VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Manila, Philippines

March 1, 2012
12-00156-110

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
FVEC	Filipino Veterans Equity Compensation
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Manila, Philippines

Why We Did This Review

The Veterans Benefits Administration (VBA) has 57 VA Regional Offices (VAROs) that process disability claims and provide a range of services to veterans. We conducted this inspection to evaluate how well the Manila VARO accomplishes this mission.

What We Found

The Manila VARO administers benefits to veterans and their survivors residing in the Philippines and is the only office located in a foreign country. Additionally, the Manila VARO is collocated with the Manila VA Outpatient Clinic creating a unique relationship between VARO staff and VA physicians. The interaction between staff and physicians increases their understanding of both the rating decision and VA examination processes. As a result, the station's rating decision accuracy and examination timeliness has improved.

Manila VARO staff accurately processed traumatic brain injury and Filipino Veterans Equity Compensation claims and provided adequate homeless outreach. Further, VARO performance was generally effective in processing herbicide exposure-related claims and in following VBA policy for correcting errors identified by Systematic Technical Accuracy Review program staff.

The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule or establish controls for medical reexaminations. Overall, VARO staff did not correctly process 10 (38 percent) of the 26 disability claims we sampled during our inspection. These results do not represent the accuracy of overall disability claims processing at this VARO.

VARO management did not ensure staff properly completed Systematic Analyses of Operations or accurately processed mail. Further, processing of competency determinations was not fully effective, resulting in unnecessary delays in making final decisions and improper benefits payments.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure oversight and control of search mail, as well as completion of Systematic Analyses of Operations. Further, VARO management needs to implement controls to ensure staff properly process competency determinations.

Agency Comments

The VARO Director concurred with our recommendations. Management's planned actions are responsive and we will follow up as required on all actions.

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high quality benefits and services.
- Determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In November 2011, the OIG conducted an inspection of the Manila VARO. The inspection focused on five protocol areas examining nine operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. We did not examine claims involving Gulf War veterans' entitlement to medical care and treatment for mental disorders because the VARO did not complete any such claims from July through September 2011. Additionally, we did not examine homeless veterans' claims as none were pending at the time of our inspection.

We reviewed 12 (80 percent) of 15 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from July through September 2011. In addition, we reviewed 14 (82 percent) of 17 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

Appendix A provides details on the VARO and the scope of the inspection. Appendix B provides the VARO Director's comments on a draft of this report. Appendix C provides criteria we used to evaluate each operational activity and a summary of our inspection results.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 The Manila VARO Could Improve Disability Claims Processing Accuracy

The Manila VARO lacked controls and accuracy in processing claims for temporary 100 percent disabilities. VARO staff incorrectly processed 10 (38 percent) of the 26 disability claims we sampled and improperly overpaid a total of $195,528 in benefits payments. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. As reported by Veterans Benefits Administration's (VBAs) Systematic Technical Accuracy Review (STAR) program as of October 2011, the overall accuracy of the Manila VARO's compensation rating–related decisions was 89.7 percent—2.3 percent below the 92 percent VBA target.

The following table reflects the inaccuracies affecting, and those with the potential to affect, veterans' benefits processed at the Manila VARO.

Table: Manila VARO Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	14	8	4	4
Traumatic Brain Injury Claims	3	0	0	0
Herbicide Exposure-Related Claims	9	2	2	0
Total	**26**	**10**	**6**	**4**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 8 (57 percent) of 14 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change veterans' payment amounts, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Available medical evidence showed that four of the eight processing inaccuracies affected veterans' benefits—three involved overpayments totaling $177,152 and one involved an underpayment totaling $13,936. Details on the most significant overpayment and underpayment follow:

- VARO staff did not schedule a follow-up medical examination to evaluate a veteran's prostate cancer. VA medical treatment records showed the veteran's cancer was in remission, warranting no more than a 40 percent disability evaluation as of October 2007. As a result, VA overpaid the veteran $102,232 over a period of 3 years and 8 months.
- A Rating Veterans Service Representative (RVSR) did not grant entitlement to an additional special monthly benefit based on evaluations of multiple disabilities, as required by VBA policy. As a result, VA underpaid the veteran $13,936 over a period of 3 years and 8 months.

The remaining four inaccuracies had the potential to affect veterans' benefits. We could not determine if these temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. Following are descriptions of these inaccuracies.

- In three cases, VSC staff did not schedule medical reexaminations needed to determine whether the temporary 100 percent disability evaluations should continue. An average of 1 year and 3 months elapsed from the time staff should have scheduled the medical reexaminations until the date of our inspection. The delays ranged from 10 months to 2 years.
- In one case, an RVSR correctly annotated the need for a medical reexamination needed to determine whether a temporary 100 percent

disability evaluation should continue. However, no control was in place to ensure the electronic system would generate a reminder notification for the required February 2012 medical reexamination.

Five of the eight inaccuracies resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. Four of these inaccuracies involved confirmed and continued rating decisions. In November 2009, VBA provided guidance to the VAROs about the need to enter suspense diaries in the electronic record as reminders to schedule reexaminations for confirmed and continued rating decisions. However, VARO management had no oversight procedure in place to ensure VSC staff established suspense diaries as required. As a result, the temporary 100 percent disability evaluations could have continued uninterrupted over the lifetime of these veterans.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. In September 2011, VBA provided each VARO with a list of temporary 100 percent disability evaluations for review. VBA directed each VARO to complete this review by the end of March 2012. As such, we made no specific recommendation for this VARO. To assist in implementing the agreed upon review, we provided the VARO with 3 claims from our universe of 17 temporary 100 percent disability evaluations that were off station at the time of our review.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff correctly processed all three TBI claims. The Manila VARO has a unique relationship with the collocated VA Outpatient Clinic that, according to the Assistant Director, has resulted in increasing both the VARO's overall claims processing accuracy and its exam timeliness. The VARO developed and implemented Rater-Physician Interaction exercises with a goal of increasing the understanding of the VA examination process from both the rater and physician perspectives. RVSRs and physicians meet to discuss accuracy and timeliness of VA examinations, RVSRs observe physicians conducting VA examinations, and physicians train on the requirements for completing disability decisions. As the VARO accurately processed all TBI claims we reviewed, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed two (22 percent) of nine herbicide exposure-related claims we reviewed. Both of these processing inaccuracies affected veterans' benefits—one involved an overpayment and one involved an underpayment. Details on the overpayment and the underpayment follow.

- An RVSR correctly granted service connection for ischemic heart disease associated with herbicide exposure; however, the effective date of August 31, 2010, for the 100 percent evaluation was incorrect. The actual date of entitlement was April 11, 2011—the date medical evidence warranted the 100 percent evaluation. As a result, VA overpaid the veteran $18,376 over a period of 8 months.
- An RVSR incorrectly evaluated ischemic heart disease as 30 percent disabling. Medical evidence showed this condition warranted a 100 percent disability evaluation. As a result, VA underpaid the veteran $6,891 over a period of 4 months.

We determined the two herbicide exposure-related claims processing issues were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

2. Management Controls

Systematic Technical Accuracy Review

We assessed whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VAROs take corrective action on errors identified by STAR.

Manila VARO staff did not correct 1 (5 percent) of 22 errors identified by STAR program staff from April through June 2011. Because VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 2 Oversight Needed to Ensure Complete SAOs

For the 12 required SAOs, management used adequate data to support their analyses. However, 5 (42 percent) of the 12 SAOs were incomplete (missing required elements). The VSC Manager is responsible for completing the 12 annual SAOs as part of the ongoing analysis of VSC operations. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, management did not adequately address existing and potential problems for corrective action to improve VSC operations.

Prior to our raising these issues during our inspection, the VSC Manager was not aware of all requirements for completing SAOs. Further, the VSC Manager stated that staff did not always reference VBA policy when completing SAOs. The last time the VARO conducted training on SAOs was in March 2009.

Recommendation

1. We recommend the Manila VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations and address all required elements.

Management Comments

The VARO Director concurred with our recommendation. The Director stated that on February 16, 2012, management provided training on the required elements of an SAO and provided a copy of the policy for use as a guide. To add another layer of oversight, a management analyst will review each SAO before submission to ensure it addresses all required elements.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

3. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Manila VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined mailroom staff were following VBA policy and made no recommendation for improvement in this area.

Triage Mail-Management Procedures

We assessed the VSC's Triage Team mail-management procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload

management. It also states that effective mail management is crucial to the control of workflow within the VSC.

Search and Drop Mail

VBA policy requires that VARO staff use the Control of Veterans Records System (COVERS), an electronic tracking system, to manage claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no processing action upon receipt. We reviewed 30 pieces of drop mail and found no inaccuracies.

Finding 3 Oversight Needed To Ensure Proper Control and Processing of Search Mail

Triage Team staff did not properly control 7 (23 percent) of 30 pieces of search mail reviewed. The most significant inaccuracy occurred when the VARO received a request from a veteran's widow for death benefits on April 22, 2008. VARO staff did not properly control this piece of mail through COVERS as required. By the time of our inspection in November 2011, the VARO had established the claim in the electronic system, but with an incorrect date of May 23, 2011. If not for our review, the widow may have received inaccurate benefits.

Inaccuracies related to search mail occurred because VARO guidance did not include provisions for supervisory oversight of the search mail holding areas. VSC management stated they do not consistently review the search mail holding areas to ensure compliance with search mail management procedures. Additionally, the Quality of Files Activities SAO was incomplete because it did not provide a timeframe for implementation of a recommendation it included for weekly supervisory review of search mail. If management had implemented this recommendation, management may have identified search mail not properly controlled in COVERS. Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims. As a result, VSC staff may not have all available evidence to make decisions, and beneficiaries may not receive accurate and timely benefits payments.

Recommendation

2. We recommend the Manila VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

Management Comments

The VARO Director concurred with our recommendation. The Director stated management implemented a weekly search mail audit to ensure staff properly control mail in COVERS and associate it with the appropriate claims folders. VSC updated the workload management plan to include the weekly audit requirement.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

4. Eligibility Determinations

Filipino Veterans Equity Compensation

Filipino veterans or their surviving spouses are eligible to receive a one-time payment through the Filipino Veterans Equity Compensation Fund (FVEC) for qualifying military service. Payments for Filipino veterans consist of $9,000 for non-United States citizens and $15,000 for those with United States citizenship. The Manila VARO is solely responsible for processing FVEC claims.

VARO staff correctly processed all 30 completed FVEC claims we reviewed. Additionally, we found no inaccuracies or excessive delays during our review of 30 pending FVEC claims. Therefore, we made no recommendation for improvement in this area.

Competency Determinations

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at the VARO to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is capable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 60-day due process period to submit evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine whether the beneficiary is competent. Effective July 2011, VBA defines "immediate" as 21 days.

Finding 4 Controls Over Competency Determinations Inadequate

As measured against VBA's definition of immediate, VARO staff unnecessarily delayed making final decisions in 3 (16 percent) of 19 competency determinations completed from July through September 2011. The delays ranged from 17 to 73 days, with an average completion time of 39 days. Delays occurred because the workload management plan did not contain oversight procedures emphasizing immediate completion of competency determinations. The VARO developed a new workload management plan in November 2011, requiring that competency determinations be finalized within 21 days from the expiration of the due

process period. However, the majority of VSC management and staff were not aware of the new standard. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

The most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final incompetency decision for a veteran for approximately one month. During this period, the veteran received approximately $1,300 in disability payments. While the veteran was entitled to this payment, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

Further, VSC staff incorrectly processed 10 (53 percent) of 19 competency determinations we reviewed. According to VBA policy, VARO staff should pay all current monthly benefits for existing disabilities, but should not release any retroactive benefits for these disabilities until making final competency determinations. In the most egregious case, staff incorrectly released two retroactive payments totaling $50,092 due to the veteran for the periods February 4, 2009 through October 31, 2010, and February 2, 2011 through April 30, 2011, before finalization of the competency determination. These inaccuracies occurred because staff received incorrect training on processing these types of payments. Staff stated that contrary to VBA policy, training instructions were to release retroactive payments prior to the appointment of a fiduciary. Further, training conducted on June 22, 2011, did not address proper processing of retroactive payments.

Recommendation

3. We recommend the Manila VA Regional Office Director develop and implement controls to ensure staff follow the workload management plan as well as implement training on Veterans Benefits Administration policy regarding processing of competency determinations.

Management Comments

The VARO Director concurred with our recommendation. The Director stated management provided training on January 6, 2012, on proper processing of final competency determinations. Additional training the following month addressed timeliness standards and other guidelines for processing the determinations. To ensure timely action within 21 days, a Management Analyst will identify each case with a due process expiration date beyond 14 days.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

5. Public Contact

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept

service. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence. VBA provided guidance to all VAROs that claims submitted by homeless veterans should receive priority processing.

Expedited Claims Processing for Homeless Veterans

At the time of our inspection, VBA determined its national performance measure for processing homeless veterans' claims based on the average days the claims were pending. VBA's national target was for the claims to be pending no more than an average of 75 days. By the time of our inspection in November 2011, the Manila VARO had no pending homeless veterans' claims.

Outreach to Homeless Shelters and Service Providers

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the coordinators at the remaining 37 VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The Manila VARO has a part-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator provided adequate homeless veterans outreach and contact with those who assist homeless veterans as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The VA office has been in operation in the Philippines since the opening of the U.S. Veterans Bureau in 1922, except for the period of Japanese occupation during WWII. It is an integral part of the United States Mission to the Republic of the Philippines and is the only VARO located in a foreign country. The Director of the Manila VARO serves as the United States Attaché for the Veterans Affairs in the Philippines. In addition to being responsible for administering medical and non-medical benefits for VA, the Director administers the U.S. Social Security Administration program for the East Asia Pacific region. The Manila VARO administers a variety of services and benefits including compensation and pension benefits; vocational rehabilitation and employment assistance; benefits counseling; fiduciary services; Filipino Veterans Equity Compensation; and outreach services.

Resources

As of September 2011, the Manila VARO had a staffing level of 219 full-time employees. Of this total, the VSC had 79 employees (36 percent) assigned.

Workload

As of October 2011, the VARO reported 3,278 pending compensation claims. The average time to complete claims was 94.4 days—135.6 days less than the national target of 230 days.

Scope

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding benefits delivery and nonmedical services provided to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 12 (80 percent) of 15 disability claims related to TBI and herbicide exposure that the VARO completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 14 (82 percent) of 17 existing claims from VBA's Corporate Database. We provided the VARO management with 3 claims remaining from our universe of 17 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability evaluations for at least 18 months as of November 2, 2011.

We reviewed the 12 mandatory SAOs completed in fiscal years 2010 and 2011. We reviewed 22 errors identified by VBA's STAR program during April through June 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for

increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims. Our process differs from STAR as we review specific types of disability claims related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the VSC. We reviewed 19 competency determinations and 30 FVEC claims completed from July through September 2011. We also reviewed 30 FVEC claims that were pending at the time of our inspection. Further, we assessed the adequacy of the VARO's homeless veterans outreach program.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: February 16, 2012

From: Director, VA Regional Office Manila, Philippines (358/00)

Subj: Inspection of the VA Regional Office Manila, Philippines

To: Assistant Inspector General for Audits and Evaluations (52)

1. Enclosed are the Manila, Philippines VA Regional Office's (RO) comments and responses to the OIG Draft Report, Inspection of the VA Regional Office, Manila, Philippines, received February 10, 2012. The RO concurs with the findings and recommendations regarding RO activities requiring improvement, which include oversight needed to ensure complete Systematic Analyses of Operations, oversight needed to ensure proper control and processing of search mail, and improved controls over competency determinations. Attached are our comments and responses to the specific recommendations and action items that arose as a result of the review.

2. We appreciate the professionalism and courtesy exhibited by the audit team members during their review of our operations, as well as the analysis they provided. This analysis and the corresponding recommendations for improvement are invaluable in our continued efforts to provide the best possible service to our Veterans.

3. Please feel free to contact me at (011) (632) 550-3974 with any questions or concerns regarding our reply.

(original signed by:)

Jon Skelly
Director

Attachment

Manila, Philippines VA Regional Office
Response to the Office of Inspector General, Benefits Inspection Division, Inspection of the VA Regional Office Draft Report

Comments and Implementation Plan

OIG Recommendations

Recommendation 1. We recommend the Manila VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations (SAO) and address all required elements.

Concur with recommendation.

Planned/Completed Action:

The Veterans Service Center employees assigned to write an SAO, received the necessary training from the Assistant Veterans Service Center Manager to address all required elements of an SAO on February 16, 2012. Each employee assigned to write an SAO was also provided a copy of the M21-4 to be used as a guide. To add another layer of oversight, the Management Analyst will review each SAO before submission to ensure all elements have been addressed.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2. We recommend the Manila VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

Concur with recommendation.

Planned/Completed Action:

The Veterans Service Center has implemented a weekly search mail audit to be conducted by the Triage Team, effective the week of February 13, 2012. The Triage coach will be responsible for controlling and monitoring the search mail bin to ensure the mail is properly controlled in COVERS and associated with the appropriate files when found. The requirement of a weekly search mail audit has been added to the Workload Management Plan.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendations 3. We recommend the Manila VA Regional Office Director develop and implement controls to ensure staff follow the workload management plan as well as implement training on Veterans Benefits Administration policy regarding processing of competency determinations

Concur with recommendation.

Planned/Completed Action:

The Veterans Service Center provided training on January 6, 2012 to appropriate staff on not releasing funds for retroactive payments until a final competency determination has been completed. On February 16, 2012, training was provided to staff on Fast letter 11-20, *Timeliness Standards for Final Competency Determination*, Fast Letter 11-17, *Processing Claims Releasing Retroactive Benefits to Beneficiaries under Fiduciary Supervision*, and Fast Letter 09-41, *Revised Procedures for Releasing Monthly Benefits with Proposal of Incompetency*. Coaches are responsible for identifying expirations of due process for incompetency decisions on a weekly basis, and ensuring completion within 21 days, as noted in the Workload Management Plan. Additionally, the Management Analyst will be responsible for identifying cases with due process expiration beyond 14 days to ensure timely action will be taken before the 21 days has lapsed.

The Veterans Benefits Administration recommends closure of this recommendation

Appendix C Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all residual disabilities related to in-service TBI.** (FL 08-34 and 08-36, Training Letter 09-01)	X	
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.** (38 CFR 3.309) (FL 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Management Controls			
4. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Workload Management			
6. Mail-Handling Procedures	**Determine whether VARO staff properly followed VBA mail-handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
7. Filipino Veterans Equity Compensation	**Determine whether VARO staff properly processed claims for Filipino Veterans Equity Compensation.** (FL 09-17) (M21-1MR Part III, Subpart iii, Chapter 2, Section E.34) (M21-1 MR Part III, Subpart vi, Chapter 4, Section B.4)	X	
8. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments.** (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X
Public Contact			
9. VBA's Homeless Veterans Program	**Determine whether VARO staff expeditiously processed homeless veterans' claims and provided effective outreach services.** (Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III Subpart iii, Chapter 2, Section I) (VBA Circular 20-91-9) (VBA Letter 20-02-34) (Compensation & Pension Service Bulletins August 2009, January 2010, April 2010, May 2010)	X	

Source: VA OIG
CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Re-write

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Dawn Provost, Director Bridget Bertino Orlan Braman Brett Byrd Madeline Cantu Kelly Crawford Lee Giesbrecht Rachel Stroup Dana Sullivan Mark Ward

Appendix E Report Distribution

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