DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings

REVIEW | REPORT #20-00049-122 | MAY 18, 2021

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Executive Summary

In calendar year 2020, the Veterans Benefits Administration (VBA) processed approximately 1.2 million disability compensation benefits claims and paid more than $90.8 billion in total disability compensation benefits to veterans. As of December 31, 2020, about five million veterans were receiving these benefits. To ensure claims decisions are accurate and consistent so that veterans receive the benefits to which they are entitled, VBA established a multifaceted quality assurance program.

The VA Office of Inspector General (OIG) conducted reviews of various components of VBA's quality assurance program and issued four reports from July to September 2020:

1. *Site Visit Program Can Do More to Improve Nationwide Claims Processing*
2. *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*
3. *Deficiencies in the Quality Review Team Program*
4. *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide*[1]

This report analyzes the systemic issues affecting VBA's quality assurance program for disability compensation benefits and provides a recommendation to improve the identified areas of weakness.

What the Review Found

Until VBA strengthens oversight of and accountability for its quality assurance program, veterans are at risk of not receiving the benefits they deserve. VBA's quality assurance program relies on two offices—the Compensation Service and the Office of Field Operations. While the Compensation Service conducts quality assurance reviews that identify deficiencies in the disability compensation benefits claims process, the Office of Field Operations has oversight responsibility for ensuring regional office employees and supervisors follow quality assurance procedures and take action to correct deficiencies identified during quality assurance reviews.[2]

[1] VA OIG, *Site Visit Program Can Do More to Improve Nationwide Claims Processing*, Report No. 19-07062-230, August 18, 2020; VA OIG, *The Systemic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, Report No. 19-07059-169, July 22, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, Report No. 19-07054-174, July 22, 2020; VA OIG, *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide*, Report No. 19-07062-255, September 29, 2020. Appendix A has additional information about these reports.

[2] For the purposes of this report, quality assurance procedures include VA Manual 21-4, chap. 3, "National Quality Reviews," January 26, 2018, August 3, 2020; and VA Manual 21-4, chap. 6, "Quality Review Team (QRT)," January 16, 2018, September 2, 2020.

The OIG found that while VBA's quality assurance program routinely identified claims-processing deficiencies and communicated results to internal and external stakeholders, the Office of Field Operations did not ensure that regional office employees took adequate corrective actions and addressed the deficiencies identified.

Examples from two prior OIG reports illustrate incorrect and untimely corrective actions to address deficiencies.[3]

Incorrectly Overturned Errors

Each month, the Quality Review Team (QRT) conducts quality reviews to determine an employee's accuracy rate. An employee can request reconsideration of an identified error, and overturning the error improves the employee's accuracy rate. Incorrectly overturned errors result in employees receiving higher accuracy rates than warranted.

During the OIG team's review, regional office managers acknowledged overturning valid errors based on personal judgment in violation of VBA's procedures.[4] From July 1 through September 30, 2018, the team estimated regional office managers inappropriately overturned errors in 430 of 870 quality reviews (about 50 percent) when employees requested reconsideration. The Compensation Service also found regional office managers incorrectly overturned errors identified during quality assurance program site visits and shared this information with the Office of Field Operations. The Office of Field Operations has the authority to hold regional office managers accountable for inappropriately overturning errors.

Untimely Error Corrections

VBA's procedures direct QRT supervisors to manage the error correction process.[5] Regional office supervisors are responsible for ensuring employees complete corrections in a timely manner. However, the OIG team found regional office managers did not follow up with employees to ensure they timely corrected errors identified by Systematic Technical Accuracy Review (STAR) and QRT personnel.

STAR-Identified Errors

STAR analysts are under the jurisdiction of the Compensation Service. When these analysts identify an error during a quality review, Office of Field Operations' regional office employees

[3] VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*; VA OIG, *Deficiencies in the Quality Review Team Program*.
[4] VA Manual 21-4, chap. 6, topic 5.h, "Reconsideration Requests on Employee Performance Reviews," July 20, 2020.
[5] VA Manual 21-4, chap. 6, topic 3.a, "Responsibilities of the QRT coach and/or other QRT supervisor," October 9, 2020.

are required to initiate and report the corrective actions taken for each error within 30 days of notification. However, the OIG determined Office of Field Operations managers did not ensure that corrections to STAR errors were made timely. The OIG team estimated that 192 of 355 quality reviews requiring corrective actions (54 percent) were not corrected in accordance with VBA's 30-day standard.

Quality Review Team-Identified Errors

Similarly, the OIG team determined the Office of Field Operations did not ensure corrections to QRT-identified errors were made timely. The OIG team estimated that 2,000 of 4,400 identified errors (45 percent) were not corrected within the required five business days. The team also found 810 of 4,400 identified errors (18 percent) were not corrected at all. The Compensation Service does not have the authority to ensure errors are corrected timely—this lies with the Office of Field Operations.

The OIG identified a systemic weakness in oversight and accountability by the Office of Field Operations. Until VBA senior leaders ensure improvements are made, veterans are at risk of not receiving the benefits they deserve.

What the OIG Recommended

The OIG recommended the acting under secretary for benefits develop and implement a written plan to strengthen oversight of the quality assurance program and monitor the plan to ensure identified deficiencies are adequately addressed.

Management Comments

The acting under secretary for benefits concurred with the OIG's recommendation and provided an acceptable action plan on implementation. The acting under secretary's comments are provided in full in appendix C. The OIG will monitor VBA's progress and follow up on the implementation of the recommendation until the proposed action is completed.

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Abbreviations

OIG	Office of Inspector General
QRT	Quality Review Team
STAR	Systematic Technical Accuracy Review
VBA	Veterans Benefits Administration

Introduction

In calendar year 2020, the Veterans Benefits Administration (VBA) processed approximately 1.2 million compensation claims and paid out more than $90.8 billion in total compensation benefits to veterans. As of December 31, 2020, about five million veterans were receiving these benefits. To ensure claims decisions are accurate and consistent so that veterans receive the benefits to which they are entitled, VBA established a multifaceted quality assurance program. The defined mission of the quality assurance program is to gauge the quality of the claims process to maintain and improve the consistency and compliance of all claims based on current policy and procedures so that benefits delivered to veterans and their families are at the highest quality possible.[6]

VBA's quality assurance program relies on two offices—the Compensation Service and the Office of Field Operations. The Compensation Service manages the quality assurance program and assesses claims-processing accuracy nationwide, and the Office of Field Operations oversees regional offices and is responsible for ensuring regional office employees and supervisors follow quality assurance procedures and take corrective actions on deficiencies identified during quality assurance reviews.[7]

As seen in figure 1, prior to June 2019, the four components of VBA's quality assurance program for disability compensation benefits were Program Operations (site visit program), Systematic Technical Accuracy Review (STAR), Quality Review Team (QRT) made up of regional office teams, and the Quality Review and Consistency Program (consistency study program).

[6] "QA Mission Statement," Compensation Service intranet, accessed September 2, 2020, https://vbaw.vba.va.gov/bl/21/data/quality/qa_home.htm. (This is an internal VA website not publicly accessible.)
[7] For the purposes of this report, quality assurance procedures include VA Manual 21-4, chap. 3, "National Quality Reviews," January 26, 2018, August 3, 2020; and VA Manual 21-4, chap. 6, "Quality Review Team (QRT)," January 16, 2018, September 2, 2020.

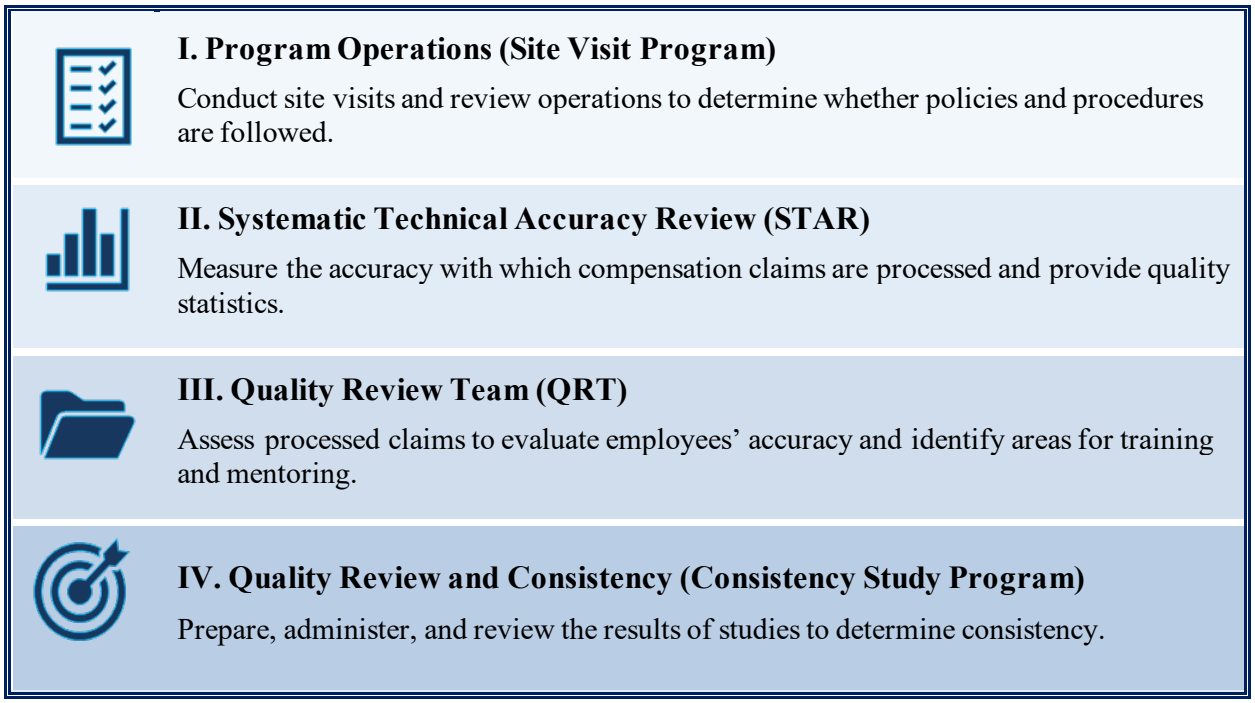

Figure 1. *Components of VBA's quality assurance program for disability compensation benefits prior to June 2019.*

Source: VA OIG analysis.

In June 2019, VBA restructured the quality assurance program to include the Advisory and Special Review Team. Staff on this team complete advisory opinions for VBA's central office and perform focused reviews on topics of special interest, such as issues where a need has been identified to ensure consistency and compliance with policy and procedures.[8]

The OIG initiated individual reviews of various components of VBA's quality assurance program prior to June 2019 and issued four reports:

1. *Site Visit Program Can Do More to Improve Nationwide Claims Processing* (August 2020)
2. *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies* (July 2020)
3. *Deficiencies in the Quality Review Team Program* (July 2020)

[8] VA Manual 21-1, part 3, sub. 6, chap. 1, sec. a, "Types of Guidance Available," April 10, 2020. An advisory opinion provides regional offices with consistent, reasonable guidance and advice for handling complex or unusual cases before a decision is made.

4. *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide* (September 2020)[9]

This report analyzes the systemic issues affecting VBA's quality assurance program for disability compensation benefits and provides a recommendation to improve the identified areas of weakness.

[9] VA OIG, *Site Visit Program Can Do More to Improve Nationwide Claims Processing*, Report No. 19-07062-230, August 18, 2020; VA OIG, *The Systemic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, Report No. 19-07059-169, July 22, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, Report No. 19-07054-174, July 22, 2020; VA OIG, *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide*, Report No. 19-07062-255, September 29, 2020. Appendix A has additional information about these reports.

Results and Recommendations

Finding: VBA's Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings, Compromising Improvements in Disability Compensation Benefits Processing

Until VBA strengthens the oversight and accountability of its quality assurance program for disability compensation, veterans are at risk of not receiving the benefits they deserve. Designed to improve the accuracy and consistency of the compensation benefit claims process, VBA's quality assurance program relies on two offices—the Compensation Service and the Office of Field Operations. While the Compensation Service conducts quality assurance reviews that identify deficiencies in the benefit claims process, the Office of Field Operations has oversight responsibility for ensuring regional office employees and supervisors follow quality assurance procedures and take action to correct deficiencies identified during quality assurance reviews. VBA senior leaders are responsible for ensuring the two offices accomplish the quality assurance program's mission.[10] The OIG's prior reviews of four components of VBA's quality assurance program—the site visit, STAR, QRT, and consistency study programs—identified deficiencies in how the Office of Field Operations addressed quality assurance program findings.

The OIG found VBA's quality assurance program routinely identified claims-processing deficiencies and communicated results to internal and external stakeholders. However, the Office of Field Operations did not ensure that regional office employees took adequate corrective actions and addressed the deficiencies identified.

What the OIG Did

The OIG reviewed four components of VBA's quality assurance program—the site visit, STAR, QRT, and consistency study programs. Table 1 provides an overview of the scope and review periods for the prior reports.

[10] For the purposes of this report, VBA senior leaders include the under secretary for benefits and the principle deputy under secretary for benefits.

Table 1. Overview of Prior Reports

OIG report	Scope of review	Review period
Site Visit Program Can Do More to Improve Nationwide Claims Processing	47 regional office site visit reports	October 1, 2015, through April 30, 2019
The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies	2,783 quality reviews*	July 1, 2018, through September 30, 2018
Deficiencies in the Quality Review Team Program	28,400 quality reviews*	July 1, 2018, through September 30, 2018
Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide	51 consistency studies	October 1, 2015, through April 30, 2019

Source: VA OIG.
**The OIG team analyzed a statistical sample.*

To identify systemic issues affecting VBA's quality assurance program for disability compensation benefits, the OIG team analyzed the results of the four prior reports. The team also interviewed VBA central office personnel. More information about the scope and methodology of the reports appears in appendix B.

Attributes of VBA's Quality Assurance Program

Based on a review of the prior four reports, the OIG team determined the attributes in figure 2 are fundamental to VBA's quality assurance program.

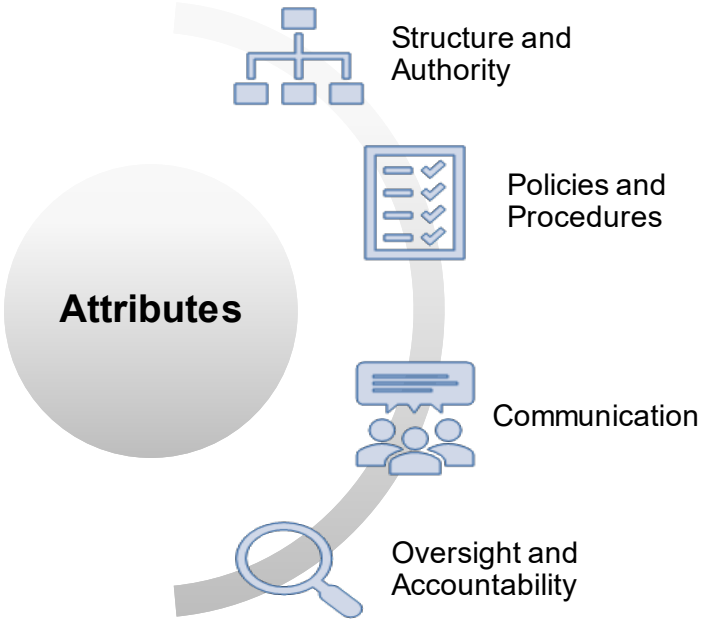

Figure 2. *Four attributes of VBA's quality assurance program.*
Source: VA OIG analysis.

Structure and Authority

Aligned under VBA's principal deputy under secretary for benefits, the Compensation Service and the Office of Field Operations both have responsibilities associated with the quality assurance program. As previously discussed, the Compensation Service conducts quality assurance reviews that identify deficiencies in the benefit claims process; the Office of Field Operations is responsible for ensuring that regional office employees follow quality assurance procedures. VBA senior leaders are responsible for ensuring that the two offices accomplish the quality assurance program's mission. Figure 3 shows VBA's organizational structure and lines of authority related to the quality assurance program.

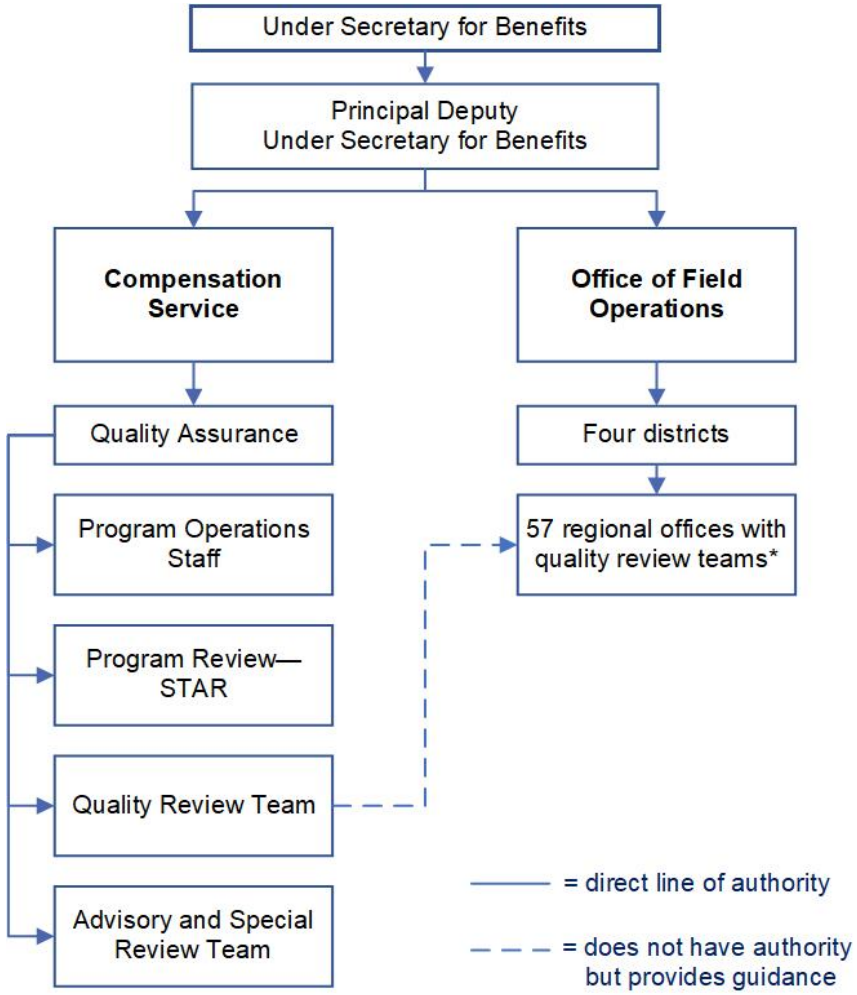

Figure 3. *Structure and lines of authority for VBA's quality assurance program.*

Source: VA OIG analysis of quality assurance program structure.

**The QRT program falls under the authority of the Compensation Service; however, the quality review teams located at the regional offices fall under the authority of the Office of Field Operations.*

Policies and Procedures

Under the existing organizational structure, the Compensation Service is responsible for establishing policies and procedures, such as updating and maintaining the claims-processing manual. The OIG team determined the office fulfilled this responsibility by, for example, including procedures for the STAR and QRT programs.[11]

The Office of Field Operations oversees district and regional offices to ensure policies and procedures are implemented nationwide. This office has the authority to require regional office managers and staff to act on deficiencies identified during quality assurance reviews.

Communication

Effective communication of quality information, both internally and externally, is vital to drive continual improvement. The OIG team found that the Compensation Service's quality assurance program communicated claims-processing deficiencies. For example, STAR data on national claims-processing accuracy is posted monthly on an internal website and made available to external stakeholders such as Congress. STAR also provides each regional office with an end-of-year performance report detailing accuracy and error trends. Site visit findings are posted on an internal website and shared with the Office of Field Operations. The Compensation Service also shares consistency study results with the Office of Field Operations and regional offices.

Oversight and Accountability of the Quality Assurance Program

Although the Compensation Service is responsible for identifying quality assurance deficiencies, only the Office of Field Operations has the authority to hold regional office staff accountable for not following quality assurance procedures. Therefore, VBA senior leaders should ensure that the two offices cooperate to address quality assurance program findings. In some areas, the OIG team found that the two offices were cooperating effectively. For example, the Compensation Service and the Office of Field Operations had an adequate process to ensure that the Office of Field Operations addressed any errors identified during site visits.

The OIG team found the quality assurance program was clearly structured, governed by adequate policies and procedures, and generally involved adequate communication. However, the OIG identified a systemic weakness in oversight and accountability, as illustrated in the following

[11] VA Manual 21-4, chap. 3, "National Quality Reviews," January 26, 2018, August 3, 2020; VA Manual 21-4, chap. 6, "Quality Review Team (QRT)," January 16, 2018, September 2, 2020.

examples of incorrectly overturned errors and untimely error corrections from two of the prior OIG reports.[12]

Example 1

Each month, the QRT conducts quality reviews to determine an employee's accuracy rate. An error cited on a quality review reduces the employee's accuracy rate, which is critical to the employee's performance evaluation. An employee can request reconsideration of an identified error if the employee believes the error was mistakenly identified.[13] Incorrectly overturned errors not only result in employees receiving higher accuracy rates than warranted but may also affect the outcome of veterans' claims and result in incorrect benefit payments.

The reconsideration process varies across regional offices, and sometimes involves regional office managers outside of the QRT making the final decision on whether to overturn an error. VBA guidance states errors are only to be overturned if the cited error was incorrect.[14] However, during the OIG team's review, regional office managers acknowledged overturning valid errors based on personal judgment, in violation of VBA's procedures. During the review period, the team estimated regional office managers inappropriately overturned errors identified by QRT specialists in 430 of 870 quality reviews (about 50 percent) where employees requested reconsideration.[15] This rate indicates that the regional office managers may lack objectivity when reconsidering errors identified. The Compensation Service also found regional office managers incorrectly overturned errors identified during quality assurance program site visits and shared this information with the Office of Field Operations.

The Office of Field Operations has the authority to hold regional office managers accountable for inappropriately overturning errors. Without additional oversight by the Office of Field Operations, regional office managers may continue to incorrectly overturn errors, resulting in inaccurate employee performance evaluations. Furthermore, regional office staff may not correct all errors identified, putting the accuracy of veterans' compensation benefits at risk.

[12] VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*; VA OIG, *Deficiencies in the Quality Review Team Program*.

[13] VA Manual 21-4 chap. 6, topic 4.a, "Overview," January 16, 2018, July 20, 2020. The standard for an error is where the decision made rises to the level of a clear and unmistakable error or a clear violation of current regulations or directives.

[14] VA Manual 21-4, chap. 6, topic 5.h, "Reconsideration Requests on Employee Performance Reviews," January 16, 2018, July 20, 2020.

[15] The review period was July 1 through September 30, 2018.

Example 2

VBA's procedures direct QRT supervisors to manage the error correction process.[16] Regional office managers are responsible for ensuring employees complete corrections in a timely manner. However, the OIG team found regional office managers did not follow up with employees to ensure they corrected errors identified by STAR and QRT timely. Additionally, the Office of Field Operations did not hold regional office managers accountable for complying with quality assurance procedures for correcting errors, as illustrated in the following examples:

- **STAR-identified errors.** STAR analysts are under the jurisdiction of the Compensation Service. When these analysts identify an error during a quality review, the Office of Field Operations' regional office employees are required to initiate and report the corrective actions taken for each error within 30 days of notification. However, STAR does not have the authority to direct regional office employees to make the corrections. Only the Office of Field Operations has this authority.

  The OIG determined the Office of Field Operations did not ensure that corrections to STAR errors were made timely. As seen in figure 4, the OIG team estimated 192 of 355 quality reviews that required corrective actions (54 percent) were not corrected in accordance with VBA's 30-day standard.

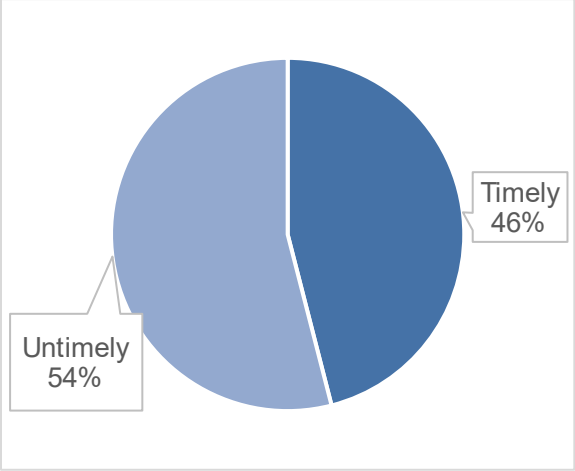

Figure 4. *Percentages of corrections initiated timely and untimely.*

Source: VA OIG analysis.

- **QRT-identified errors.** Similarly, the OIG determined the Office of Field Operations did not ensure timely corrections to QRT-identified errors. As seen in figure 5, the OIG team estimated that 2,000 of 4,400 identified errors (45 percent) were not corrected

[16] VA Manual 21-4, chap. 6, topic 3.a, "Responsibilities of the QRT coach and/or other QRT supervisor," January 16, 2018, October 9, 2020.

within the required five business days. The team also found 810 of 4,400 identified errors (18 percent) were not corrected at all.

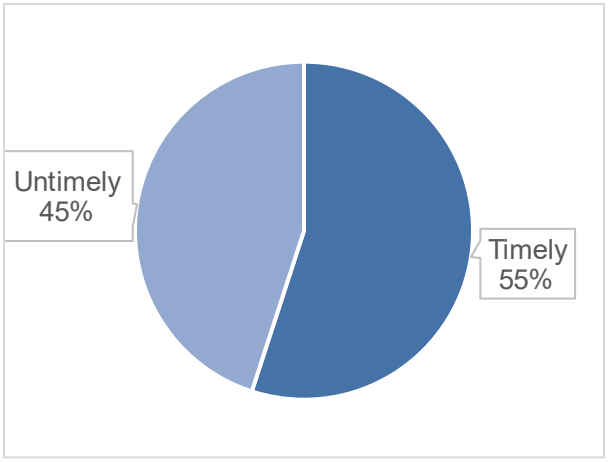

Figure 5. *Percentages of corrections initiated timely and untimely.*

Source: VA OIG analysis.

The organizational alignment of the QRT program complicates oversight of the error correction process. As discussed in this finding, the Compensation Service does not have the authority to ensure errors are corrected timely—this lies with the Office of Field Operations.

Although quality assurance procedures establish timeliness requirements for corrections, the Office of Field Operations did not hold regional office managers accountable for following this procedure. The deputy under secretary for field operations stated regional offices are responsible for ensuring corrections are made. He also stated that the Office of Field Operations does not micromanage the regional offices or dictate what they should do.

Conclusion

VBA's quality assurance program was established to improve the accuracy and consistency of the compensation benefit claims process, thereby ensuring that veterans receive the benefits to which they are entitled. VBA has established a structured relationship and adequate policies and procedures between the Compensation Service and the Office of Field Operations. The two offices generally communicate effectively. However, the OIG identified a systemic weakness in oversight and accountability by the Office of Field Operations. Until VBA senior leaders ensure improvements are made, veterans are at risk of not receiving the benefits they deserve.

Recommendation 1

The OIG made the following recommendation to VBA's acting under secretary for benefits:

1. Develop and implement a written plan to strengthen oversight of the quality assurance program for disability compensation benefits and monitor the plan to ensure identified deficiencies are adequately addressed.

Management Comments

The acting under secretary for benefits concurred with the OIG recommendation. VBA will develop and implement a plan to strengthen oversight of the quality assurance program for disability compensation benefits and monitor the plan to ensure identified deficiencies are adequately addressed.

OIG Response

The acting under secretary for benefits concurred with the recommendation and provided an acceptable action plan. The OIG will monitor VBA's progress and follow up on implementation of the recommendation until all proposed actions are completed.

Appendix A: Prior OIG Reports

I. Program Operations (Site Visit Program)

Read the full report here: ***Site Visit Program Can Do More to Improve Nationwide Claims Processing***

Overview	Staff conduct site visits to review veterans service center operations, maintain the quality assurance manual, review and approve changes to controls for pending workload, and provide special assistance to regional offices and other stakeholders regarding compensation benefits.
Why the OIG conducted this review	To determine whether the site visit program conducted site visits and identified deficiencies at regional offices, and if managers took sufficient follow-up action on frequently identified errors (error trends) to improve disability claims processing.
Finding	**VBA Missed Opportunities to Improve Claims Processing Nationwide by Leveraging the Results of the Site Visit Program** • Compensation Service identified deficiencies during site visits and communicated results to the relevant offices. • Regional offices generally addressed their own deficiencies, but the Office of Field Operations did not require all offices to apply the information to achieve nationwide improvements.
Recommendations to the under secretary for benefits	1. Direct Compensation Service to formalize the Hot Topics list into an annual report submitted to the Office of Field Operations detailing all recurring deficiencies and action items identified throughout the inspection year from its site visit program. 2. Require the Office of Field Operations to initiate a recurring plan to correct all recurring deficiencies and action items identified by Compensation Service throughout the inspection year from its site visit program annual report. 3. Direct the Office of Field Operations to establish a follow-up process to monitor compliance with the new requirement and hold regional office managers accountable for making corrections and addressing action items in a timely manner.

II. Systematic Technical Accuracy Review (STAR)

Read the full report here: ***The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies***

Overview	VBA uses this program to measure the accuracy with which compensation claims are processed nationwide. Results from these evaluations determine the quality statistics VBA reports to the public and are used in trend analyses to identify training needs. The reviews affect regional office quality metrics but do not affect employees' individual performance assessments.
Why the OIG conducted this review	To determine whether the STAR program ○ ensured accurate quality reviews, ○ included adequate procedures to ensure accuracy and timeliness on initiated and finalized corrective actions on STAR errors, and ○ provided feedback to management and staff to facilitate improvements in the decision-making process and enhance the quality of claims decisions for all veterans and their beneficiaries based on STAR's mission.
Finding	**VBA Has Not Effectively Managed the STAR Program to Fully Achieve Its Mission** • STAR quality reviews did not adequately identify claims-processing deficiencies. • Regional office staff failed to correct identified claims-processing deficiencies in a timely or accurate manner. • STAR feedback and data were not beneficial to enhance the quality of claims decisions.
Recommendations to the under secretary for benefits	1. Improve the current second-review process for quality reviews when STAR analysts identify claims-processing deficiencies and consider requiring senior reviewers to conduct a comprehensive review of all issues assessed by the analyst. 2. Establish a formal second-review process for quality reviews when STAR analysts do not identify claims-processing deficiencies. 3. Assess the current training requirements for STAR staff and establish a formal training plan that promotes claims-processing expertise and accuracy. 4. Implement a plan to ensure STAR analysts place more emphasis on and assess all procedural deficiency elements included on the quality review checklist. 5. Establish adequate policies, procedures, and monitoring to ensure corrections are completed timely and accurately. 6. Ensure STAR develops a plan to provide usable data and meaningful feedback to assist regional offices in improving the quality of decision-making.

III. Quality Review Team (QRT)

Read the full report here: ***Deficiencies in the Quality Review Team Program***

Overview	Staff conduct quality reviews of regional office employees and perform error trend analyses to identify areas for training and mentoring. The purpose of the program is to enhance quality in every VBA facility that processes compensation claims. According to the Compensation Service executive director, quality results are not made available to the public.
Why the OIG conducted this review	To determine whether QRT specialists conducted accurate quality reviews, regional office managers appropriately decided requests for reconsideration, and employees initiated timely action to correct identified claims-processing errors based on established standards.
Finding	**The QRT Program Lacks Adequate Oversight and Objectivity to Promote Claims-Processing Improvement** • QRT specialists missed claims-processing errors that should have been identified. • Errors identified by QRT specialists were inappropriately overturned by regional office managers. • Corrective actions on errors identified by QRT specialists were not initiated timely or at all.
Recommendations to the under secretary for benefits	1. Assess the current peer review process and determine whether a more in-depth review should be required to ensure claims-processing errors are identified. 2. Establish a process where a sampling of non-error quality reviews undergoes peer review to ensure claims-processing errors are identified. 3. Revise the QRT specialist performance review process to include more objectivity to ensure constructive feedback is provided to promote competency. 4. Revise the error reconsideration process to ensure objectivity and adherence to current VBA procedures. 5. Improve oversight procedures for monitoring the timeliness of error corrections.

IV. Quality Review and Consistency (Consistency Study Program)

Read the full report here: ***Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide***

Overview	This program assesses regional office variance in disability ratings for the most frequently rated disabilities, conducts studies to evaluate the consistency of raters across regional offices, and provides guidance to quality review teams.
Why the OIG conducted this review	To determine whether VBA managed this program to improve nationwide consistency in processing veterans' disability benefit claims.
Finding	**VBA Missed Some Opportunities with Its Consistency Study Program to Drive Nationwide Improvements in Claims Processing** • Compensation Service developed and administered consistency studies as required by law. • Compensation Service could share more detailed consistency study results with the Office of Field Operations to help improve claims processing. • The Office of Field Operations did not adequately follow up on consistency study results.
Recommendations to the under secretary for benefits	1. Direct Compensation Service to provide the Administration Results Report for each consistency study to the Office of Field Operations and to managers at all regional offices. 2. Ensure the Office of Field Operations develops a process to monitor regional offices to ensure maximum employee participation in consistency studies. 3. Make certain the Office of Field Operations establishes a requirement for regional office managers to review consistency study results and develop a plan for corrective action based on the performance of their regional office. 4. Require the Office of Field Operations to develop a follow-up process to confirm all corrective actions identified are completed by regional office managers.

Appendix B: Scope and Methodology

Scope

The OIG team conducted its work from September 2020 to March 2021 to identify overall systemic deficiencies hindering the effectiveness of VBA's quality assurance program.

Methodology

To accomplish the review objective, the OIG team analyzed four prior reports on VBA's quality assurance program:

- *Site Visit Program Can Do More to Improve Nationwide Claims Processing* (issued August 18, 2020)
- *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims Processing Deficiencies* (issued July 22, 2020)
- *Deficiencies in the Quality Review Team Program* (issued July 22, 2020)
- *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide* (issued September 29, 2020)

The team identified and reviewed applicable regulatory requirements, documentation, and actions related to VBA's quality assurance program. The team interviewed and obtained information related to the program from management and staff at VBA central office.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators:

- Identified VA manual procedures related to the review subject matter.
- Assessed previous reviews, audits, and inspections as reported by the OIG and other auditing organizations regarding VBA's quality assurance program.
- Completed the Fraud Indicators and Assessment Checklist.

The OIG team did not identify any instances of fraud or potential fraud during this or the prior reviews.

Data Reliability

The OIG team used data from the following OIG reports:

- *Deficiencies in the Quality Review Team Program:* The OIG team used computer-processed data from the Quality Management System that were stored on and pulled from the Electronic Data Warehouse by VBA's Performance Analysis and Integrity staff. 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, had alphabetic or numeric characters in incorrect fields, or contained illogical relationships among data elements. Furthermore, the team compared veterans' benefit claim identification numbers, end product codes, dates of claim, and regional office numbers to information in the 180 Veterans Benefits Management System electronic claims folders that were reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives. Comparison of the data with information contained in the veterans' electronic claims folders reviewed did not disclose any problems with data reliability.
- *The STAR Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies:* The OIG team used computer-processed data from VBA STAR reports generated by the Office of Performance Analysis and Integrity. 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 elements of VBA STAR data, such as veterans' file numbers, end product codes, claim labels, completion dates, and individuals who processed the claims, against information contained in the 100 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 C: Management Comments

Department of Veterans Affairs Memorandum

Date: April 27, 2021

From: Under Secretary for Benefits (20)

Subj: OIG Draft Report – The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings. [Project No. 2020-03229-DN-0395)] – VIEWS 04834988

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

Attached is VBA's response to the OIG Draft Report: The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings.

The OIG removed point of contact information prior to publication.

(Original signed by)

Thomas J. Murphy

Acting

Attachment

Attachment

Veterans Benefits Administration (VBA)
Comments on OIG Draft Report
The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings

VBA concurs with the findings in OIG's draft report and provides the following comments in response to the recommendation:

Recommendation: Develop and implement a written plan to strengthen oversight of the quality assurance program for disability compensation benefits and monitor the plan to ensure identified deficiencies are adequately addressed.

VBA Response: Concur. VBA will develop and implement a plan to strengthen oversight of the quality assurance program for disability compensation benefits and monitor the plan to ensure identified deficiencies are adequately addressed.

Target Completion Date: October 31, 2021.

OIG Contact and Staff Acknowledgments

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