VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Department of Veterans Affairs

Review of Second Instance of Employee Manipulation at the Houston VA Regional Office

June 15, 2015
15-02354-220

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration

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EXECUTIVE SUMMARY

On December 13, 2014, the Office of Inspector General (OIG) received an allegation from Veterans Benefits Administration (VBA) senior leadership in VA Central Office that a Houston VA Regional Office (VARO) employee inappropriately removed veteran benefit claims controls from their electronic record. VBA uses electronic system controls to identify types of claims, and manage and measure its pending and completed workloads. Generally, such controls should remain in place until all required actions are completed on claims, including providing notices of benefits decisions to the claimants. Similarly, the OIG received, and confirmed, an allegation of data manipulation at the Houston VARO several months earlier by another employee. However, the periods of each employee's alleged data manipulations did not overlap.

We substantiated the most recent allegation that the employee inappropriately cancelled and cleared controls in the electronic record used to track and identify benefits claims without taking proper actions to complete the claims. VBA's internal review team determined the employee incorrectly cancelled and cleared system controls in 81 (89 percent) of 91 claims pending in Fiscal Year (FY) 2013. The VBA team's review was limited to FY 2013 as a specific inventory goal was in place that year, and as the employee's number of cases cancelled in FY 2014 was determined to be significantly lower. We sampled 32 of the 81 (40 percent) cases and determined the internal review team accurately identified cases that were not completed properly. VBA's review also determined that the data manipulation of claims in FY 2013 was limited to the employee's actions cited in the allegation. The employee conceded the actions were inappropriate, and stated the actions were the result of attempts to improve the appearance of the pending claim inventory for the employee's team. Furthermore, the employee stated he had no knowledge of any other employees manipulating data. To address the issue of the employee's data manipulation, VBA leadership initiated administrative action, to include removal of the employee's system access.

These inappropriate actions misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may never have received decisions on their claims if the VARO's internal review team had not discovered the improper actions by the employee. However, as VBA completed over 1.1 million claims in FY 2013, and the Houston VARO completed over 38,200 in FY 2013, the 81 cases determined to be incorrectly cancelled and cleared by the employee does not materially impair VBA's data integrity associated with its reported pending workload of claims nationwide.

Our review did not find any instances in which veterans' benefits were rerouted to the employee as a result of the data manipulation. However, our review did identify that the employee received a performance bonus based upon the inappropriate actions. When interviewed by OIG officials though, the employee agreed to repay the bonus monies received in FY 2013. The inappropriate actions described in this report undermine program effectiveness.

Therefore, we recommended the Houston VARO Director take immediate action to correct, as appropriate, all actions the employee took to cancel and clear controls so that veterans claims are accurate moving forward. We also recommended the Director confer with VA Regional Counsel

to determine the appropriate administrative action to take, if any, against this employee. Finally, we recommended the Director submit the remaining and previously unavailable claims the employee cancelled in FY 2013 to OIG for our review.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

RESULTS AND RECOMMENDATIONS

Allegation

Did a Houston VARO employee inappropriately remove claims processing controls?

On December 13, 2014, the Office of Inspector General received an allegation from Veterans Benefits Administration (VBA) senior leadership in VA Central Office that a Houston VA Regional Office (VARO) employee inappropriately removed system controls for benefits claims in FY 2013 without taking proper actions on the claims. Five months earlier OIG had substantiated a similar allegation regarding a different employee at the Houston VARO. However, the periods of each employee's alleged data manipulation did not overlap.

Background

A Houston VARO employee notified VARO leadership that another employee had cleared a system control for a claim without taking action to complete the claim. VBA uses electronic system controls to identify types of claims, and manage and measure its pending and completed workloads. Generally, such controls should remain in place until all required actions are completed on claims, including providing notices of benefits decisions to the claimants. In addition, VBA uses these controls to identify pending claims that require action. Inappropriately removing these controls misrepresents the VARO's claims inventory and timeliness measures, and impairs the VARO's ability to monitor and manage its workload.

Prior to contacting VA OIG, VBA leadership tasked an internal team to review the allegation. The VBA team evaluated the employee's actions and found that in FY 2013, the employee cancelled and cleared controls for 104 claims. The VBA team was only able to review 91 of the 104 claims (88 percent), as 13 cases were not available to be fully reviewed. For example, some of the 13 cases were at an offsite facility to be scanned for VBA's paperless claims initiative. It was determined by the VBA team that the employee cited in the allegation incorrectly cancelled or cleared controls in 81 of the 91 cases reviewed (89 percent). Furthermore, the team reviewed the actions taken by other employees during FY 2013 to determine if they were inappropriately removing system controls on other veteran benefit claims. The VBA team reviewed 427 actions, found 49 errors (11 percent), and concluded the errors to be human errors that did not follow the same inappropriate fact pattern as the employee cited in the allegation. The VBA team's review was limited to FY 2013 because a specific inventory goal was in place that year, and as the employee's number of cases cancelled in FY 2014 was determined to be significantly lower.

Because of the inappropriate actions discovered, the Houston VARO leadership initiated certain administrative actions against the employee cited

in the allegation. The administrative actions included placing the employee on administrative leave, removal of the employee's system access, and referral of the allegation to the Office of Inspector General.

What We Did

We conducted a site visit at the Houston VARO in January 2015 to assess the merits of the allegation. We obtained and analyzed the results of VBA's review of what had occurred. We sampled 32 out of 81 (40 percent) instances where VBA found the employee took inappropriate actions to cancel or clear controls for benefits claims to confirm whether the actions were appropriate. Also, we reviewed each case to determine whether fraudulent payments resulted from the employee's inappropriate actions. Further, we interviewed the employee who was the subject of the allegation, as well as other VARO leadership.

What We Found

Five months following the confirmation of data manipulation by an employee at the Houston VARO, we found another Houston VARO employee inappropriately cancelled and cleared controls used to track and identify benefits claims without taking proper actions. We sampled 32 of the 81 cases (40 percent) the VBA team had identified and reviewed where this employee cancelled or cleared controls for claims. We determined that in all 32 cases, the VBA team accurately identified whether corrective action was needed and established new controls where required. If the VBA team had not identified the cases needing corrective actions, the claimants may never have received decisions on their claims. Our review did not find any instances in which veterans' benefits were rerouted to the employee as a result of the data manipulation. However, our review did identify that the employee received a performance bonus based upon the inappropriate actions. The inappropriate actions described in this report undermine program effectiveness and impair the data integrity of the VARO's reported pending workload.

We interviewed the employee involved in the allegation who acknowledged the actions of cancelling and clearing controls were done to improve the appearance of the claims inventory for the employee's team. The employee stated pressure to meet goals might have led to overly aggressive actions that deviated from proper procedures. Further, the employee stated VARO management had not provided directions to take the inappropriate actions, nor did the employee instruct other staff to take similar actions. Additionally, the employee was not aware of any other management or staff manipulating data, and cited having no knowledge regarding the previous employee who was also found to be manipulating data at the Houston VARO. Finally, the employee agreed to repay bonus money that was received for performance measures met in FY 2013, valued at $2,648.

Interviews with other staff members at the Houston VARO, did not reveal any indication of data manipulation beyond the actions the one employee took and cited in the current allegation. Other staff members additionally

stated they were not aware of any data manipulation by staff at the Houston VARO, other than the employee cited in a recent allegation.

Conclusion

Based on our interviews and examination of a total 32 actions, we substantiated the allegation that the employee inappropriately cancelled and cleared system controls for benefits claims. These actions had the adverse impact of misrepresenting the VARO's claims inventory and timeliness measures, while impairing the VARO's ability to monitor and manage its workload. Further, some veterans may never have received decisions on their claims if VBA's internal review team had not identified the inappropriate actions. However, as VBA completed over 1.1 million claims in FY 2013, and the Houston VARO completed over 38,200 claims in FY 2013, the 81 cases determined to be incorrectly cancelled and cleared by the employee did not materially impair VBA's data integrity associated with its reported pending workload of claims nationwide. We briefed VARO management on the results of this review on January 21, 2015. Given the nature and seriousness of the employee's errors, the VARO needs to take immediate action to fully review and correct, all actions this employee took to inappropriately cancel or clear controls for claims.

Recommendations

1. We recommended the Houston VA Regional Office Director take immediate action to fully review and correct, as appropriate, all actions the employee took to clear or cancel controls for claims.
2. We recommended the Houston VA Regional Office Director confer with Regional Counsel to determine the appropriate administrative action to take, if any, against this employee.
3. We recommended the Houston VA Regional Office Director implement a plan to routinely monitor system controls for pending claims, to prevent further manipulation attempts and ensure staff do not prematurely change or remove controls.
4. We recommended the Houston VA Regional Office Director submit the 13 remaining and previously unavailable claims the employee cancelled in FY 2013 to OIG for review.

Management Comments

The VARO Director concurred with our recommendations and immediately assigned a supervisor to review all 104 inappropriately cancelled or completed claims. The supervisor found 25 claims that required corrective action. The employee that took the inappropriate actions resigned from Federal Service on February 7, 2015. The Director implemented a plan to conduct monthly monitoring of claims cleared or canceled by staff. Findings from the monthly monitoring are presented to the Veterans Service Center Manager and any inappropriate actions found are investigated. Finally, the

Director notified the OIG that the previously unavailable claims inappropriately cancelled by the employee were available for review.

OIG Response The Director's comments and actions are responsive to the recommendations. We will follow up as necessary during a future inspection of the Houston VARO.

Data Integrity

The VBA internal review team provided OIG their methodology for obtaining the computer-processed data showing the cancelled and cleared actions the Houston VARO employee in the allegation took in FY 2013. We then obtained the data from VBA to address the allegation. To test the reliability of this data, we compared information to data contained in claims folders. Our comparison did not disclose any problems with the reliability of the data overall.

Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix A Management Comments

Department of Veterans Affairs

Memorandum

Date: May 8, 2015

From: Director, VA Regional Office, Houston, Texas

Subj: Review of Additional Data Manipulation at the VA Regional Office, Houston, Texas

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

1. The Houston VARO provides the following response to the OIG investigation and report regarding *Additional Data Manipulation at the Houston VA Regional Office.*

2. Please refer questions to James Hedge, Assistant Director, at 713-383-1720.

(original signed by:)
Marlan Waldrop
Director

Attachment

The Houston VARO provides the following response to the OIG investigation and report regarding Additional Data Manipulation at the Houston VARO.

Recommendation 1: We recommend the Houston VA Regional Office Director take immediate action to fully review and correct, as appropriate, all actions the employee took to clear or cancel controls for claims.

RO Response: The Houston VARO Director immediately assigned a Supervisor to review 104 inappropriately cancelled/completed claims. Of the 104 claims, 25 were found in need of corrective action. The remaining 79 claims had corrective action taken previously. Of the 25 that needed a corrective action, all but three (3) have been completed. Those three (3) are pending an exam or results from an exam before final action can be taken. The three (3) remaining cases will be closely monitored until completion.

Status: We request closure based upon the information provided above.

Recommendation 2: We recommend the Houston VA Regional Office Director confer with Regional Counsel to determine the appropriate administrative action to take, if any, against the employee.

RO Response: The employee resigned from Federal Service on February 7, 2015.

Status: We request closure based upon the information provided above.

Recommendation 3: We recommend the Houston VA Regional Office Director implement a plan to routinely monitor system controls for pending claims, to prevent further manipulation attempts and ensure staff do not prematurely change or remove controls.

RO Response: Houston VARO Director implemented a Pending Issue Clear (PCLR) and Pending Issue Cancel (PCAN) analysis to be conducted monthly by the Management Analyst in the Veterans Service Center. A random sample of PCLR and PCAN actions for the month are selected for review. The findings are provided to the Veterans Service Center Manager and the VARO Director each month. Any inappropriate PCLR or PCAN actions found are investigated to determine if human error or a systemic problem can be identified. Any identified claims are placed under control and corrective action is taken.

Status: We request closure based upon the information provided above.

Recommendation 4: We recommend the Houston VA Regional Office Director submit the 13 remaining and previously unavailable claims the employee cancelled in FY 2013 to OIG for review.

RO Response: On March 24, 2015, the office of OIG was notified that 12 of the remaining 13 files were available for review via VBMS and the last remaining file was still being researched for review. The file was later identified as being included in the initial list and had been reviewed. All files have been reviewed and corrective action has been taken.

Status: We request closure based upon the information provided above.

Appendix B 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	Brent Arronte, Director Brett Byrd Dana Sullivan

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