



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the VA Regional Office Waco, Texas

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 November 14–18, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Regional Office Waco, TX. The purpose of the review was to evaluate selected regional office operations, focusing on benefits claims processing and financial and administrative controls. The regional office is under the jurisdiction of the Veterans Benefits Administration's (VBA's) Central Area. During the review, we also provided fraud and integrity awareness training to 314 employees.

Results of Review

The CAP review focused on eight operational activities. The regional office complied with selected standards in four activities.

- Government Purchase Card Program
- Information Technology (IT) Security
- Large Retroactive Payment Controls
- Security of Sensitive Records

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

- Properly reduce compensation and pension (C&P) payments for veterans who are hospitalized for extended periods of time at Government expense.
- Strengthen monitoring of Vocational Rehabilitation and Employment (VR&E) program participants' progress.
- Ensure that Fiduciary and Field Examination (F&FE) personnel follow up on overdue accountings in accordance with VBA policy.
- Properly process notifications of veterans' incarceration.

This report was prepared under the direction of Mr. Michael Guier, Director, and Mr. Jehri Lawson, CAP Review Coordinator, Dallas Audit Operations Division.

Area and 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 8–12, for the full text of the Directors’ comments.) We will follow up on the implementation of planned improvement actions.

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

Introduction

Facility Profile

Organization. The regional office provides C&P, VR&E, and burial benefits to eligible veterans, dependents, and beneficiaries residing in 164 counties in Texas. The regional office serves a veteran population of about 928,000. Within the regional office's jurisdiction, approximately 158,000 veterans and survivors are receiving C&P benefits, and about 6,000 veterans are receiving VR&E services.

Resources. The regional office's general operating expenditures were about \$33.8 million in fiscal year (FY) 2005. As of September 30, 2005, the regional office had 454 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 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.

The review covered selected aspects of the following activities:

| | |
|----------------------------------|------------------------------------|
| C&P Hospitalization Adjustments | Large Retroactive Payment Controls |
| F&FE Activities | Payments for Incarcerated Veterans |
| Government Purchase Card Program | Security of Sensitive Records |
| IT Security | VR&E Program |

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 facility operations for FYs 2004 and 2005 and FY 2006 through

November 17, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews.

We also presented four fraud and integrity awareness training sessions. A total of 314 employees attended the training, which covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

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.

Follow-Up on Prior CAP Review Recommendations

As part of our review, we followed up on three recommendations resulting from the prior CAP review of the regional office (*Combined Assessment Program Review of the VA Regional Office Waco, Texas*, Report No. 02-00970-122, June 21, 2002). We found that regional office managers had effectively addressed two of the previous recommendations, but the regional office continued to need improvement in the area of C&P hospitalization adjustments.

Results of Review

Opportunities for Improvement

Compensation and Pension Hospitalization Adjustments – Payments to Hospitalized Veterans Needed To Be Reduced

Condition Needing Improvement. Veterans Service Center (VSC) and Pension Maintenance Center (PMC) personnel did not properly reduce C&P payments to veterans hospitalized for extended periods of time at Government expense. In certain situations, Federal law requires 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 a period exceeding 1 full calendar month.

At our request, 6 VA health care facilities that serve veterans residing in Texas identified 699 veterans who had been continuously hospitalized at Government expense for 90 days or more as of September 30, 2005. We compared the information provided by these health care facilities with the C&P records for the 699 veterans and identified 18 veterans whose records were located at the regional office and whose C&P payments had not been properly reduced. These veterans had been overpaid a total of \$157,326 while hospitalized at Government expense. The overpayments occurred for the following reasons:

- In seven cases, overpayments totaling \$29,845 occurred because VA health care facilities did not notify the regional office when the veterans were hospitalized.
- In nine cases, overpayments totaling \$112,345 occurred because VSC personnel did not take appropriate actions to reduce benefits after receiving notifications of the veterans' hospitalizations from VA health care facilities.
- In two cases, overpayments totaling \$15,136 occurred because PMC personnel did not take appropriate actions to reduce benefits after receiving notifications of the veterans' hospitalizations from the regional office.

VSC personnel agreed that the C&P payments should have been reduced and initiated actions to adjust the payments.

Recommendation 1. We recommended the Central Area Director ensure that the Regional Office Director takes action to: (a) reduce C&P payments as appropriate for the 18 veterans we identified who were hospitalized for extended periods at Government expense, (b) coordinate with appropriate VA health care facilities to ensure VSC personnel are properly notified when veterans are hospitalized, and (c) provide

appropriate VSC personnel refresher training concerning required reductions of C&P payments to hospitalized veterans.

The Central Area and Regional Office Directors agreed with the finding and recommendations and reported that payments for the 18 veterans have been adjusted as appropriate. They provided the results of our review to Veterans Integrated Service Network (VISN) personnel, who oversee VA health care facilities, and they agreed to continue training VSC personnel concerning required reductions of C&P payments to hospitalized veterans. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

Vocational Rehabilitation and Employment Program – Case Management Needed Improvement

Condition Needing Improvement. VR&E case managers needed to strengthen monitoring of program participants' progress. The VR&E program provides services and assistance enabling eligible veterans to obtain and maintain suitable employment. Veterans participating in the program are assigned case managers, who monitor their progress and assist them through the different phases of the program. 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. When veterans complete their training programs and obtain gainful employment, case managers classify them as rehabilitated. Veterans who temporarily stop their programs but plan to restart in the near future are placed in interrupted status, while veterans who leave the VR&E program without being classified as rehabilitated are placed in discontinued status.

To evaluate VR&E case management, we reviewed the Counseling, Evaluation, and Rehabilitation folders and IT system records of 20 veterans selected from the "Inventory – Chapter 31 Veterans in Open Case Status" report as of August 31, 2005. Of the 20 veterans selected, 5 were in applicant status, 5 in evaluation and planning status, 5 in rehabilitation to the point of employability status, and 5 in interrupted status. We found that case managers did not adequately monitor the progress of 12 (60 percent) of the 20 veterans—3 in evaluation and planning status, 5 in rehabilitation to the point of employability status, and 4 in interrupted status. In all 12 cases, there were periods exceeding 1 year during which the case managers did not document any contacts with the veterans. For example, one veteran was counseled and placed in evaluation and planning status on February 12, 2004. The case manager did not document further attempts to contact the veteran until April 16, 2005, when a letter was sent scheduling an appointment. Another veteran was placed in interrupted status on September 28, 2002. Documentation in the veteran's records showed the case manager sent the veteran a letter on April 2, 2004, but the veteran did not respond and no other contacts were documented until August 2005.

VR&E personnel attributed the case management deficiencies we identified to turnover of case managers and their heavy workload. Case managers should maintain frequent contact with program participants to ensure that the veterans' needs are being met and to help overcome any obstacles to accomplishment of the veterans' objectives.

Recommendation 2. We recommended the Central Area Director ensure that the Regional Office Director takes action to strengthen monitoring of VR&E program participants' progress.

The Central Area and Regional Office Directors agreed with the finding and recommendation. They reported that five new employees have been added to the VR&E staff since January 2006, and the new employees are being trained in proper case management and follow-up procedures. They noted that their efforts have resulted in improved timeliness for veterans in evaluation and planning status and interrupted status, and the numbers of veterans in those phases of the rehabilitation process have been reduced. The improvement plans are acceptable, and we will follow up on completion of planned actions until they are completed.

Fiduciary and Field Examination Activities – Follow-Up on Overdue Accountings Needed Improvement

Condition Needing Improvement. F&FE personnel needed to follow up more aggressively when fiduciaries did not provide timely accountings. F&FE personnel are responsible for protecting the interests of incompetent or minor beneficiaries by appointing fiduciaries when necessary to manage the beneficiaries' funds and by monitoring the fiduciaries' activities. One method of monitoring fiduciaries' activities is to require the fiduciaries to submit annual accountings of beneficiaries' assets, income, and expenses. When an accounting is not received timely, VBA policy requires F&FE personnel to send a follow-up letter within 35–65 days after the due date. If the accounting is not received within 90 days after the due date, a second follow-up contact is required. If the accounting is not received within 120 days and there is no valid excuse for the delay, F&FE personnel are instructed to refer the issue to a VA field examiner, the OIG, or the VA Regional Counsel.

We reviewed the Principal Guardianship Folders for 11 beneficiaries whose fiduciaries were required to submit annual accountings. Fiduciaries for four of the beneficiaries had not submitted timely accountings, and F&FE personnel had not properly followed up in three of the four cases. For example, the fiduciary for one beneficiary was required to submit an accounting by November 30, 2003. F&FE personnel received the accounting 465 days after the due date on March 9, 2005. At the time of our review in November 2005, F&FE personnel had not yet received the accounting due from the same fiduciary on November 30, 2004. There was no documentation of follow-up on either of

the overdue accountings in this case. Inadequate follow-up on overdue accountings increases the risk that the funds of incompetent beneficiaries will be misused.

Recommendation 3. We recommended the Central Area Director ensure that the Regional Office Director takes action to follow up on overdue accountings in accordance with VBA policy.

The Central Area and Regional Office Directors agreed with the finding and recommendation. They stated that follow-up actions have been initiated for all overdue accountings, and the overdue accountings will be resolved by June 1, 2006. The improvement plans are acceptable, and we will follow up on completion of planned actions until they are completed.

Payments for Incarcerated Veterans – Benefit Payments Needed To Be Adjusted

Condition Needing Improvement. VSC personnel needed to improve the processing of notifications of veterans' incarceration. Federal law requires adjustments to C&P benefits for veterans incarcerated in Federal, State, or local penal institutions for periods exceeding 60 days. Generally, disability compensation payments must be reduced to the 10 percent rate when a veteran is convicted of a felony, and disability pension payments must be terminated when a veteran is convicted of either a felony or a misdemeanor.

To help identify incarcerated veterans, VA has database matching agreements with the Bureau of Prisons and the Social Security Administration. VBA sends each regional office monthly listings of inmates who may be receiving VA benefits. VBA policy requires VSC personnel to review these listings and to reduce veterans' compensation payments when necessary. If incarcerated veterans are receiving pension benefits, VSC personnel are required to notify the appropriate PMC, which is responsible for terminating pension payments.

During the 6-month period ending September 30, 2005, the regional office received inmate listings that included 615 names. To determine whether VSC personnel took appropriate actions upon receipt of these listings, we reviewed the actions taken regarding 24 of the inmates. VSC personnel took appropriate actions in 22 (92 percent) of the 24 cases. However, VSC personnel did not properly reduce the compensation benefits of one incarcerated veteran, who was overpaid \$368. Also, they did not notify the PMC of the incarceration of a pension recipient, who was overpaid \$4,512. These deficiencies occurred because VSC personnel overlooked the evidence of incarceration or were not familiar with applicable requirements.

Recommendation 4. We recommended the Central Area Director ensure that the Regional Office Director takes action to (a) correct the two specific deficiencies

identified in our review and (b) provide appropriate VSC personnel refresher training concerning required adjustments of C&P payments to incarcerated veterans.

The Central Area and Regional Office Directors agreed with the finding and recommendations. They reported that the two specific deficiencies identified in our review have been corrected and agreed to provide periodic refresher training concerning adjustments of C&P payments to incarcerated veterans. The improvement plans are acceptable, and we will follow up on completion of planned actions until they are completed.

Central Area Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 5, 2006
From: Central Area Director
Subject: VA Regional Office Waco, Texas
To: Director, Dallas Audit Operations Division

The Director, Central Area Office concurs in the Waco Regional Office Director's response to the Combined Assessment Program (CAP) Review Draft Report of the Waco Regional Office.

(original signed by:)

William D. Fillman, Jr.

Regional Office Director Comments



DEPARTMENT OF VETERANS AFFAIRS

Regional Office
One Veterans Plaza
701 Clay Avenue
Waco, Texas 76799

May 4, 2006

In Reply Refer To: 349/00

• Director, Dallas Audit Operations Division
VA Office of Inspector General
1420 W. Mockingbird Lane, Suite 550, Room 404
Dallas, Texas 75247

SUBJ: Combined Assessment Program Review

On November 14-18, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Department of Veterans Affairs Regional Office (VARO) in Waco, Texas. The review was conducted in a business-like manner, and each member of the CAP team was very professional and helpful throughout their review and analysis of our office. We believe the assistance they provided during their visit will facilitate improvements in our operations.

Our Responses To Recommendations

The Waco Regional Office responses to the OIG Recommendations are enclosed.

Who Do You Contact If You Have Any Questions?

Please contact Vicky Wilcoxon, Assistant Director, at (254) 299-9012, if you have any questions.

(original signed by:)
CARL E. LOWE II, Director
Waco VA Regional Office (349)

Enclosure

Director 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's report:

OIG Recommendations

Recommendation 1. We recommend the Central Area Director ensure that the Regional Office Director takes action to: (a) reduce C&P payments as appropriate for the 18 veterans we identified who were hospitalized for extended periods at Government expense, (b) coordinate with appropriate VA health care facilities to ensure VSC personnel are properly notified when veterans are hospitalized, and (c) provide appropriate VSC personnel refresher training concerning required reductions of C&P payments to hospitalized veterans.

Concur

Target Completion Date: 4/15/06

- a. We have made the appropriate adjustments on all 18 cases.
- b. The VISN has been provided with a copy of this report.
- c. As pointed out by your statistics, we are doing an outstanding job in this area. 699 records were reviewed and out of the 18 cases not adjusted, 11 were the fault of the regional office. This means the regional office's actual error rate was only 1.5%. We believe our outstanding performance in this area is the result of on-going training on hospital adjustments. We will continue to conduct training in this area to insure our performance does not deteriorate.

Recommendation 2. We recommend the Central Area Director ensure that the Regional Office Director takes action to strengthen monitoring of VR&E program participants' progress.

Concur

Target Completion Date: 09/30/07

We concur that there are cases that need better monitoring, but are compelled to note that the sample used was not random or reflective of our case work overall. With the acquisition of five new employees since January, we have been training them in proper case management and follow up procedures and using the older cases in the process. Our objective is to contact and re-engage the veterans in the rehabilitation process, when possible. For those veterans not interested in or not in need of further services, appropriate action is then taken to ensure each veteran is provided due process before closing the case. Our success is being reflected in an improvement in the average timeliness for cases in Evaluation and Planning and Interrupted Status, as well as, in a reduction in the number of the cases in each status. With our continued concerted efforts to improve services in these areas, our goal is to have the cases corrected by 09/30/07, or sooner.

Recommendation 3. We recommend the Central Area Director ensure that the Regional Office Director takes action to follow up on overdue accountings in accordance with VBA policy.

Concur

Target Completion Date: 6/01/06

The F&FE section continues to excell in processing accountings and ensuring there are a minimal amount of accountings overdue. According to FBS, Waco has 3,711 active claimants and of these there are only 17 overdue accountings. In addition to controlling and processing accountings with great success, Waco has brokered in 75 accountings from the Portland Regional Office and 25 from the Houston Regional Office. The 17 accountings overdue for Waco have follow-up actions pending, including special assignments and field exams if appropriate, and will be resolved by the target completion date.

Recommendation 4. We recommend the Central Area Director ensure that the Regional Office Director takes action to (a) correct the two specific deficiencies identified in our review and (b) provide appropriate VSC personnel refresher training concerning required adjustments of C&P payments to incarcerated veterans.

Concur

Target Completion Date: 3/06/06

- a. The two cases identified in your report have been corrected.
- b. We believe that our accuracy rate of 92% in this area is very good. We conduct refresher training on this topic at least once a year. To maintain our performance in this area, we will continue to conduct refresher training periodically.

Monetary Benefits in Accordance with IG Act Amendments

| <u>Recommendation</u> | <u>Explanation of Benefit(s)</u> | <u>Better Use of Funds</u> |
|-----------------------|--|--------------------------------|
| 1a | C&P payments for hospitalized veterans needed to be reduced. | \$157,326 |
| 4a | C&P payments for incarcerated veterans needed to be reduced or terminated. | 4,880 |
| | Total | \$162,206 |

OIG Contact and Staff Acknowledgments

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|-------------|------------------------------|
| OIG Contact | Michael Guier (214) 253-3301 |
|-------------|------------------------------|

| | |
|-----------------|-------------------|
| Acknowledgments | William Bailey |
| | Jacki G. Billings |
| | Clenes Duhon |
| | Glen Gowans |
| | Heather Jones |
| | Jehri Lawson |
| | Joel Snyderman |
| | Sally Stevens |

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