DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

Boston, Massachusetts, VA Regional Office Supervisor Incorrectly Processed Work Items

REVIEW | REPORT #19-07350-192 | SEPTEMBER 19, 2019

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted this review to determine whether a supervisor at the Boston, Massachusetts, VA Regional Office (VARO) incorrectly processed system-generated messages that affected, or may have affected, recipients' benefits. These messages are called "work items." Work items are a type of internal control the Veterans Benefits Administration (VBA) uses to track cases that may require follow-up action for benefit payments to continue. For example, if VA receives information that a veteran receiving benefits may have died, a work item will be generated to notify employees to verify the death and stop the payments.

A work item should be cancelled if it requires no action. For example, a work item should be cancelled if it noted a beneficiary was deceased, but the benefits had already been stopped. A work item should be cleared from the electronic record if additional action was needed and taken. For example, if a work item was issued noting a beneficiary *may* be deceased and benefits were still being paid, employees should confirm that information and clear the work item once that action is undertaken. If employees do not process work items correctly, benefit payments may be made in error.

While conducting research for a potential review concerning deaths of VA beneficiaries, the OIG team identified a trend showing a Boston VARO supervisor appeared to have been incorrectly cancelling work items in the electronic system since at least 2012. The OIG team further determined the supervisor was responsible for 50 percent of the nation's cancelled work items for potential death notices from the electronic system during fiscal year 2018. Therefore, the OIG initiated this review of the supervisor's actions.

What the Review Found

The OIG determined the supervisor incorrectly processed work items and related actions. This finding was based on a review of 110 cases that the supervisor processed from October 1, 2017, to February 6, 2019. The supervisor incorrectly cancelled 33 of 55 work items and improperly cleared nine of 55 work items and related processing actions from the electronic record because he did not reduce or increase beneficiaries' benefit payments or confirm whether recurrent benefit payments were still appropriate.

Because of these incorrectly processed cases, VBA made about $117,300 in improper payments to veterans or other beneficiaries. About $112,900 were overpayments (of which approximately $32,800 was eventually recovered). There were approximately $4,300 in underpayments to VA beneficiaries.[1] Veterans or other beneficiaries also experienced about $8,600 in delayed

[1] Due to rounding, numbers presented throughout this report may not add up precisely to the totals.

payments because of the supervisor's actions. For example, the supervisor cancelled a work item showing a veteran had a payment returned as undelivered. Instead of reprocessing and releasing a new payment, the supervisor cancelled the work item from the system and took no further action. In addition, because the supervisor did not request necessary information to determine whether benefits were still warranted, veterans also potentially received compensation for benefits for which they were no longer eligible, such as payments for dependents whose status was not verified.

The supervisor stated that he did not intentionally process the work items incorrectly, and the errors were the result of working too quickly and misunderstanding procedures. VBA's oversight processes did not detect the supervisor's incorrect processing because work items and claims processed by supervisors were not subject to national or local quality reviews. Local quality review staff did not evaluate the quality of supervisors' work because performance standards focused on management duties and not claims processing.

What the OIG Recommended

The OIG recommended that the Boston VARO director immediately review and correct all cases that the supervisor incorrectly processed that are likely to result in adjustments to recipients' benefits. The director should also confer with regional counsel to determine the appropriate administrative action to take, if any. The OIG further recommended the director implement a plan to ensure internal controls for assessing the quality of supervisors' work on processed claims.

Management Comments

The Boston VARO director concurred with Recommendations 1–3 and provided acceptable action plans for all recommendations. The OIG will monitor the Boston VARO's progress and follow up on implementation of the recommendations until all proposed actions are completed.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

FY	fiscal year
OIG	Office of Inspector General
VARO	Veterans Affairs regional office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Introduction

While conducting research to determine whether Veterans Benefits Administration (VBA) staff were addressing ongoing VA payments for deceased beneficiaries, the VA Office of Inspector General (OIG) team determined that a supervisor at the Boston, Massachusetts, VA Regional Office (VARO) appeared to be incorrectly cancelling work items related to staff notifications of possible beneficiaries' deaths. The initial review of the work items indicated the supervisor cancelled them without taking appropriate actions, such as confirming the beneficiaries' deaths, terminating payments, or establishing other controls.

An expanded review of the supervisor's work revealed he had been incorrectly cancelling potential death notices since at least 2012. During fiscal year (FY) 2018, the supervisor cancelled 299 potential death notices at the Boston VARO, out of the 596 notices cancelled nationwide. The average number of these potential death notices that were cancelled at other VAROs in FY 2018 was less than seven. Therefore, as the Boston VARO supervisor was responsible for 50 percent of the nation's cancelled work items for potential death notices, and more than 40 times as much as the average of the other VAROs, the OIG team focused its review on his actions.

The OIG conducted this review to determine to what extent the supervisor at the Boston VARO incorrectly processed work items and a related end product that affected, or may have affected, recipients' benefits.

General Claims Process for Work Items

Work items are system-generated messages designed to assist Veterans Service Centers in identifying and tracking cases that require follow-up actions. These include the following:

- Verifying deaths of beneficiaries determined to be deceased by the Social Security Administration
- Reducing payments for veterans receiving benefits for dependents who failed to provide information regarding the status of the dependents
- Determining why returned payments were not delivered to beneficiaries
- Locating beneficiaries' social security numbers that are not on record
- Confirming veterans in receipt of unemployment benefits due to service-connected conditions have not been gainfully employed

If no action is required on a work item, it is cancelled. For instance, a cancellation would be warranted if a work item was generated noting a beneficiary may be deceased, but the benefits were already terminated. If additional action is required on a work item, it is to be cleared once

the required action is taken. For instance, if a work item was generated noting a beneficiary may be deceased and benefits were continuing, the death should be confirmed, and the work item cleared once appropriate action is completed. VBA policy notes that work items affecting payments require prompt attention and Veterans Service Center (VSC) staff must consistently prioritize work items that could result in an underpayment, overpayment, or potential financial hardship.[2]

General Claims Process for "Authorization Review End Products"

The end product system is the primary workload monitoring and management tool for staff within the VSC. Correct use of the end product system facilitates proper control of pending workloads and appropriate work measurement credit. If it is discovered that no work measurement credit is warranted for the end product during claims processing, the end product should be cancelled, not cleared. Per VBA policy, correct work measurement is essential to substantiate proper staffing requirements and determine productive capacity.[3] An "authorization review end product" is a control used to ensure actions are taken such as social security verification, compensation cost-of-living allowance adjustments, status of veterans' dependents, and continued eligibility for unemployability benefits.

[2] M21-1, Adjudication Procedures Manual, part III, subpart v, chapter 10, section A, topic 2, "Prioritizing 800 Series Work Item."

[3] M21-4, Manual, appendix B, topic 1, "End Products – General Principles."

Results and Recommendations

Finding: A Boston VARO Supervisor Incorrectly Processed Work Items, Resulting in Improper Payments

A supervisor at the Boston VARO processed work items and a related end product, used to ensure actions are taken such as social security verification, compensation cost-of-living allowance adjustments, status of veterans' dependents, and continued eligibility for unemployability benefits (referred to collectively in this report as work items), without taking required actions. Required actions included confirming whether recurrent benefits were still warranted for beneficiaries. VBA uses work items to track cases that may require follow-up action for benefit payments to continue.

The OIG team reviewed a stratified random sample of 110 specific work items that a supervisor at the Boston VARO processed from October 1, 2017, to February 6, 2019 (the review period).[4] The supervisor cancelled 33 of 55 work items without taking needed actions. In addition, nine of 55 work items were processed as though actions had been taken by the supervisor, when they had not. Before processing these cases, payments to the beneficiaries should have been reduced or increased, or required information requested.

As a result, during the review period, VBA processed nearly $117,300 in improper payments to veterans or other beneficiaries. About $112,900 were overpayments (of which approximately $32,800 was eventually recovered). There were approximately $4,300 in underpayments to VA beneficiaries.[5] In addition, veterans or other beneficiaries experienced more than $8,600 in delayed payments. Veterans also potentially received compensation for benefits they may no longer be eligible for, such as payments for being unemployable and payments for their dependents. The supervisor informed the OIG team that he did not intentionally process the work items incorrectly, and the errors were the result of working too quickly. In addition, the supervisor demonstrated a misunderstanding of work item procedures. VBA's oversight processes did not detect the supervisor's incorrect processing because work items and processes completed by supervisors were not subject to national or local quality reviews. Local quality review staff did not evaluate the accuracy of supervisors' work, as performance standards for supervisors mainly focus on assessing management duties and not claims processing.

What the OIG Did

The OIG team created a statistical stratified sample from more than 2,000 specific work items processed by the Boston VARO supervisor during the review period. The team selected a sample

[4] See Appendix A for list of specified work items.

[5] Due to rounding, numbers presented throughout this report may not add up precisely to the totals.

of 110 work items and determined whether they were processed correctly. The team also interviewed VBA managers, as well as managers and staff at the Boston VARO. Appendix A provides additional details on OIG team actions and methodology.

This report discusses the following issues that support the OIG's finding:

- The supervisor incorrectly processed work items.
- The supervisor demonstrated errors occurred due to his misunderstanding of the process.
- VBA lacked effective oversight of cancelled work items and claims processed by supervisors.

Work Items Were Incorrectly Processed by a Supervisor

The OIG team obtained data for cases the Boston supervisor cancelled from October 1, 2017, to February 6, 2019. The data showed the supervisor cancelled nearly 2,900 cases during that time. Further analysis of the data revealed the supervisor was often cancelling several of these cases within seconds of each other, and he cancelled as many as 139 in one day. Therefore, it appeared unlikely the supervisor did a thorough review of these cases prior to cancelling them.

The OIG team conducted a detailed review of 110 specific work items of the approximately 2,000 processed by the supervisor during the review period.[6] If VBA claims processors are not required to act on work items, they should cancel the items. However, if claims processors are required to act on work items, such as requesting evidence to show benefits are still warranted, then they should clear the work items after acting on them.

The team determined the supervisor made 42 errors consisting of incorrectly cancelling 33 of 55 work items and incorrectly clearing nine of 55 work items. VBA management officials concurred with all errors identified by the review.

The work items that were incorrectly processed by the Boston supervisor led, or potentially led, to overpayments and underpayments to veterans and other beneficiaries. The term "potentially led" is used to indicate that insufficient action was taken to acquire the information that would have provided VBA with assurance that payments were made in the proper amount.

Additionally, veterans or other beneficiaries experienced delayed payments. Table 1 summarizes the number and effect of the types of errors.

[6] See Appendix A for list of specific work items reviewed.

Table 1. Number of Errors by Effect

Effect of errors	Number of errors
Potential improper payments	25
Actual improper payments (under- or overpayment)	10
Delayed payments	7
Total	**42**

Source: VA OIG analysis of statistically sampled work items completed during the review period

Improper Payments with Potential Under- or Overpayment

Incorrectly processed work items could have led to improper payments because the Boston supervisor was found to have not taken required follow-up actions when he cancelled or cleared them. These included failures to request necessary information to determine whether benefits for veterans or other recipients were still warranted. Example 1 provides details of a case that was incorrectly cleared and had the potential to affect benefits.

Example 1

The supervisor cleared an end product without taking any action following a veteran's failure to verify the status of his dependents as requested. Per VBA policy, when veterans receiving compensation for dependents provide information verifying continued status of their dependents, an end product should be cleared with no additional action.[7] However, if the veterans fail to provide this information, it should be requested again, and the end product not cleared until the information is received. If needed, changes to benefits payments should also be completed. Because the supervisor incorrectly cleared the case without taking required action, VBA lacked assurance the veteran was receiving the correct payments for dependents.

Improper Payments

The OIG team determined improper payments resulted when the supervisor processed work items without taking appropriate action. As mentioned earlier, approximately $117,300 in improper payments were made to beneficiaries. About $112,900 were overpayments (of which approximately $32,800 was eventually recovered). There were also approximately $4,300 in

[7] M21-1, Adjudication Procedures Manual, part III, subpart iii, chapter 5, section K, topic 2, "Processing VA Form 21-0538."

underpayments to VA beneficiaries. Example 2 provides details of a work item that the supervisor incorrectly cancelled, and the OIG team determined to have affected benefits.

Example 2

A veteran was getting additional compensation benefits because he had a spouse as a dependent. To keep receiving the additional amount, the veteran had to verify he was still married to this spouse. However, the veteran did not provide the required information that he was still married, and a work item generated. As a result, the veteran should have stopped receiving compensation for his spouse from the first of the month following the date he last verified his marriage to his spouse of record. However, the supervisor cancelled the work item rather than reducing the compensation payments. Consequently, the veteran was overpaid more than $5,300 for nine years.

Table 2 summarizes the types and amounts of improper payments.

Table 2. Errors with Improper Payments

Type of improper payment	Number of cases	Approximate amount of improper payments made
Unrecovered overpayments	6	$80,100
Underpayments not provided to beneficiaries	4	$4,300
Subtotal of unresolved improper payments	10	$84,400
Recovered overpayments by VA	5	$32,800
Total	**15**	**$117,300***

Source: VA OIG analysis of statistically sampled work items completed during the review period
** Total combined represents all improper payments, unresolved and recovered. Total combined value does not add up precisely due to rounding.*

Delayed Payments

In addition, the OIG team determined about $8,600 in payments to veterans or other beneficiaries were delayed because the supervisor incorrectly cancelled work items. The payments were correct but delayed several months because of the supervisor. Example 3 provides details of a work item that was incorrectly cancelled and led to delayed payments.

Example 3

A work item was generated noting an undeliverable returned payment. Per VBA policy, the supervisor should have determined the cause of the returned payment.[8] *If the payment could be reprocessed, he should have reprocessed and released it as applicable. However, the supervisor cancelled the work item, rather than taking the required actions. After the cancellation, other staff released the payment. As a result, the veteran's returned payment of approximately $500 was delayed by 84 days.*

Table 3 summarizes the number of errors with delayed payments and their effect.

Table 3. Errors with Delayed Payments

Number of errors with delayed payments	Approximate amount of delayed payments	Average delayed payment in days	Range of delayed payment in days
7	$8,600	96	10–335

Source: VA OIG analysis of statistically sampled work items completed during the review period

The Supervisor Stated Errors Occurred Due to His Misunderstanding of the Process

The OIG team interviewed the Boston supervisor, who acknowledged he had processed work items for the VARO. He stated he took on the role of processing work items, so his staff could focus on processing incoming mail. The supervisor displayed an understanding of how to process some work items but provided incorrect explanations on how to process others. When questioned as to why he made so many errors, the supervisor stated it was the result of working too quickly and misunderstanding the process. The supervisor noted he cancelled work items if he was unable to locate information needed for processing, or he believed no actions were needed.

He further noted he was under the impression that if the work item was cancelled, it would regenerate if actions were still needed and would eventually be resolved by him or other staff. The supervisor stated he processed work items quickly so he could focus on other priorities such as processing incoming mail for the VARO.

The supervisor stated any mistakes made were his responsibility, and not the result of instructions from his management staff. He also noted he was never previously made aware that he was incorrectly processing work items. The Boston VARO VSC manager and assistant director noted they were unaware the supervisor had been incorrectly processing work items.

[8] M21-1, Adjudication Procedures Manual, part III, subpart ii, chapter 1, section B, topic 6, "Processing 800 Series Work Items Commonly Related to Lack of a Correct Address."

VBA Lacked Effective Oversight of Cancelled Work Items and Supervisor Workloads

VBA procedures for national quality reviews do not include overseeing the work items or the related end products. The Systematic Technical Accuracy Review process is a quality review and analysis of the elements for processing associated with a specific claim on an identified end product. The OIG team interviewed the quality assurance officer for VBA, who noted that reviewers with the Systematic Technical Accuracy Review program do not, however, evaluate work items because their focus is primarily on end products involving service-connected compensation decisions and the associated awards for entitlement payments.

The Compensation Service Quality Review Team Program also establishes a group of dedicated quality review specialists with a focused emphasis on station quality in every VBA facility that processes compensation claims. These local quality reviews of claims processing did not include reviews of work completed by supervisors. Previous OIG reviews had found supervisors at the Houston and Honolulu VAROs were improperly processing claims, underscoring the need for closer oversight of supervisors.[9] The deputy under secretary for field operations informed the OIG team that reviews of cases processed by supervisors were not part of local quality reviews. He explained that performance standards for supervisors do not include metrics for claims processing, but rather focus on their management duties. The deputy under secretary also noted modifying this practice would be something he would evaluate to prevent occurrences such as this from happening again. Finally, the assistant director of VBA's Office of Performance Analysis and Integrity informed the OIG team that advanced analytics staff were currently reviewing data analysis procedures to improve VBA's ability to identify erroneous actions such as incorrect cancellations of work items.

Conclusion

The Boston VARO supervisor incorrectly processed work items, resulting in improper payments, potential improper payments, and delayed payments to beneficiaries. By reviewing and correcting the erroneously processed work items, the Boston VARO director can minimize the effect of any improper payments on beneficiaries. The director also can hold the supervisor accountable for his actions by conferring with regional counsel to determine the appropriate administrative action to take, if any.

The supervisor demonstrated he misunderstood the process, and VBA did not provide adequate oversight of the supervisor's work. The director can minimize further improper and delayed payments to beneficiaries, as well as manipulation attempts by employees identified in prior OIG

[9] VA Office of Inspector General, *Review of Alleged Data Manipulation at the VA Regional Office Houston, TX*, Report No. 14-04003-298, September 30, 2014; and VA Office of Inspector General, *Review of Alleged Data Manipulation at the VA Regional Office Honolulu, HI,* Report No. 15-00880-157, March 26, 2015.

reviews, if a plan to assess the quality of processed claims completed by supervisors is implemented.

Recommendations 1–3

1. The director of the Boston VA Regional Office reviews and corrects all work items that were cancelled or cleared by the supervisor that are likely to result in adjustments to recipients' benefit payments.
2. The director of the Boston VA Regional Office confers with regional counsel to determine the appropriate administrative action to take, if any, against the supervisor.
3. The director of the Boston VA Regional Office implements a plan to ensure internal controls for assessing the quality of claims processed by supervisors.

Management Comments

The Boston VARO director concurred with Recommendations 1–3 and provided acceptable action plans for all recommendations.

To address Recommendation 1, the Boston VARO director stated his office will work with the VBA Office of Field Operations to identify all 800-series work items in categories that were cancelled or cleared without additional adjudicative action by the supervisor from 2014 to present. Further, once the population of work items has been identified, the Boston VARO will develop a plan and initiate a review. The plan will be provided to the OIG and include milestones for completion.

To address Recommendation 2, an Office of General Counsel staff attorney conferred with the deciding official following a review of the evidence file, which included a local fact-finding review. Appropriate administrative action has been taken, and a record of the action was recorded in the supervisor's electronic official personnel file.

To address Recommendation 3, the director initiated development of a plan to ensure internal controls are established for assessing the quality of claims processed by supervisors. The director's office will provide the plan to the OIG upon completion.

In addition, the Boston VARO director noted the report did not indicate how many death notice work items were generated (not just cancelled) for the nation during FY 2018. The director stated that information would be helpful in providing additional context surrounding his office's share of this segment of the workload.

OIG Response

The Boston VARO director's comments and actions are responsive to the recommendations, and the OIG considers Recommendation 2 closed. For Recommendations 1 and 3, the OIG will

monitor the Boston VARO's progress and follow up on implementation of the recommendations until all proposed actions are completed.

The director asked the OIG to discuss the number of death notice work items that were generated (not just cancelled, as discussed in the report) for the nation. The OIG provides the following information: In FY 2018, a total of 19,119 death mismatch work items were processed by VBA nationwide. The Boston VARO processed 332 death mismatches in that fiscal year, of which 299 were cancelled by the Boston supervisor. This further demonstrates the irregularity associated with the high cancellation rate attributed to the Boston supervisor, as the Boston VARO was responsible for just two percent of the nation's processed death mismatches in FY 2018, but the supervisor alone was responsible for 50 percent of the nation's *cancelled* death mismatches in FY 2018.

Appendix A: Scope and Methodology

Scope

The OIG team conducted its review work from February through August 2019. The team evaluated specific work items and end products with claim labels the Boston VARO supervisor cancelled or cleared from October 1, 2017, to February 6, 2019. Claim labels provide a more specific description of the claim type that a corresponding end product represents. The timeframe was based on data available from VBA's Tableau server on February 6, 2019. The following list contains the specific end products and claim labels (hereafter referred to collectively as work items):

- 810 – LROSU (Local Regional Office Special Use)10
- 810 – PEPR (Proceeds Established in Participant Record)
- 810 – RFRVAF (Review for Return of VA Form 21-4140)
- 820 – SSADDM (Social Security Administration Death Date of Birth Mismatch)
- 820 – CIFR (Combined Interface File Reject – Missing Social Security Number)
- 820 – ELNS (Employability Letter Not Sent)
- 692 – REVAUTH2 (Reviews - Authorization Only 2)

Methodology

To accomplish the review objective, the OIG team identified and reviewed applicable laws, regulations, policies, procedures, and guidelines related to work items. In April 2019, the team interviewed personnel related to work items and processes, including managers and staff at the Boston VARO, as well as VBA managers.

In coordination with VA OIG statisticians, the OIG team reviewed a stratified random sample of 110 work items that were cancelled or cleared by the Boston VARO supervisor from October 1, 2017, to February 6, 2019. The team then determined whether the Boston VARO supervisor correctly cancelled or cleared the work items. The team used VBA's electronic systems, including the Veterans Benefits Management System, to review the sample veteran electronic claims folders and relevant documentation for its assessment. The team discussed the findings with VBA officials and included their comments as appropriate.

[10] For the 810 – LROSU claim label, only cases involving veterans' dependency verification were reviewed.

Sampling Design

The OIG team treated work items that were cancelled and cleared as two distinct data sets (universes). Within each universe, data was split into strata based on the claim label used for the record. The sampling method used was a stratified random sample in proportion to the size of each stratum. During the review, the team excluded one work item determined to be outside the scope of review. The case was removed as the claim label associated with the work item did not involve a veteran's dependency verification. The team was unable to limit that aspect of the data prior to the review. Table A.1 provides the population and sample size for each stratum reviewed of the universe for cancelled work items meeting the scope of the review.

Table A.1. Population and Sample Size of Cancelled Work Items Reviewed

Stratum (claim label)	Population	Sample size
810LROSU	281	17
810PEPR	220	9
810RFRVAF	107	5
820CIFR	154	6
820ELNS	139	6
820SSADDM	285	12
Total	**1186**	**55**

Source: The OIG obtained the data from VBA's Tableau Server. Sample size determined by OIG statistician in proportion to the size of each stratum.

Table A.2 presents the population and sample size for each stratum of the universe of cleared work items.

Table A.2. Population and Sample Size of Cleared Work Items Reviewed

Stratum (claim label)	Population	Sample size
692REVAUTH2	630	40
810RFRVAF	99	6
820CIFR	56	4
820SSADDM	77	5
Total	**862**	**55**

Source: The OIG obtained the data from VBA's Tableau Server. Sample size determined by OIG statistician in proportion to the size of each stratum.

Fraud Assessment

The review team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. The OIG team exercised due diligence in staying alert to any fraud indicators by taking actions such as

- Soliciting the OIG's Office of Investigations for indicators, and
- Completing the Fraud Indicators and Assessment Checklist.

In addition, the team conducted a review of the Boston VARO's supervisor's history of bonuses and performance evaluations to determine if he had received payments or accolades solely for the processing of work items. It was determined the supervisor did not receive bonuses or awards exclusively because of his work on work items. The team concluded the supervisor had not received financial benefit from the incorrect processing of work items. As such, the OIG did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The OIG team used computer-processed data from VBA's Tableau server. To test for reliability, the team determined whether any data were missing from key fields or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared data provided in the Tableau report, such as veterans' file numbers, EP code, claim label, completion date, and individual who processed the claim, against information contained in the 110 Veterans Benefits Management System electronic claims folders reviewed.

Testing of the data disclosed that they were sufficiently reliable for the review objective. Comparison of the data with information contained in the veterans' claims folders reviewed did not disclose any problems with data reliability.

Government Standards

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

Appendix B: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–3	The incorrect processing of work items resulted in improper payments to beneficiaries that were not resolved at the time of the OIG's review.		$84,400
	Total		**$84,400**

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: August 16, 2019

From: Director, Boston, Manchester and White River Junction VA Regional Offices (VARO)

Subj: Response to OIG's Draft Report, Incorrect Processing of Work Items by a Supervisor at the Boston, Massachusetts VARO, (project number 2019-07350-SD-0002)

To: Dana Sullivan, Director, VA Office of Inspector General

1. Thank you for the opportunity to respond to the Draft Report, Incorrect Processing of Work Items by a Supervisor at the Boston, Massachusetts VARO. Our specific responses to the three recommendations in the Draft Report are included as an attachment to this memorandum.

2. In addition to our specific responses to the recommendations contained in the Draft Report, I would like to incorporate for the record my comments concerning the scope of this review. The Introduction of the Draft Report states the following:

> *While conducting research to determine whether Veterans Benefits Administration (VBA) staff were addressing ongoing VA payments for deceased beneficiaries, the OIG team determined that a supervisor at the Boston, Massachusetts, VA Regional Office (Boston VARO) appeared to be incorrectly cancelling work items related to staff notifications of possible beneficiaries' deaths, terminating payments, or establishing other controls.*
>
> *An expanded review of the supervisor's work revealed he had been incorrectly cancelling potential death notices since at least 2012. During fiscal year (FY) 2018, the supervisor cancelled a total of 299 potential death notices at the Boston VARO, out of the 596 notices cancelled nationwide. The average number of these potential death notices that were cancelled by other VAROs in FY 2018 was less than seven. Therefore, as the Boston VARO supervisor was responsible for 50 percent of the nation's cancelled work items for potential death notices, and more than 40 times as much as the average of the other VAROs, the OIG team focused its review on his actions.*

3. The local process for conducting these reviews was to have the Supervisor responsible for all claim intake and mail processing activities also responsible for screening the 800-Series Work Items in the VETSNET Corporate Database. The process was implemented to improve efficiency for the Division by eliminating the need for these reviews to be spread over multiple claims processing personnel with varying degrees of expertise and allowed them to focus their efforts on processing claims from Veterans and their dependents. The fact that the Boston VARO assigned all 800-Series Work Item processing to one individual contributed to the data anomaly.

4. The report also does not indicate how many 800-Series Death Notice Work Items were generated (not just cancelled) for the nation during FY 2018, which would be helpful in providing additional context surrounding Boston's share of this segment of the workload. While I don't dispute the fact that the Boston VARO supervisor was responsible for processing a high number of 800-Series Work Items incorrectly, I am concerned the context in this section of the report has the potential to distract the reader from the actual error rates observed in the sample review as depicted in Table 2. Errors with Improper Payments, on page 6 of the Draft Report.

5. Finally, thank you for helping the Boston VA Regional Benefits Office identify and correct these payment errors. Your review will certainly help us improve the accuracy of 800-Series Work Item processing. I also appreciate the courtesy and cooperation your staff showed during the Inspection. If you have any questions or would like to discuss our response, please contact me at 617-303-4250.

(Original signed by)

Bradley G. Mayes

Director

cc: Northeast District Director's Office

Attachment

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Attachment

OIG Site Visit Response – Boston VARO

Recommendation 1:	The Director of the Boston VA Regional Office takes action to review and correct all work items that were cancelled or cleared by the supervisor that are likely to result in adjustments to recipients' benefit payments.
RO Response:	**Concur.** Audit findings and findings from a local 100 percent review of 800-Series Work Items processed by the supervisor during FY 19 as part of a Fact Finding revealed a high error rated in the 810-LROSU (Local Regional Office Special Use) and 820-CIFR (Combined Interface File Reject – Missing Social Security Number) categories. The Fact Finding also determined that the supervisor assumed responsibility for 800-Series Work Item screening at the beginning of FY 2014. Based on these findings, the Boston VA Regional Office proposes to work with the VBA Office of Field Operations to identify all 800-Series Work Items in these two categories that were cancelled or cleared without additional adjudicative action by the supervisor from FY 2014 to the present. Once the population of 800-series Work Items subject to review has been identified, the Boston VA Regional Office will develop a plan and initiate review of the Work Items. The Plan will be delivered to OIG by 9 September 2019 and include milestones for completion.
Applicable Attachment(s):	N/A

Recommendation 2:	The Director of the Boston VA Regional Office confers with Regional Counsel to determine the appropriate administrative action to take, if any, against the supervisor.
RO Response:	**Concur.** Appropriate Administrative Action has been taken following a thorough review of the evidence file, to include a local Fact Finding. The Deciding Official conferred with Office of General Counsel Staff Attorney, Mr. Paul Usera, on June 10, 2019, prior to rendering her decision. A record of the Administrative Action was recorded in the supervisor's Electronic Official Personnel File (EOPF).
Applicable Attachment(s):	N/A

Recommendation 3:	The Director of the Boston VA Regional Office implement a plan to ensure internal controls for assessing the quality of claims processed by supervisors.
RO Response:	**Concur.** The Director of the Boston VA Regional Office directed development of a plan to ensure internal controls for assessing the quality of claims processed by supervisors. The Plan will be delivered to OIG by 9 September 2019.
Applicable Attachment(s):	N/A

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Dana Sullivan, Director Iris Barber Daphne Brantley Brett Byrd Robert Grooms Richard Johnson

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Additional Directors

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Ed Markey, Elizabeth Warren
U.S. House of Representatives: Katherine Clark, William Keating, Joseph Kennedy III, Stephen Lynch, James "Jim" McGovern, Seth Moulton, Richard Neal, Ayanna Pressley, Lori Trahan