrity awareness training to 42 regional office employees.

Results of Review

The CAP review covered 10 operational activities. The regional office complied with selected standards in six activities:

- Benefits Delivery Network (BDN) Security
- Convenience Checks
- Employee Claims Folder Security
- Government Purchase Card Program
- Payments to Incarcerated Veterans
- System Error Messages

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

- Promptly reduce benefit payments for veterans hospitalized at Government expense for extended periods.
- Strengthen controls over compensation and pension (C&P) benefits.
- Ensure that large retroactive payments are properly processed.
- Enhance physical security over automated information systems (AIS).

Western Area and Regional Office Directors Comments

The Western Area and Regional Office Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7–13, for the full text of the Directors' comments.) We will follow up on the implementation of recommended improvement actions. This report was prepared

under the direction of Ms. Claire McDonald, Director, and Ms. Myra Taylor, CAP Review Coordinator, Seattle Audit Operations Division.

(original signed by:)
JON A. WOODITCH
Acting Inspector General

Introduction

Regional Office Profile

Organization and Programs. The regional office provides C&P and burial benefits to eligible veterans, dependents, and survivors in Idaho. The estimated veteran population served by the regional office is 136,600. During fiscal year (FY) 2004, the regional office authorized approximately $158 million in C&P payments for 17,584 beneficiaries.

Resources. In FY 2004, regional office operating expenditures were about $3.2 million. As of September 2004, the regional office had 51 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 for benefits and requests for services are processed promptly and accurately. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. In performing the CAP review, we interviewed managers and employees, reviewed beneficiary files and financial and administrative records, and inspected work areas. The review covered the following 10 activities:

Automated Information Systems Security
Benefits Delivery Network Security
Compensation and Pension Benefits Death Match
Convenience Checks
Employee Claims Folder Security
Government Purchase Card Program
Hospital Adjustments
Large Retroactive Payment Controls
Payments to Incarcerated Veterans
System Error Messages

The review covered regional office operations for FY 2003, FY 2004, and FY 2005 through June 2005 and was done in accordance with OIG standard operating procedures for CAP reviews.

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3–6). 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 the activities not discussed in the Opportunities for Improvement section, we did not identify any reportable deficiencies.

Results of Review

Opportunities for Improvement

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

Condition Needing Improvement. Veterans Service Center (VSC) management needed to improve the processing of hospital adjustments. In certain situations, Federal law requires the reduction of C&P payments for veterans hospitalized at Government expense for extended periods. As of April 2005, there were 36 veterans under the jurisdiction of the regional office who had been hospitalized continuously for 90 days or more at community nursing homes under VA contract or at VA medical facilities in Boise, ID, Spokane, WA, and Salt Lake City, UT.

To determine if VSC staff had properly processed hospital adjustments, we reviewed BDN records, selected claims folders, VA medical facility admission records, and other relevant information for all 36 veterans. For 31 veterans, hospital adjustments had been properly made or no actions were required. However, overpayments totaling $66,441 had been made for the remaining five veterans. Overpayments to one veteran occurred because the Boise VA Medical Center did not notify the VSC that the veteran had been hospitalized. For the other four veterans, VSC staff did not take proper actions to reduce payments when they received notifications or they overlooked evidence, such as medical records, in the claims folders that indicated the veterans had been hospitalized. As of June 2005, VSC management was in the process of adjusting benefit payments for the five veterans we identified.

Recommendation 1. We recommended that the Western Area Director ensure that the Regional Office Director requires that (a) VSC management coordinates with appropriate Boise VA Medical Center staff to ensure that the VSC is notified when veterans are hospitalized and (b) VSC staff properly process adjustments upon notification that veterans are hospitalized and thoroughly review claims folder documents to prevent overpayments.

The Western Area and Regional Office Directors agreed and reported that in July 2005 bimonthly notifications of hospitalized veterans in their jurisdiction had been requested from the VA medical facilities. In addition, in June 2005 VSC staff received training that addressed hospital adjustments. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Compensation and Pension Benefits Death Match – Controls Should Be Strengthened

Conditions Needing Improvement. The regional office needed to pursue recovery of C&P benefit overpayments and obtain complete monthly death notification reports from the VA Hines Benefits Delivery Center (BDC). The BDC matches C&P master records to Social Security Administration (SSA) death records and reports possible veteran or spouse deaths to regional offices on a monthly basis. VSC staff are required to confirm if the identified individuals are dead and then suspend or terminate C&P benefit payments and pursue the recovery of any overpayments. If the VSC staff do not receive a BDC report for a particular month, they are required to contact the BDC.

To evaluate controls over selected C&P benefit payments, we reviewed BDN records and selected claims folders for 18 veterans or spouses who were listed on SSA death records as of March 2005. For 16 of the 18 veterans or spouses, the C&P benefit payments were appropriately suspended or terminated or no action was required because the veterans or spouses were still alive. However, we found problems with the remaining two cases.

- In January 2005 a fiduciary notified the VSC staff that a spouse who was receiving C&P benefit payments had died in June 2004. VSC staff appropriately suspended payments but did not pursue recovery of the $8,488 the regional office had overpaid. As a result of our review, VSC staff began the process of recovering the overpayment.

- During our review, we identified a veteran who reportedly died in January 2005. We estimated that $840 in overpayments could be recovered. VSC staff responsible for tracking the monthly BDC reports believed that the BDC had not reported the veteran's death. However, the VSC staff could not confirm this because they did not have all of the pages of the BDC monthly reports following the veteran's death. VSC staff acknowledged that they did not routinely follow up with the BDC when they did not receive a monthly report or were missing pages.

Recommendation 2. We recommended that the Western Area Director ensure that the Regional Office Director requires that VSC staff (a) promptly pursue recovery of C&P benefit overpayments and (b) follow up with the BDC when monthly BDC reports are not received or are incomplete.

The Western Area and Regional Office Directors agreed and reported that in June 2005 VSC supervisors reminded staff of proper procedures in pursuing recovery of overpayments. In addition, the VSC Manager emphasized to staff to follow up on BDC reports that are not received or are incomplete. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Large Retroactive Payment Controls – Procedures Should Be Improved

Conditions Needing Improvement. Regional office controls for retroactive C&P benefit payments of $25,000 or more needed to be improved. VBA policy requires that the VSC Manager or supervisory designee perform a third-signature review after VSC staff, including a supervisor or a coach, authorize payments of $25,000 or more. We reviewed a judgment sample of 50 retroactive payments with a combined value of $2.5 million. We selected the payments from the BDN Target Payment History File for FY 2003, FY 2004, and FY 2005 through December 2004. All 50 payments were valid and had received the appropriate third-signature reviews. However, the following deficiencies should be addressed.

Supervisory Reviews Not Performed. For retroactive payments of $25,000 or more involving incompetent beneficiaries, the supervisor of the Fiduciary and Field Examination (F&FE) activity is required to review the awards before payments are authorized. Of the 50 payments we reviewed, 4 required this F&FE supervisory review. However, none had been reviewed. According to the VSC Manager, although VSC staff had received training, they had not submitted the four awards to the F&FE supervisor for review before authorizing payment.

Payment to Spouse Before Fiduciary Appointment. Before issuing any retroactive payment to the spouse of an incompetent veteran, VBA requires that the spouse be officially appointed as the fiduciary, custodian, or guardian. In January 2004 a retroactive payment of $68,581 was issued to a spouse who had not been appointed as the incompetent veteran's fiduciary until April 2004.

Recommendation 3. We recommended that the Western Area Director ensure that the Regional Office Director requires that (a) VSC staff receive refresher training on the requirement to submit retroactive payments of $25,000 or more involving incompetent beneficiaries to the F&FE supervisor for review and (b) any retroactive payments for incompetent veterans be issued only to appointed fiduciaries, custodians, or guardians.

The Western Area and Regional Office Directors agreed and reported that in June 2005 VSC staff had received training that addressed F&FE supervisory reviews, and the F&FE supervisor will ensure that retroactive payments for incompetent veterans are released only to appointed fiduciaries. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Automated Information Systems Security – Physical Security Should Be Enhanced

Conditions Needing Improvement. Regional office management needed to strengthen controls over AIS security. Critical data was regularly backed up and properly stored offsite, annual computer security awareness training was provided, and alternate processing sites had been established as required. However, we identified three issues that needed corrective action.

Water Detector Not Installed. The computer room did not have a water detector. VBA policy requires a water detector to provide early warning of water leaks under the raised flooring.

Computer Room Windows Not Protected. The computer room, which is located on a ground-level floor, had two large glass windows that did not have the required wire mesh to prevent forcible entry.

Computer Room Not Secured. Three walls in the computer room were not floor-to-ceiling. Because the ceiling consisted of easily removable tiles, unauthorized entry into the computer room would be possible from an adjoining room or hallway through the unsecured ceiling. VA policy requires that a barrier be installed to prevent up-and-over access to rooms that should be secured.

Recommendation 4. We recommended that the Western Area Director ensure that the Regional Office Director requires that computer room physical security be upgraded by installing a water detector, windows with wire mesh, and a barrier to prevent up-and-over access into the room.

The Western Area and Regional Office Directors agreed and reported that by September 30, 2005, a water detector and a mesh barrier will be installed in the computer room. In addition, by August 31, 2005, windows with wire mesh will be installed in the computer room. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Appendix A

Western Area Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2005

From: Director, Western Area Office

Subject: Response – Combined Assessment Program Review of the VA Regional Office Boise, Idaho

To: Audit Manager, Seattle Audit Operations Division

Enclosed is the response to the Combined Assessment Program Review of the VA Regional Office Boise Idaho.

I would like to thank the Office of the Inspector General for the time and attention they have given to the Boise Regional Office CAP Review. I have reviewed the recommendations contained in the Boise Regional Office's plan, which is attached, and I concur with the Boise Director's actions and assessments.

If you have any questions or concerns, please feel free to contact me at 602-627-2746.

Sincerely,

(original signed by:)

Diana M. Rubens

Appendix B

Regional Office Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2005

From: Director, VA Regional Office Boise (00/347)

Subject: CAP Review Report

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

1. Attached is the response to the OIG CAP Site Review.

2. I appreciate the genuine courtesy and spirit of cooperativeness displayed by you and all members of the IG Team throughout this review process.

(original signed by:)

Jim Vance

Attachment

VARO BOISE (347)

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

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

Recommendation 1. We recommend that the Western Area Director ensure that the Regional Office Director requires that (a) VSC management coordinates with appropriate Boise VA Medical Center staff to ensure that the VSC is notified when veterans are hospitalized and (b) VSC staff properly process adjustments upon notification that veterans are hospitalized and thoroughly review claims folder documents to prevent overpayments.

Concur with recommended improvement actions

a. VSC management coordinates with appropriate Boise VA Medical Center staff:

Planned Action: We have started conducting bimonthly validations that all required benefit reductions have been made. We will request a listing of hospitalized veterans from VAMCs to be provided on a bimonthly basis. We should then be able to identify any/all cases that may not have been handled appropriately for whatever reasons, and rectify such situations. We have instituted these steps to ensure that we receive from the VAMCs in our area (Boise, Salt Lake City, Walla Walla and Spokane) admission information essential to supplement what the regional office had already been routinely relying upon from CAPRI/AMIE; i.e. notices of placement of veterans on VA contract for admissions straight from the community to a community nursing home (as opposed to discharge there on a contract from a VAMC admission), and notices of transfer of veterans from VAMC hospital care to a VA nursing home care unit.

We understand that VBA's C&P Service is revising hospital admission/benefit reduction procedures, and that they plan to

have a detailed directive out to regional offices in the near future. We notified them of our discovery that not all VAMC nursing home care unit authorizations nor all community contract nursing home care authorizations are electronically entered into the CAPRI/AMIE system, and hence the information is not available to ROs via the systems upon which most offices rely. We look forward to the possibility of improved, streamlined procedures for all offices.

b. VSC staff properly process adjustments upon notification that veterans are hospitalized and thoroughly review claims folder documents to prevent overpayments:

Planned Action: We conducted training with all Veterans Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) immediately upon learning of the IG auditor's findings concerning the need to be conscious of the possibility of first learning of a nursing home placement or an extended hospitalization within the body of a VAMC treatment or examination report.

2. Compensation and Pension Benefits Death Match – Controls Should Be Strengthened

Recommendation 2. We recommend that the Western Area Director ensure that the Regional Office Director requires that VSC staff (a) promptly pursue recovery of C&P benefit overpayments and (b) follow up with the BDC when monthly BDC reports are not received or are incomplete.

Concur with recommended improvement actions

a. Promptly pursue recovery of C&P benefit overpayments:

Planned Action: Although the one suspended case that had never been finalized appears to have been an isolated oversight, VSC supervisors have reminded all VSRs of the need to control all suspended cases, for ultimate termination and debt recovery procedures.

b. Follow up with the BDC when monthly BDC reports are not received or are incomplete:

Planned Action: The Veterans Service Center Manager (VSCM) has discussed with the VSR and Supervisor responsible for the C&P/SSA Death Records Match, the need to follow up with Hines if monthly reports or portions of same are not received.

3. Large Retroactive Payment Controls – Procedures Should Be Improved

Recommendation 3. We recommend that the Western Area Director ensure that the Regional Office Director requires that (a) VSC staff receive refresher training on the requirement to submit retroactive payments of $25,000 or more involving incompetent beneficiaries to the F&FE supervisor for review and (b) any retroactive payments for incompetent veterans be issued only to appointed fiduciaries, custodians, or guardians.

Concur with recommended improvement actions

a. VSC staff receive refresher training on the requirement to submit retroactive payments of $25,000 or more involving incompetent beneficiaries to the F&FE supervisor for review:

Planned Action: During the IG visit, VSC staff involved in the second and third signature process received refresher training on the mandate in M21-1, Part V, 9.01 b. requiring the signature of the F&FE supervisor on payments to guardians. All involved are now aware of this provision and will insure its implementation.

b. Any retroactive payments for incompetent veterans be issued only to appointed fiduciaries, custodians, or guardians:

Planned Action: As a result of the training mentioned in "a" above, the F&FE supervisor will be able to review all payments, and will ensure that payments will only be issued to appointed fiduciaries, custodians, or guardians. We find noteworthy the fact that all 50 large retroactive payments reviewed were timely, valid, had the required third signature reviews, and were released to the appropriate payees, including the spouse payee awarded under 38 CFR 3.850 (a)

(2) who was ultimately affirmed as custodian by the F&FE Unit.

We hope that those in the C&P Service responsible for the large payment verification program, would send a message to all station "RETRO" e-mailboxes informing Directors of the requirement for the F&FE coach to review and sign off on all greater $25,000 payments to fiduciaries. That would add a final review of the F&FE signature to the Director's evaluation of the payment.

4. Automated Information Systems Security – Physical Security Should Be Enhanced

Recommendation 4. We recommend that the Western Area Director ensure that the Regional Office Director requires that computer room physical security be upgraded by installing a water detector, windows with wire mesh, and a barrier to prevent up-and-over access into the room.

Concur with recommended improvement actions.

Planned Action:

Water Detector: We anticipate the replacement of the existing building security system by September 30, 2005. The new system will include a water detector under the computer room.

Computer Room Windows: The landlord of our building and Homeland Security are currently working on having the computer room windows which open to the outdoors protected as required. The anticipated date of completion is August 31, 2005.

Up-And-Over Access: The regional office's computer room walls run from the floor slab only up to the ceiling tiles and not all the way to the ceiling slab. The space from the ceiling tiles up to the ceiling slab is open air circulation plenum, and any walls running up to the ceiling slab would block air circulation. As a result, it would be possible for an intruder to climb over the wall and enter the computer room. We have requested that the building's landlord install a mesh barrier from the top of the computer room walls up to the ceiling

slab. That will prevent intruder access without blocking air circulation. Installation will be complete by September 30, 2005.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
1	Reduce payments for certain veterans who were hospitalized at Government expense for extended periods.	$66,441
2	Pursue recovery of C&P overpayments.	9,328
	Total	$75,769

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Claire McDonald (206) 220-6654
Acknowledgments	Myra Taylor Walter Stucky Gary Abe Randall Alley Theresa Kwiecinski Tom Phillips Orlando Velásquez Cristina Andreozzi

Appendix E

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