DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims

REVIEW | REPORT #21-03916-103 | APRIL 27, 2022

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Executive Summary

On September 17, 2021, the *Atlanta Journal-Constitution* began publishing a series of articles about large quantities of unopened mail being stored in the warehouse basement of the Atlanta VA medical facility.[1] A team from the VA Office of Inspector General (OIG) subsequently visited the Atlanta facility to evaluate the content of the mail backlog and identify which personnel were responsible for processing the items, to determine the origin of the problem, and to assess mail processing procedures. When the team arrived at the facility on September 24, 2021, they found that the Atlanta VA Health Care System (HCS) had formed a task force to open, sort, and process stacks of mail reportedly piled as high as 10 feet (some dating back at least 10 months) that had accumulated in the warehouse basement.[2]

On September 27, an Atlanta VA HCS staff member indicated they had finished opening all the backlogged mail. In total, they counted 17,660 pieces of mail containing these important documents:

- **10,020 medical records (about 57 percent).**[3] Community care providers and veterans send medical documents to VA medical facilities for their staff to scan or import into patients' electronic health records, which is critical to supporting care given the need for complete, accurate, and timely information.
- **7,295 claims (approximately 41 percent).** Claims can be submitted to Payment Operations and Management (POM) from community care providers seeking reimbursement for medical services rendered to VA patients. Timely processing of claims is important so that non-VA providers continue to engage with VA and do not bill veterans for costs of medical services, which can result in a substantial undue financial burden for the veteran.
- **84 checks (less than 1 percent).** The mail backlog contained checks from community care providers to refund VA for overpayments. The checks identified in September 2021 totaled nearly $207,000.

[1] Christopher Quinn, "Months-old mail piles up in Atlanta Veterans Affairs hospital basement," Atlanta Journal-Constitution, September 17, 2021; Christopher Quinn, "VA launches two inquiries into 10 pallets of unopened mail," Atlanta Journal-Constitution, September 28, 2021; Christopher Quinn, "Former VA employee says he reported pallets on unopened mail last year," Atlanta Journal-Constitution, October 7, 2021. The Atlanta VA medical facility in Decatur, Georgia, is the main location of the Atlanta VA Health Care System (HCS).

[2] Appendix A includes a timeline of events related to this issue, and appendix B summarizes OIG reports that focus on other mail processing issues.

[3] In January 2022, the VISN 7 chief medical officer reported that after facility staff reviewed the pieces of mail that were medical records, they identified 5,496 total episodes of care. Of those, the chief medical officer reported that 907 of the episodes of care were already in the patients' electronic health record, and 4,589 were not.

- **261 miscellaneous items (about 1 percent).** The unopened mail also included insurance explanation of benefit forms, VA pending invoices, travel payment requests, and other correspondence from veterans.

Although the OIG acknowledges the steps Atlanta VA HCS employees have taken to clear this backlog, it notes that the Atlanta facility needs a plan for handling all the mail going forward. Moreover, the circumstances that led to the backlog in Atlanta could occur at other medical facilities across the nation—requiring proactive measures and better controls.

What the Review Found

The review team determined that the mail backlog began following a November 2020 verbal agreement between Atlanta VA HCS officials and POM personnel regarding POM staff vacating space where its mail was being processed at Atlanta's Summit Building—a space leased by the HCS.[4] That agreement was worked out between the deputy director of the Atlanta VA HCS and the POM area manager within the Veterans Health Administration's (VHA) Office of Community Care. On November 4, 2020, POM agreed to give up the Summit Building space and have their staff telework indefinitely if Atlanta facility personnel took over the responsibility for processing the mail that POM employees previously managed on-site. According to meeting minutes, both sides accepted this agreement. However, the Atlanta officials in charge of managing the mailroom were not involved in this meeting.[5] On November 9, 2020, just five days after the verbal agreement, POM staff vacated the Summit Building.

When the Atlanta VA HCS mailroom staff learned of this additional responsibility on November 17, 2020, they expressed concerns that they could handle neither the additional volume of mail nor its complexity. Handling POM's mail was not simply a matter of delivering it to the addressee or sending it on to POM. Instead, mailroom staff needed to open every item, identify what type of mail it was (such as medical records, checks, or community care provider claims), sort it, and then take varying actions.[6] In January, February, and March of 2021, Atlanta VA HCS staff reached out to POM to communicate their challenges with handling the mail, but POM was reluctant to assist, referencing the agreement and lack of on-site personnel. Facility staff processed some of the mail during March 2021 through July 2021, but the backlog continued to build.

[4] Although meeting minutes documented a high-level summary of this verbal agreement, there was no formal written document that detailed the terms of the agreement, including who would be responsible for processing the mail. See appendix C for details about this review's scope and methodology.

[5] Atlanta VA HCS attendees of this meeting included the deputy director, deputy chief of staff, chief health administrator, and chief of the Strategic Planning Office.

[6] Appendix D summarizes the mail instructions.

As late as September 16, 2021, the Atlanta mailroom manager wrote, "We need to get this mail processed and out of the basement and have a plan to process this mail in the future."

Based on its review, the OIG made several determinations. First, the November 2020 agreement between POM and the Atlanta VA HCS was not formally documented. Given the significance of this transition, VA should have established a formal agreement clearly detailing each office's responsibilities. Second, because the Atlanta VA HCS did not include the managers who were responsible for processing the mail in the November 2020 meeting, facility officials lacked their expert guidance and did not have a clear understanding of the volume, complexity, or processes required for managing the additional mail processing work they were accepting. The Atlanta VA HCS mailroom staff also incorrectly assumed that all contents of the unopened mail belonged to POM based on a POM address or other indicators on the envelope. Because they did not open and process all the mail, they did not realize that about 57 percent included medical records that medical facility staff—not POM—were responsible for processing. Third, the Atlanta VA HCS leaders did not ensure mail room staff were adequately prepared or trained to handle the influx of mail, to conduct multistep sorting (sometimes by type of claim, medical records, or cashier's checks), and then to identify to whom the documents should be forwarded. In some cases, documents were to go to a medical group for scanning, to a cashier for handling checks, to POM for reimbursing community care providers, or to others who help respond to veterans' correspondence. Finally, POM officials cited the verbal agreement when voicing reluctance to assist the Atlanta VA HCS when the facility staff could not manage the mail processing tasks they took over, despite the backlogged mail including claims that POM staff needed to process.

Given how the responsibility for handling the mail was mismanaged in Atlanta, VHA should ascertain what effects the delays in processing have had on veterans' care, community care providers submitting claims for reimbursement, veterans potentially billed because the providers were not promptly paid, VA's financial management of expired checks, and any other impact from miscellaneous pieces of mail and then take corrective action. The OIG assessed the following issues resulting from the mail backlog:

- **Veterans' care.** More than half of the mail caught in the backlog contained medical records related to care obtained in the community, which can be sent by non-VA care providers or veterans. It is important that this type of mail is accurately and promptly processed and acted upon.
- **Community care provider's claims for reimbursement.** Providers may have been negatively affected by delays or nonpayment that can create disincentives to providing care to veterans in the community.
- **Veterans inaccurately billed.** Veterans' claims for reimbursement of non-VA emergency care can be denied because the claimant missed the deadline for filing. Atlanta VA HCS staff identified 72 pieces of mail directly from patients requesting assistance with paying their medical bills.

- **VA's financial management of expired checks.** Atlanta VA HCS officials reported that 84 checks totaling $206,724 were caught in the backlog, some of which were expired and will require additional steps to recoup the money.
- **Miscellaneous mail.** Correspondence from veterans and other items that fall into this category need to be assessed to determine if any consequences require additional action.

Finally, because POM is in the process of similar transitions at sites across the country, POM and medical facilities need to ensure there is adequate staff with sufficient training to handle the on-site mail processing workload.[7]

What the OIG Recommended

The OIG made five recommendations, including that the director of Veterans Integrated Service Network (VISN) 7 should make certain that (1) the Atlanta VA HCS develops and implements a plan for the routine proper and prompt processing of mail, including adequate mailroom staffing with appropriately trained personnel; and (2) assist the VA HCS in taking steps to recoup money owed from expired checks when appropriate. The under secretary for health should also (3) assess the remaining negative effects of the mail backlog on veterans, care providers, and others and take needed corrective action; (4) determine if unprocessed mail backlogs exist at other VA medical facilities; and (5) ensure procedures and controls are developed to make certain that medical facility personnel taking over POM on-site mail processing have the necessary resources and expertise to accomplish this work accurately and within prescribed timelines.

VA Comments and OIG Response

The director of VISN 7 and the deputy under secretary for health concurred with the recommendations and submitted responsive corrective action plans. Appendixes E and F provide the full text of the VISN's and the deputy under secretary's comments. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress addressing the issues identified.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

[7] The magnitude of this transition is set forth in an April 2021 memo to VISNs, in which the assistant under secretary for health operations stated that the Office of Community Care Delivery Operation was in the process of consolidating 82 distinct claims processing operation sites as of April 2021, affecting approximately 333 employees.

Contents

Abbreviations

HCS	Health Care System
OIG	Office of Inspector General
POM	Payment Operations and Management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

On September 17, 2021, the *Atlanta Journal-Constitution* published an article about 10 pallets of months-old, unopened mail being stored in the warehouse basement of the Atlanta VA medical facility, some with postmarks dating back at least 10 months.[8] Photographs documented this mail backlog as envelopes and parcels stacked from three feet to 10 feet high. Subsequent articles were published on September 28 and October 7, 2021, emphasizing the potential effect on veterans' health care and community care provider claims for reimbursement related to those correspondences.[9]

After the first *Atlanta Journal-Constitution* article, a team from the VA Office of Inspector General (OIG) started a review of the Atlanta facility to evaluate the mail backlog content and responsible personnel, determine the origin of the problem, and assess mail processing procedures. The review was conducted in recognition of the significant possible effect on veterans. Figure 1 summarizes the early actions during the OIG review:

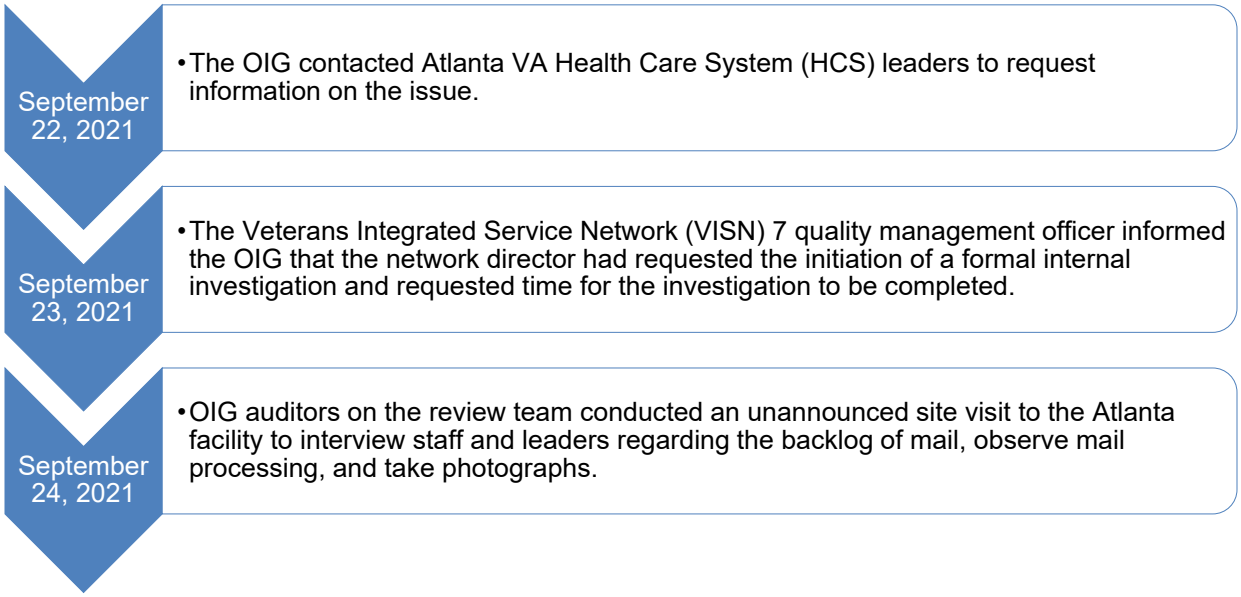

Figure 1. *OIG timeline of actions taken.*
Source: OIG analysis.

[8] The Atlanta VA medical facility in Decatur, Georgia, is the main location within the Atlanta VA Health Care System (HCS).

[9] Christopher Quinn, "Months-old mail piles up in Atlanta Veterans Affairs hospital basement," Atlanta Journal-Constitution, September 17, 2021; Christopher Quinn, "VA launches two inquiries into 10 pallets of unopened mail," Atlanta Journal-Constitution, September 28, 2021; Christopher Quinn, "Former VA employee says he reported pallets on unopened mail last year," Atlanta Journal-Constitution, October 7, 2021.

The OIG review team returned to the Atlanta medical facility for additional interviews and to make observations during September and October 2021. See appendix A for a timeline of significant Veterans Health Administration (VHA) events.

Key Mail Processing Responsibilities

As a result of a November 4, 2020, verbal agreement made by the Atlanta VA Health Care System (HCS) deputy director and the Office of Community Care's Payment Operations and Management (POM) officials, POM's mail processing responsibilities shifted to the mailroom staff. The sections below outline the Atlanta VA HCS mailroom and POM personnel's mail processing responsibilities before and after the agreement was made.

Prior to November 4, 2020

The Atlanta VA HCS mailroom staff were responsible for multiple mail-related tasks, such as receiving and separating facility incoming mail for distribution and then delivering the mail. According to a POM official, mail that was addressed to POM was first delivered to the medical facility mailroom and then placed into bins and delivered to the Summit Building—a leased space used by the Atlanta VA HCS where POM staff were located.[10] According to this official, POM received mail addressed in many different ways, including marked with the POM mail stop code of 136F, Billing, Fee Basis, or combinations of these indicators.[11]

Once the mail was delivered to the Summit Building, POM staff were then responsible for opening, sorting, and rerouting mail that was addressed to them. Each day, one or two POM employees would open, sort, and then send the mail to the correct recipient group or department based on the contents of the mail. For example, if the mail contained a community care provider's claim for reimbursement, the claim needed to be rerouted to the Office of Community Care's scanning contractor in Tampa, Florida. Although addressed to the local POM Atlanta office, the POM official stated that not all mail belonged to them, such as mail containing medical records. The same POM official stated that POM staff would separate the medical records and send them back to the Atlanta medical facility, where the mailroom staff would distribute the records to the Health Information Management Service. POM staff did not maintain a log of the mail they processed.

[10] At that time, the Atlanta medical facility mailroom staff were not responsible for opening, then further sorting, or rerouting mail if it was specifically addressed or otherwise directed to POM.

[11] An Atlanta VA HCS mail clerk also stated that they identified mail that belong to POM based on keywords on the envelope or package.

Beginning November 9, 2020

On November 4, 2020, the Atlanta VA HCS deputy director and POM officials verbally agreed to assign space that POM staff had occupied in Atlanta's Summit Building to HCS staff.[12] Before this agreement, POM staff used this space to process mail transferred from the medical facility's mailroom that indicated it was addressed to them.[13] In exchange for the return of the space, Atlanta VA HCS leaders agreed to take responsibility for mail operations that POM staff previously handled.

Organizational Structure

Personnel from two distinct VA entities were directly involved in amassing the mail backlog: (1) staff from the Atlanta VA HCS and (2) staff from the Office of Community Care's POM directorate.

Atlanta VA HCS Personnel

During fiscal year 2021, the Atlanta medical facility mailroom consisted of four mail clerks responsible for mail-related tasks who reported to a material handler. The Atlanta VA HCS chief of supply chain management oversees and manages the material handler and other staff who work in the mail room. The chief of supply chain management reported directly to the Atlanta VA HCS associate director, who then reported up the chain of command from the deputy director to the HCS director, as illustrated in the following organizational chart starting from the bottom (figure 2). Regional oversight for VA medical facility directors is the responsibility of the director of Veterans Integrated Service Network (VISN) 7, who reports to the assistant undersecretary for health for operations at the national level:

[12] Although meeting minutes documented a high-level summary of this verbal agreement, no formal written agreement details its conditions.

[13] According to a POM official, POM staff were mostly teleworking during this time due to COVID-19 restrictions, but staff rotated into the Summit Building to continue to process their mail.

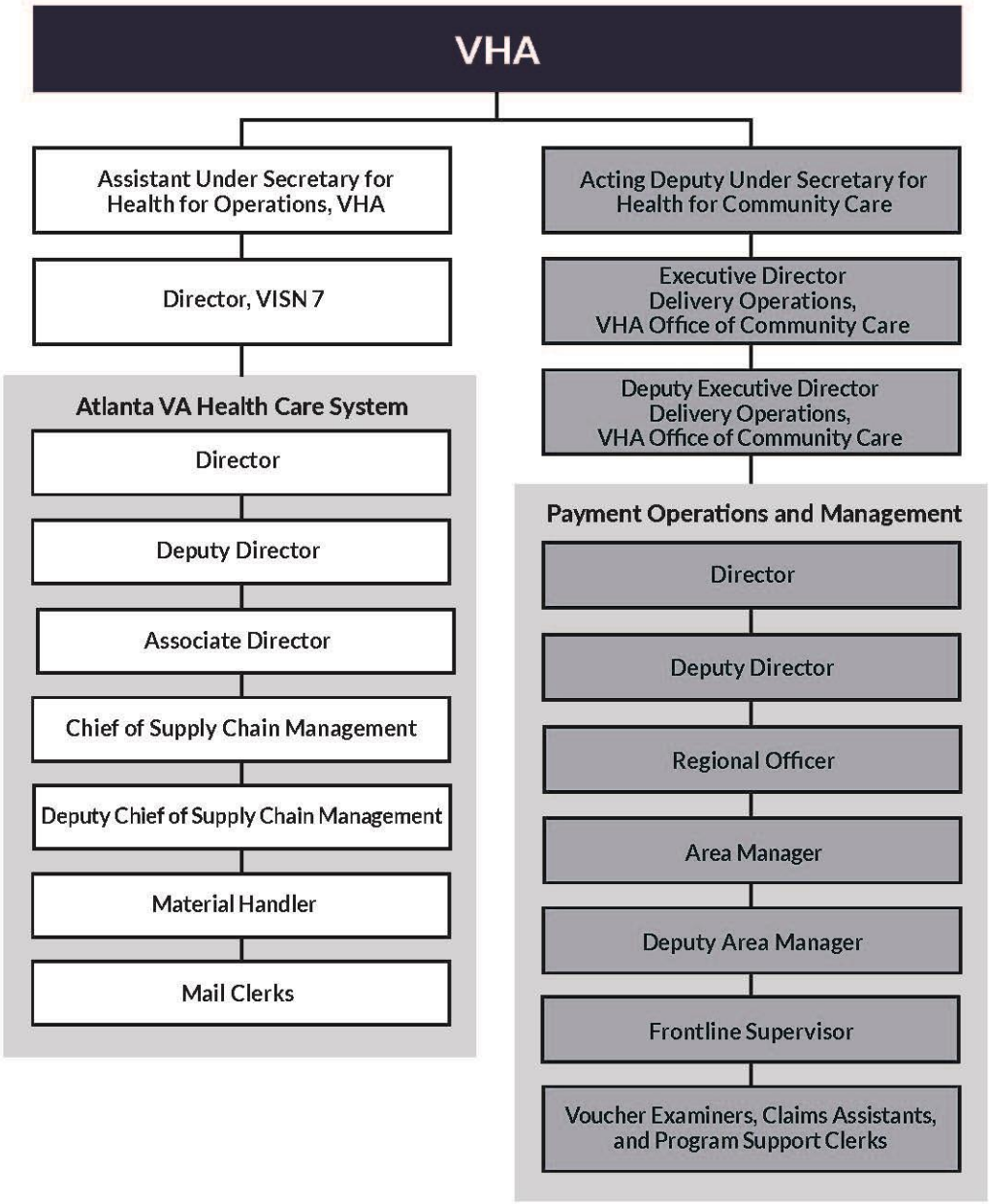

Figure 2. *Atlanta VA HCS and POM organizational chart with regional and national oversight. Source: OIG analysis.*

Veterans Health Administration Office of Community Care's POM Directorate

Although often physically located in the same location as a VA medical facility, POM staff work for the VHA Office of Community Care, not a VA medical facility. The Office of Community Care works with veterans to obtain medical care and services through providers outside of VA and is led by the deputy under secretary for health for community care. A primary service line in

the Office of Community Care is Delivery Operations. Staff in Delivery Operations manage all programs that allow veterans and their family members to receive care and services outside of VA and manage programs that pay for such care. Delivery Operations includes POM.[14] According to a POM official, POM staff primarily process claims for care that were not previously authorized, such as emergency care.

[14] The director of POM reports to the executive director of the Office of Community Care's Delivery Operations.

Results and Recommendations

Finding: Atlanta VA HCS Leaders Did Not Ensure That Mail with Patient Health Information and Care Providers' Claims Was Appropriately Processed, Leading to a 10-Month Accumulation of More Than 17,000 Items

The OIG determined that Atlanta VA HCS leaders did not ensure that mail would be promptly opened and distributed after the Office of Community Care's POM staff agreed to vacate space in the Summit Building. Officials at the Atlanta VA HCS did not take adequate steps to open and process this mail, even though they were aware by at least January 2021 that the mail was accumulating in the basement. From November 2020 to September 2021, the Atlanta VA HCS did not take responsibility for processing this mail and then did not identify a solution for expeditiously addressing the backlog, which amounted to more than 17,000 pieces of mail as of late September 2021.[15]

Due to this lapse, medical records went unscanned into VA's electronic health record for many months, which can affect the quality of care provided to patients when clinicians cannot access the most comprehensive and updated information. Moreover, community care providers' claims for reimbursement may not have been reviewed and paid, which provides a disincentive to remain in VA's network. Finally, financial management was potentially affected as checks made out to the facility expired before they were processed.

As VA resolves this backlog, VA needs to identify and correct the negative effect the backlog has had and take steps to ensure this backlog is not occurring at other facilities. Because POM is conducting a similar transition out of VA medical facilities across the country, VHA faces a similar risk that backlogs will develop undetected.[16]

In support of the OIG's finding, this report discusses the following determinations made by the review team:

- **The size and content of the mail backlog and responsible offices:** A discussion of the September 2021 backlog and how Atlanta VA HCS staff were opening, sorting, and then resolving the backlogged mail with POM.

[15] See appendix B for information on prior OIG reports that focus on other mail processing issues. VA's responses to the recommendations in this report are included in appendixes E and F, including reported corrective actions since the close of this review.

[16] The magnitude of this transition is set forth in an April 2021 memo to VISNs, in which the assistant under secretary for health operations stated that the Office of Community Care Delivery Operation was in the process of consolidating 82 distinct claims processing operation sites as of April 2021, affecting approximately 333 employees.

- **How the backlog had accrued:** An assessment of how the backlog originated due to the verbal space agreement between the Atlanta VA HCS and POM in November 2020 and other deficiencies that allowed the backlog to persist.
- **The potential consequences:** A summary of the possible impact of the mail backlog on veterans, community care providers, and VA's financial management as a result of not opening the mail for many months.
- **Mail processing needs going forward:** An analysis of the steps VA could take to safeguard against the kinds of deficiencies found in Atlanta and ensure the prompt processing of mail as POM consolidates employees at other sites.

What the OIG Did

Auditors from the OIG visited the Atlanta VA medical facility to observe the progress of processing and scanning the backlogged mail and to interview Atlanta VA HCS leaders and other personnel. The team also interviewed personnel from the Office of Community Care's POM directorate. POM personnel have a different function from medical facility employees in that they process community care provider claims and report to the Office of Community Care, not to a VA medical facility.

Based on these interviews, the team obtained and reviewed supporting documentation, including the following:

- Emails from facility, POM, and VISN 7 personnel dating back to 2020
- Shipping receipts for mail sent from the Atlanta VA HCS to another POM office
- A log of over 900 pages describing the more than 17,000 pieces of processed mail, documented by Atlanta VA HCS staff[17]
- Logs of payment checks information from March, April, May, and September 2021[18]

The Size and Content of the Mail Backlog and Responsible Offices

After the September 2021 publication of the initial news article in the *Atlanta Journal-Constitution*, officials at the Atlanta VA HCS dedicated staff (the task force) to open, sort, and process the pallets of mail that had accumulated in the warehouse basement. When the OIG review team visited the facility in late September, VA employees were busy sorting and processing more than 17,000 pieces of mail, some of which had remained unopened for months.

[17] The review team did not verify the count or category of mail, or monetary value of checks referenced in the logs.
[18] See appendix C for scope and methodology.

The following photographs document the progression of this effort. Sorting was a multistep, complex undertaking. Staff moved the mail from its initial location in the warehouse basement (figures 3 and 4) to hallways (figures 5 and 6) to separate the documentation by category (for example, medical records and community care provider claims) that came out of the unopened mail, according to the supervisor of the mail-opening task force.

Figure 3. ***Figure 4.***
The basement of the Atlanta VA medical facility warehouse where unopened mail was initially stored.
Source: An Atlanta VA HCS staff member provided these pictures to the review team. The staff member indicated that these pictures were taken on June 18, 2021, (figure 3) and July 7, 2021 (figure 4).

Figure 5. ***Figure 6.***
Once opened, mail of all types was then moved to the hallway of the facility's Community Living Center, which was already temporarily closed.
Source: OIG, September 24, 2021.

Later, facility staff transferred the medical records and other mail to rooms in the Community Living Center to sort the mail backlog further (figures 7 and 8). The supervisor of the mail-opening task force stated that Atlanta VA HCS staff needed to sort medical records not only by provider type (such as inpatient, emergency room, and specialty) but also by patient. All these steps needed to occur before Atlanta VA HCS staff could scan them.

Figure 7 (above). *Medical records and mail were then moved for sorting to various rooms in the Community Living Center, like this conference room.*
Source: OIG, September 24, 2021.

Figure 8 (left). *Stacks of medical records (blurred for privacy purposes) from the backlog of previously unopened mail, now sorted by category and assigned a corresponding color. These records still needed to be sorted by patient, according to the supervisor of the mail-opening task force.*
Source: OIG, September 27, 2021.

On September 27, 2021, an Atlanta VA HCS staff member indicated that the task force had finished opening all the backlogged mail. The staff member provided logs that showed, in total, the backlogged mail included 17,660 pieces of mail, which contained the following important documents:

- **10,020 medical records (about 57 percent).**[19] Community care providers and veterans send patients' documents to VA medical facilities for staff to scan or import into VA's electronic health records, which helps ensure continuity of care. Incorporating these non-VA medical documents into the patients' electronic health records is critical to supporting high-quality patient care because it contributes to more complete, accurate, and readily accessible health records that guide clinicians' decisions. VA medical facility staff are responsible for reviewing and scanning these medical records.

[19] In January 2022, the VISN 7 chief medical officer reported that after facility staff reviewed the pieces of mail that were medical records, they identified 5,496 total episodes of care. Of those, the chief medical officer reported that 907 of the episodes of care were already in the patients' electronic health record, and 4,589 were not.

- **7,295 claims (approximately 41 percent).** Claims can be submitted from community care providers seeking reimbursement for medical services rendered to VA patients. For example, the mail backlog contained a claim submitted by a non-VA provider on behalf of a veteran for emergency services provided in May 2021 totaling over $3,000. According to a POM official, the Office of Community Care primarily processes claims that were not previously authorized, such as emergency claims. Processing claims in a timely manner is important so that non-VA providers do not bill veterans for costs of medical services, which can result in a substantial undue financial burden on the veteran. Delays in paying community care providers can also increase the risk that they will opt not to participate in future VA care.
- **84 checks (less than 1 percent).** The mail backlog contained numerous checks from community care providers to refund VA for overpayments. The checks identified in September 2021 totaled nearly $207,000. Many of these checks had disclaimers noting that the check became void if not cashed within a certain amount of time (such as 60 days, 90 days, or six months). For example, Atlanta VA HCS staff identified several checks in September 2021 that were voided because they exceeded the designated amount of time. One check dated back to October 21, 2020—11 months prior—and stated, "Void after 90 days."[20]
- **261 miscellaneous items (about 1 percent).** The unopened mail also included explanation of benefit forms, VA pending invoices, travel payment requests, and correspondence from veterans. For example, a veteran sent an unpaid bill totaling about $1,000 for emergency services received from a non-VA care provider to the Atlanta VA HCS. On this bill, the veteran wrote "PLEASE HELP ME" (figure 9).

[20] According to the Atlanta VA HCS interim chief financial officer, the facility took steps to review if checks were expired, and if so, to request reissuance.

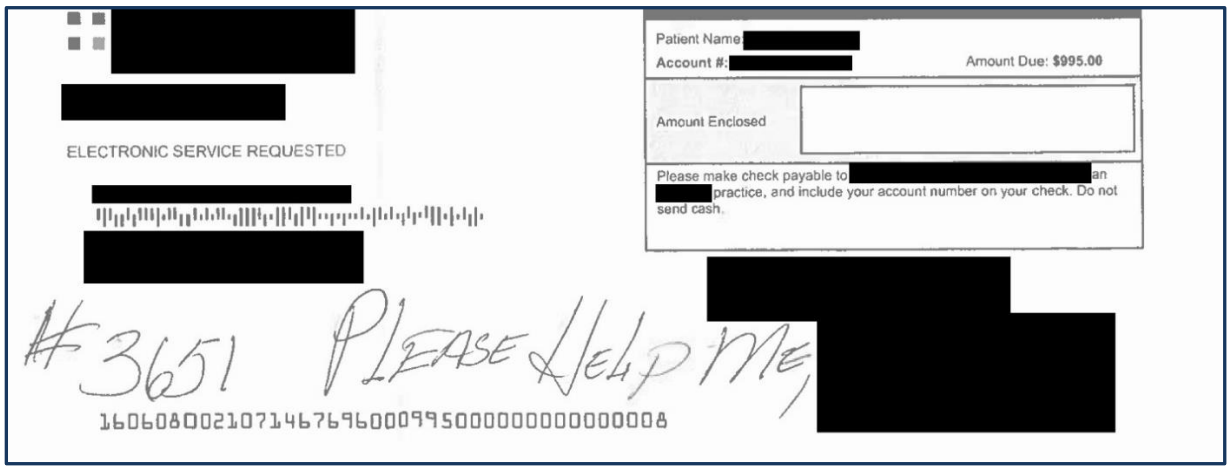

Figure 9. *Correspondence from a veteran who forwarded a bill for emergency services provided in October 2020, included in the mail backlog that was processed in September 2021 (redacted for privacy purposes). Source: Atlanta VA HCS.*

Immediately after the *Atlanta Journal-Constitution* article was published, Atlanta VA HCS leaders approved overtime for facility staff to process the mail backlog and ensured mailroom staff were trained. However, the OIG concluded that if the Atlanta facility was capable of coordinating staff to open and process this mail in September, then it could have processed the mail and cleared this backlog months earlier. As shown in the sections that follow, officials in Atlanta were aware that the backlog was accumulating as early as January 2021 but did not take adequate steps to reduce the backlog until after the *Atlanta Journal-Constitution* drew public attention to the problem.

How the Mail Backlog at the Atlanta VA Medical Facility Accrued

The September 2021 mail backlog began after a verbal agreement between Atlanta VA HCS and POM personnel regarding Atlanta VA HCS leased space at the Summit Building. On November 4, 2020, these two parties met to discuss the issue—Atlanta VA HCS officials wanted to use the space occupied by POM employees, and POM officials were willing to have their employees transition to telework indefinitely if another office processed the mail.[21] As one POM official explained, POM was engaged in a process of consolidating the locations of its staff. However, POM employees had been physically present to handle the mail forwarded to the Summit Building up to that time.

The POM area manager and the Atlanta VA HCS deputy director verbally agreed that if POM vacated the space, the Atlanta VA HCS employees would take responsibility for handling the mail. The OIG notes that although there were minutes from this meeting, there was no written

[21] Atlanta VA HCS attendees of this meeting included the deputy director, deputy chief of staff, chief health administrator, and chief of the Strategic Planning Office.

memorandum of understanding between the two offices. Regarding the agreement discussed between POM and the Atlanta VA HCS officials, the meeting minutes only noted, "[The Atlanta VA HCS deputy director] agrees to stop processing mail to the Summit Building and reroute the mail to another service and reorganize the process. POM will work on an SOP [standard operating procedure] for the process."[22] The meeting minutes did not describe what POM disclosed as to volume, process, or number of people needed to accomplish the work, nor did the minutes address timing. Further, the review team found that the Atlanta officials in charge of managing the mailroom were not involved in this meeting.

On November 9, 2020, POM staff vacated the Summit Building, just five days after the initial meeting. A POM official provided mail instructions to the Atlanta VA HCS deputy director on November 16, 2020 (these instructions are included in full in appendix D of this report). The instructions provided guidance on how the mail should be distributed based on the contents of the mail. For example, all refund checks should go to the agent cashier. On November 17, 2020, when the Atlanta VA HCS mailroom staff learned of this additional responsibility, they immediately expressed concerns. One mailroom clerk wrote to his supervisor that he did not know "how or when we would have the time or space/extra personnel to do this additional task. These are unrealistic expectations of the mailroom staff. Our current workload keeps us busy all day."

In addition to volume, there was also the question of complexity. Handling POM's mail was not simply a matter of delivering it to the addressee or sending it on to POM. Instead, mailroom staff needed to open every item, identify what type of mail it was (such as medical records, community care provider claims, or checks), sort it, and then take varying actions. According to a VA handbook in effect at the time of the verbal space agreement, mail clerks had the authority to open mail.[23] However, it was unclear if the Atlanta mailroom staff had the expertise to properly determine each type of mail to then move the contents of the mail to where they needed to go (including the Health Information Management Service for medical records, POM contractor for community care provider claims, and the agent cashier for checks). The POM program management officer of the Southeast Region told the review team that the mail instructions were not as clear as they could have been.

On November 16, 2020, a POM official suggested in an email to the HCS deputy director that for a clean hand off, two POM employees should assist with the mail processing so that the "mail is caught up and there are no hiccups." However, another POM official stated that the POM assistance never occurred because the Atlanta VA HCS never set a time.

[22] For the purposes of this report, the standard operating procedure is referred to as "mail instructions."
[23] VA Handbook 6340, *Mail Management Procedures,* July 26, 2018.

On January 8, 2021, the Atlanta VA HCS facility deputy chief of staff reached out to POM officials, writing that

> despite our best intentions there seems to be an issue with the POM mail from the summit building. The mail is being forwarded to the mail room at the main medical center and the mail room staff has the instructions that were sent. However, determining where to send the mail based on these instructions can't be determined in most cases without opening the mail and reviewing documents. This is outside the scope of the mail room. As a result, POM mail has been accumulating in the mail room.

Two weeks later, as the mail was accumulating, the POM area manager replied,

> We can talk about this, but I confirmed with [POM supervisor] that we do not have anyone onsite at the Summit building as [Atlanta VA HCS deputy chief of staff] described to work it and we have given up our seating in the agreement to have the mail done by the facility. That is what [Atlanta VA HCS deputy director] and the entire group agreed to when we conferenced on the subject. We were very upfront about the volume of mail and what the details of the process were in our discussion and [Atlanta VA HCS deputy director] was very pleased with the outcome of the meeting and we were only able to meet Atlanta VA [HCS] space needs because of this concession.

Atlanta VA HCS officials reached out to POM officials multiple times in January, February, and March 2021, but POM was reluctant to assist, even though it was aware that mail it needed for its business was piling up in the warehouse. For instance, on February 17, 2021, the Atlanta VA HCS associate director reached out to the POM area manager:

> I need to speak to you about the POM mail that is now being delivered to our main facility. There are now five (5) carts of mail in our warehouse. I know that we developed this plan to have mail delivered to our mail room, however we need to revisit this plan (see January 8th email). We have no way of knowing where this mail should go to unless we open it (and our mailroom staff don't need to be opening it).

A day later, the POM deputy area manager replied,

> The POM office does not have anyone one [sic] site at the Summit Building to receive and open mail. POM management agreed to give up our seating space in the agreement that the facility would do the mail. [The Atlanta VA HCS deputy director] and the entire group agreed to this arrangement. The attached instructions were provided to the Atlanta VA [HCS] staff for processing of mail.

Atlanta VA HCS Health Information Management Service officials decided that they would attempt to process some mail in March 2021. A report of contact dated February 16, 2021, made

by a medical records release of information supervisor to the chief of Health Information Management Service noted that approximately 125 boxes of mail addressed to POM were in the basement of the medical facility.[24] According to the chief of Health Administration Services, these efforts involved facility staff who began to assist with the mail backlog, in addition to their regular duties. The review team determined that these efforts were minimal compared to the efforts taken after the *Atlanta Journal-Constitution* article was published, and the efforts ceased around June or July 2021 due to other competing priorities. The Atlanta VA HCS medical records release of information supervisor stated that the Atlanta VA HCS staff did not log the amount of mail opened during this effort; however, the review team determined they did log the mail in September 2021.

The Mail Backlog Was Shipped to and from the Birmingham POM Office Multiple Times

In June 2021, the accumulating mail was shipped to and from a POM office in Birmingham, Alabama, as that was one of the addresses included in POM's instructions where its mail was to be forwarded.[25] In mid-June, The POM area manager reported to the VISN 7 business health program manager that earlier in the month 14 boxes of unopened and unsorted mail were sent from the Atlanta VA medical facility to the Birmingham POM office. According to POM's mail instructions provided to the facility, medical records, claims, and refund checks should not have been forwarded to Birmingham, Alabama.[26] Although this mail was addressed to POM, the POM area manager claimed that 80 percent of the total mail was instead medical records that were the responsibility of the Atlanta VA HCS Health Information Management Service. According to POM, after opening and sorting the mail, a staff member estimated it would cost over $1,200 to ship the medical records-related mail back to the Atlanta VA medical facility and ship any community healthcare-related claims on to POM's contractor in Tampa, Florida, which is responsible for scanning provider claims for payment.[27]

Later that month, Birmingham POM staff reported that the Atlanta VA medical facility shipped another 13 boxes of unopened mail to Birmingham and that this shipment included at least one box of mail from the first shipment that was already sent back. The POM area manager alleged that most of the mail in this second shipment did not belong to Birmingham POM, as it included primarily medical records and only about 50 claims. The POM area manager stressed to the

[24] VA Form 119, Report of Contact, February 16, 2021.

[25] The review team could not determine if the mail that was sent to Birmingham, Alabama, did in fact belong to POM.

[26] The full mail instructions are in appendix D.

[27] A POM official estimated that it would cost over $1,200 for Birmingham to send the mail to the appropriate location—Atlanta, or to the POM contractor in Tampa, Florida. According to Atlanta VA HCS deputy chief of supply chain management, the price to ship the mail from Atlanta to Birmingham was significantly less—about $278. The review team was unable to determine why the reported shipping costs differed.

VISN 7 business health program manager that these incorrect shipments wasted the government's time and money, and that it was critical that the matter be resolved so that veterans' mail would receive a timely and appropriate response.

Contrary to the POM area manager's description, the Atlanta VA HCS medical records release of information supervisor told the review team that HCS staff had opened and sorted the mail before sending it to Birmingham. Additionally, the Atlanta VA HCS chief of supply chain management indicated that the mail was sent to Birmingham because that was the address where POM directed the facility to send the mail, and it was his understanding that POM would process the mail. The review team determined that the ongoing confusion was a result of the undocumented, informal space agreement; the incomplete terms of the agreement, including mail processing responsibilities; and the lack of implementation of the mail instructions that POM provided.

Although some of the mail backlog was processed during this time, much of it was not. As late as September 16, 2021, the Atlanta mailroom manager wrote, again, "We need to get this mail processed and out of the basement and have a plan to process this mail in the future."

Multiple Deficiencies Allowed the Backlog to Persist

From November 2020 to September 2021, the Atlanta VA HCS and POM failed to take responsibility or identify a solution for expeditiously processing this mail, which affects veterans the facility serves and non-VA providers that VHA leverages. The OIG drew several conclusions from these events:

- First, POM and the Atlanta VA HCS's November 2020 agreement was not formally documented. Although meeting minutes documented a high-level summary of this agreement, no formal, written document details the terms of the agreement, including who would be responsible for processing the mail. Both the POM regional officer and the Atlanta VA HCS deputy director told the review team that there was no formal documentation outlining the conditions of this agreement. The lack of formal documentation made it difficult to understand what was disclosed in reaching the agreement and the details of each party's responsibilities. Given this agreement's subsequent significance, VA should have established a formal agreement clearly stating each office's responsibilities, the scope of those responsibilities, and any requirements for training or guidance on how to meet those responsibilities.
- Second, Atlanta VA HCS did not include the managers responsible for processing the mail in the November 2020 meeting and, therefore, could not bring their experience and knowledge to bear in shaping any agreement. Those managers were unaware of the workload that the Atlanta VA HCS leadership team agreed to accept. Specifically, mail clerks were not made aware of the newly assigned workload until almost two weeks after the verbal agreement was made—after POM staff had already vacated the Summit

Building. Although POM officials contend that the workload was discussed, it appeared that Atlanta VA HCS leaders did not have a clear understanding of the volume of new work they were accepting, given the complexity of that work or specifics on how their mailroom would handle the new responsibilities. Although some of the mail was opened since November 2020 through various efforts, the Atlanta VA HCS mailroom staff inaccurately assumed that all the contents of the unopened mail belonged to POM based on an address or other indicators on the envelope. Because of mailroom staff's resistance to opening and processing all the mail, they did not determine until September 2021 that much of the mail was, in fact, medical records that the facility staff were responsible for reviewing and scanning—about 57 percent.

- Third, Atlanta VA HCS leaders did not ensure that mail room staff were adequately prepared or trained to handle the influx of mail. Several officials stated that the mailroom staff were not qualified or trained to determine what sort of documents the mail contained (sometimes by type of claim, medical records, or cashier's checks) and identify to whom it should be sent. In some cases, documents were to go to a medical group for scanning, to a cashier to handle checks, to POM for reimbursing community care providers, or to others who help respond to veterans' correspondence.
- Fourth, once it became clear that Atlanta VA HCS had taken on responsibilities that it would find difficult to fulfill, POM was not willing to assist, even though the unopened mail also included claims that POM staff needed to process. Although POM had employees who were experienced in processing this mail, POM was reluctant to assist.

Potential Consequences of Not Opening Mail for Many Months

As the Atlanta VA HCS was still resolving the management of more than 17,000 pieces of mail in the backlog during this review, it is difficult to determine the precise consequences of not processing this mail for so many months. According to the VA mail handbook, facility mail needs to be opened, sorted, and routed to the appropriate location promptly, and the "objective of incoming mail management is to deliver mail to the action office within the shortest possible time after receipt, at least within 4 to 6 hours whenever possible."[28] The review team determined that most of the mail contained time-sensitive documents, including medical records and community care provider claims.

The OIG contends that VHA must ascertain what negative effect the mail backlog has had on veterans' care, community care providers submitting claims for reimbursement, veterans

[28] VA Handbook 6340, *Mail Management Procedures*, July 26, 2018. VA updated its policy to VA Handbook 6340, *Enterprise Mail Management Procedures*, on June 21, 2021, stating, "The objective of incoming mail management is to deliver mail to the intended end recipient or office address within the shortest possible time after receipt, within one business day."

potentially billed because community care providers were not promptly paid, and VA's financial management of expired checks and determine any other impact from the miscellaneous pieces of mail.

Veterans' Care

As stated earlier, approximately 57 percent of the mail caught in the backlog was medical documentation related to care obtained in the community, which can be sent by non-VA providers or veterans. If this type of mail is not processed and scanned in a timely manner, patients' future care could be delayed, or medical decisions could be based on incomplete documentation. VHA policy states that all documents must be scanned into the electronic health record within five business days of receipt, allowing clinical and administrative staff to view the information without delays.[29] In addition, care providers or administrative staff could spend time searching for necessary medical documents that were not indexed to the veterans' health records—time better used for other patient needs.

Example 1

> *An Atlanta VA HCS primary care provider stated that since November 2020, he has encountered instances in which a veteran's medical history was not fully available to him. Further, he stated that it has delayed patient care because he did not have the necessary information to enter consults (referrals) to specialists or delayed the prescribing of certain medications due to his concerns for the patient's safety. It has also caused unnecessary duplication of healthcare services in the form of lab tests or imaging that has already been completed in the community but were not made available to him.*

Example 2

> *Another Atlanta VA HCS primary care provider stated that the lack of medical records frustrates veterans as they are not able to fully discuss their care during their scheduled appointments.*

Although it is unknown if these specific instances were the result of this mail backlog, these examples emphasize the importance of timely opening and processing veterans' medical records when providing patient care.

Community Care Providers' Claims for Reimbursement

If community care providers' submitted claims for payment are caught up in the backlog, then those providers will not be reimbursed on time. With nonpayment comes the potential that the

[29] VHA Directive 1907.01, VHA Health Information Management and Health Records, April 5, 2021.

relationship between non-VA care providers and VA could become strained. VA should determine if any providers were negatively affected by this backlog and take steps to mitigate the harm done.

Veterans Inaccurately Billed

Veterans' claims for reimbursement of non-VA emergency care can be denied because the claimant missed the deadline for filing. Separately, claims can also be denied if pertinent medical documentation, such as discharge summaries and progress notes, is not submitted. Atlanta VA HCS staff identified 72 pieces of mail directly from patients requesting assistance paying their medical bills. VA needs to ascertain how many veterans' claims were denied due to timeliness or completeness issues related to the backlog and take steps to correct these denied claims. Timely processing of claims is important so that non-VA providers do not potentially bill veterans for costs of medical services, which can result in a substantial undue financial burden on the veteran.

When claims for reimbursement are denied by POM claims processors, claimants can appeal the decision within one year from the date of the denial letter. If appeals are not received and postmarked on time, there is a chance that the appeal may be unjustly denied. VA needs to determine if the mail backlog caused any veterans to have an appeal denied.

VA's Financial Management of Expired Checks

Atlanta VA HCS officials reported that 84 checks totaling about $206,724 were caught in the backlog. The review team determined that some of these checks were expired. VA needs to take appropriate steps to recoup this money.

Miscellaneous Mail

Finally, VA needs to assess the importance of the mail categorized as miscellaneous, ensure those items have been properly addressed, and determine if there were negative consequences for not handling these documents expeditiously that require additional corrective action.

According to the Atlanta VA HCS performance improvement program coordinator, as of September 27, 2021, facility staff had completed opening and sorting the backlogged mail. The OIG concluded that since the Atlanta VA HCS has completed processing the mail backlog, VA must ascertain what negative effect it has had on veterans, community care providers, and other parties. The department must then take steps to remedy this harm where possible.

Assessment of Mail Processing Needs Going Forward as POM Consolidates Employees

Although the Atlanta VA HCS took steps to open and sort the mail, additional work should be done to prevent backlog recurrence in Atlanta and across the nation. The OIG notes that without

appropriate action (such as ensuring an adequate number of properly trained mailroom staff), Atlanta and other medical facilities may continue to face similar problems and consequences. The review team found that the Atlanta mailroom was still receiving large quantities of mail addressed to POM that need to be sorted. According to the Atlanta VA HCS deputy chief of supply chain management, the Atlanta mail room received 2,592 pieces of mail over about one month, or an average of 123 pieces of mail per business day.[30] Because, moving forward, Atlanta mail room staff will open, sort, and distribute mail addressed to POM, they must be trained and have the time and resources to handle these additional mail processing responsibilities.[31]

Furthermore, it is increasingly crucial that POM and medical facilities ensure there is adequate staff to handle the on-site workload, as POM has been in the process of a similar consolidation effort nationwide that may result in fewer POM personnel in facilities. In April 2021, the assistant under secretary for health for operations sent a memo to all VISNs informing them that the Office of Community Care's Delivery Operations (which oversees POM) was in the process of "consolidating 82 distinct claims processing operations sites into five payment centers and eight satellite locations." This consolidation would affect approximately 333 employees. The assistant under secretary continued by stating that VISNs can assist by selecting these staff for existing replacements or accepting their reassignment for equivalent positions. This memo did not discuss mail processing workload or responsibilities. However, POM staff were responsible for opening and sorting mail at other VHA medical facility locations, like the process in Atlanta.

The OIG is concerned that unless medical facility employees are sufficiently prepared, the backlog experienced in Atlanta could occur in other facilities—a concern shared by other VISN 7 staff in addition to Atlanta. For example, the review team learned through a POM official that, in June 2021, POM standardized its mail processing to have medical facility staff assume the responsibility of processing mail that was addressed to POM (which POM staff had previously handled) across all medical facilities in POM Region 2—not just facilities where POM staff were vacating.[32] In September 2021, the VISN 7 chief supply chain officer queried eight VISN 7 medical facilities about the POM mail volume received at each facility. Five of the medical facilities responded that they require additional support and resources to support POM mail processing, to include additional staff, POM operating procedures, and clearer directions.

Similarly, in June 2021, staff at two other facilities voiced concerns to the VISN regarding the additional mail responsibilities. The concerns included having limited staff, uncertainty regarding where to send billing statements, an increase in the receipt of mail and checks, and

[30] After the backlog items had been opened and sorted, the Atlanta VA HCS deputy chief of supply chain management created and maintained a detailed log of mail addressed to POM received from September 30 through October 29, 2021.

[31] The chief of supply chain management has requested additional staff for the mailroom, but the positions had not been filled as of November 4, 2021.

[32] POM is divided into five different regions. Region 2 consists of VISNs 5, 6, 7, and 8.

confusing instructions pertaining to mail distribution. Specifically, a Birmingham VA medical facility business management service chief stated, "I have great concerns with what POM is asking us to do. My mailroom staff … do not have any knowledge how to interpret the mail that comes in that needs to go to POM." Although other sites voiced concerns, the VISN 7 business health program manager instructed the sites to ensure that the mail was properly processed.

While medical facility staff in POM Region 2 were taking on this new responsibility, the POM director stated that not all POM mail responsibilities were taken over by medical facilities. A POM representative stated that 62 of 82 medical facilities (76 percent) had taken over POM staff's mailing responsibilities because of the consolidation. The POM director indicated that because each location was different, POM leaders would work with the affected medical facility to disseminate guidance. As POM continues to consolidate employees from the physical office where they used to process mail, VHA must ensure that the employees reassigned that responsibility have the expertise necessary to process the mail.

Conclusion

Overall, Atlanta VA HCS and POM mismanaged the handling of incoming mail in November 2020, resulting in a 10-month backlog of more than 17,000 pieces of mail as of September 2021. The mail included veterans' medical records, claims from veterans and community care providers, and checks totaling more than $200,000. In the short term, Atlanta VA HCS should develop a plan for handling the larger volume of mail requiring more complex sorting. VHA also needs to assess the effects of this backlog for veterans and community care providers; where possible, VHA needs to remedy any negative consequences. Finally, as it transitions POM employees away from being physically located at many of its medical facilities, VHA needs to ensure that the medical facility employees can efficiently and effectively handle any additional mail processing responsibilities within prescribed timelines.

Recommendations 1–5

The OIG made the following recommendations to the director of VISN 7:

1. Ensure the Atlanta VA Health Care System develops and implements a plan for the routine proper and prompt processing of mail. That plan should include adequate staffing of the mailroom and sufficient training for mailroom personnel.
2. Assist the Atlanta VA Health Care System in taking steps when appropriate to recoup money owed from expired checks that were identified in the mail backlog.

The OIG made these three recommendations to the under secretary for health:

3. Assess the negative effects of this mail backlog on veterans, community care providers, and other parties, and where possible take steps to remedy those effects.
4. Determine if unprocessed mail backlogs exist at other VA medical facilities.

5. Develop procedures and controls to make certain that medical facility personnel taking over POM on-site mail processing have the necessary resources and expertise to accomplish this work accurately and within prescribed timelines.

VA Management Comments

The director of VISN 7 concurred with recommendations 1 and 2 and provided corrective action plans. For recommendation 1, the network director's comments included that the Atlanta VA HCS developed a new policy, trained mail clerks, and is in the process of hiring an additional mail clerk lead. The response to recommendation 2 stated that the Atlanta VA HCS has processed all checks that were identified in the mail backlog and returned all expired checks for reissuance.

The deputy under secretary for health concurred with the remaining three recommendations and provided corrective action plans. For recommendation 3, the deputy under secretary stated that the Atlanta VA HCS reviewed all medical records, and quality management staff are currently conducting a quality review of selected medical records and will take action when appropriate to "remedy any abnormal findings and to communicate with any effected [sic] veterans." HCS staff also reviewed veteran and provider questions and complaints related to billing and claims to assess any financial impact and complete service recovery. HCS and POM staff are also collaborating to identify and address potential concerns from community providers on all claims.

To address recommendation 4, the deputy under secretary stated that the assistant under secretary for health for operations will direct VISNs to determine if unprocessed mail backlogs exist at their medical facilities. Finally, for recommendation 5, the deputy under secretary reported that a tracking system and dashboard was implemented in November 2021 and a transition memorandum from POM to VISN and medical center leaders will also be disseminated that clarifies responsibilities and standard operating procedures for transitioning mail duties.

Appendixes E and F provide the full text of the comments from the VISN director and the deputy under secretary, including reported corrective actions since the close of this review.

OIG Response

VHA's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.

Appendix A: Timeline of Significant VHA Events

Date	Event
November 4, 2020	The Atlanta VA HCS director scheduled a meeting with facility leaders and POM personnel to discuss Summit Building space. The review team noted that the Atlanta VA HCS associate director and chief of supply chain management (in charge of mailroom staff) were not invited and did not attend this meeting. Meeting minutes revealed a verbal agreement for POM to vacate the space and in return, medical facility staff would assume mail duties.
November 9, 2020	POM staff vacated the Summit Building.
November 16, 2020	The POM area manager emailed mail instructions to the Atlanta VA HCS deputy director. The POM area manager also suggested that for a "clean hand-off," POM staff located at the Summit Building should assist for a few days so that the mail is "caught up and there are no hiccups."
November 17–19, 2020[33]	The Atlanta VA HCS deputy director forwarded the mail instructions to the chief of supply chain management, chief of Health Administration Services, the non-VA community care chief, and the deputy chief of staff. The Atlanta VA HCS chief of supply chain management then forwarded the mail instructions to mailroom staff. At this time, a mail clerk immediately shared concerns with his supervisor, the Atlanta VA HCS chief of supply chain management, noting that he did not know "how or when we would have the time or space/extra personal [personnel] to do this additional task. These are unrealistic expectations of the mailroom staff. Our current workload keeps us busy all day." The Atlanta VA HCS chief of supply chain management shared these concerns with the Atlanta VA HSC associate director.
January 5, 2021	The Atlanta VA HCS chief of supply chain management emailed the Atlanta VA HCS associate director and asked about an update on the mail. The chief of supply chain management added that the mail was just "sitting in the basement."
January 8, 2021[34]	The Atlanta VA HCS deputy chief of staff emailed the POM area manager, the Atlanta VA HCS chief of supply chain management, Atlanta VA HCS deputy director, and Atlanta VA HCS associate director and stated, "Despite our best intentions there seems to be an issue with the POM mail from the summit building. The mail is being forwarded to the mail room at the main medical center and the mail room staff has the instructions that were sent (attached). However, determining where to send the mail based on these instructions can't be determined in most cases without opening the mail and reviewing documents. This is outside the scope of the mail room. As a result, POM mail has been accumulating in the mail room."

[33] The OIG found that this was the first time that the Atlanta VA HCS associate director and chief of supply chain management were informed of the mailroom's new responsibilities and the associated concerns.

[34] This appeared to be the first time that the Atlanta VA HCS leaders reached out to POM with concerns about processing the mail. Also, the review team concluded that, at that time, facility leaders were aware of the backlog.

Date	Event
	The Atlanta VA HCS deputy chief of staff provided potential solutions to either have the remaining POM staff at the Summit Building continue to be responsible for POM mail or forward the mail from the Summit Building to another location where POM staff are available to sort and forward as needed.
January 22, 2021	The email sent January 8, 2021, went unanswered by the POM area manager until January 22, 2021, when he stated to the Atlanta VA HCS associate director "that we do not have anyone onsite at the Summit building as [Atlanta VA HCS deputy chief of staff] described to work it and we have given up our seating in the agreement to have the mail done by the facility. That is what [Atlanta VA HCS deputy director] and the entire group agreed to when we conferenced on the subject. We were very upfront about the volume of mail and what the details of the process were in our discussion and [Atlanta VA HCS deputy director] was very pleased with the outcome of the meeting and we were only able to meet Atlanta VA [HCS] space needs because of this concession."
February 16, 2021	The Atlanta VA HCS medical records release of information supervisor documented a report of contact (a written concern sent to the chief of Health Information Management Service), which stated that the mailroom clerk advised her "that there are over 100 mail containers of medical records that came through the mail that they are unsure what to do with and he believed that they are FEE based [Fee Basis] documents." The medical records release of information supervisor advised her supervisor, the Atlanta VA HCS chief of Health Information Management Service.
February 17, 2021	The Atlanta VA HCS chief of supply chain management emailed the Atlanta VA HCS associate director and asked, "what is the status on getting that mail out of the basement?" He added that there were "5 of these big bins full and no one has contacted us about getting this mail taken care of." Then, the Atlanta VA HCS associate director emailed the POM area manager and stated that he had been "Trying to call you & text you unsuccessfully. I need to speak to you about the POM mail that is now being delivered to our main facility. There are now five (5) carts (see picture) of mail in our warehouse. I know that we developed this plan to have mail delivered to our mail room, however, we need to revisit this plan (see January 8th email). We have no way of knowing where this mail should go to unless we open it (and our mailroom staff don't need to be opening it)."
February 18, 2021	The POM deputy area manager emailed the Atlanta VA HCS associate director and stated, "The POM office does not have anyone on site at the Summit Building to receive and open mail. POM management agreed to give up our seating space in the agreement that the facility would do the mail. [The Atlanta VA HCS deputy director] and the entire group agreed to this arrangement." The POM deputy area manager also reattached the mail instructions.
March 4, 2021	The Atlanta VA HCS deputy director emailed the POM deputy area manager and the POM area manager (and copied other Atlanta VA HCS leaders) and stated, "We have identified that the agreed upon process back in January (attached) has posed a big hurdle. We need to have a meeting of the minds to assist with getting the documentation/mail to the respective

Date	Event
	parties." The attachment referenced in this email was the mail processing instructions.
March 24, 2021	The Atlanta VA HCS chief of Health Administration Services emailed the POM area and deputy area managers to follow up on their concerns regarding the mail backlog and to attempt to schedule a meeting. The POM area manager indicated again that the mail processing was "clearly laid out and was accepted. We have lost some additional local staff since then and have even fewer people locally that before, so we have even less ability to take on that work." A meeting was tentatively scheduled for the following week, but according to the Atlanta VA HCS chief of Health Administration Services, this meeting never occurred.
March 2021	According to the Atlanta VA HCS chief of Health Administration Services, facility staff began to help with the mail backlog. This was in addition to their regular duties. According to the Atlanta VA HCS medical records release of information supervisor, limited overtime was offered to facilitate these efforts. The supervisor further noted that these efforts ceased around June or July 2021 due to other competing priorities and that these efforts led to sending some of the boxes of mail to POM in Birmingham, Alabama, in June 2021.[35]
April 21, 2021	The assistant under secretary for health for operations sent a memo to all VISNs informing them that the Office of Community Care's Delivery Operations (which oversees POM) was in the process of "consolidating 82 distinct claims processing operations sites into five payment centers and eight satellite locations." This consolidation would affect approximately 333 employees. The assistant under secretary stated that VISNs can assist this consolidation by selecting these POM staff for existing replacements or accepting reassignments to equivalent positions (where vacancies existed nationally).
May 14, 2021	The Atlanta VA HCS deputy chief of supply chain management emailed a POM supervisor and the Atlanta VA HCS chief of Health Administration Services and asked, "is there any update on the action towards the POM Mail. It was paused last weekend due to HAS [Health Administration Services] Staffing issues." The deputy chief of supply chain management further stated, "We really need to get this done since we are running out of space and the mail has been here way too long."
May 17, 2021	In response to the email sent on May 14, 2021, the POM area manager emailed the Atlanta VA HCS chief, the deputy chief of supply chain management, and the Atlanta VA HCS chief of Health Administration Services and indicated again that the mail "process was handed off in an agreement between [the Atlanta VA HCS deputy director] and his Atlanta VA [HCS] team and our Regional Manager and our POM Team during a meeting to trade our space at the Summit Building for the mail processing."

[35] The Atlanta VA HCS deputy director told the review team that he did not know about these efforts.

Date	Event
May 18, 2021[36]	The POM area manager sent a VISN 7 business health program manager an email with the mail instructions. The POM area manager stated in his email that the business health program manager must be unaware of the space agreement, according to a Microsoft Teams message. In the Teams message, the business health program manager stated, "I received a question about mail for POM. It appears ATL [Atlanta] is receiving mail for POM and do not know what to do with it. Any information on the process? Last time we spoke you stated staff was coming into the office a couple days a week and picking up the mail. Is this true for all sites, if not what should we do with the mail?" The POM area manager responded that back in early November, the POM team met with Atlanta VA HCS leaders regarding space at the Summit Building. The POM area manager explained that POM could not give up its space as it rotated its team through the office to process mail. The Atlanta VA HCS leaders agreed to take the responsibility of mail processing for POM's space. The POM area manager stated POM clearly described the volume of mail and provided instructions on how to process the mail. In response, the VISN 7 business health program manager stated that she had a greater concern about other facilities in the VISN. She asked, "what are the other stations to do with the mail that is being sent to the facilities for POM when staff will no longer report to the stations due to the transition?"
June 3–9, 2021	Mail from the Atlanta VA medical facility was shipped to Birmingham, unopened and unresearched, according to the POM area manager. However, according to Atlanta VA HCS medical records release of information supervisor, the mail sent in June was triaged by the records management staff. According to the Atlanta VA HCS chief of supply chain management, the returned mail was unprocessed.
June 4, 2021	The POM area manager sent the VISN 7 business health program manager new POM mail instructions for all of Region 2.[37] The POM area manager added that POM had "standardized this process across the board and this process is for all the facilities in the VISN/Region, not just the ones that we [POM staff] are moved out of." The VISN 7 business health program manager then forwarded these instructions to community care and Health Administration Services managers in VISN 7.
June 8–10, 2021	Chiefs at three medical facilities emailed the VISN 7 business health program manager to share concerns about POM transitioning mail responsibilities to medical facilities. Staff sent a consolidated list of concerns to the VISN 7 business health program manager on June 14, 2021.
June 15, 2021	The POM area manager emailed the VISN 7 business health program manager that the mail from the Atlanta VA medical facility was inappropriately mailed to Birmingham.

[36] Based on communications with the VISN 7 business health program manager, the review team found this to be the first time VISN 7 was involved with concerns about processing the mail.

[37] POM's Region 2 comprised VISNs 5, 6, 7, and 8. Atlanta VA HCS is part of VISN 7.

Date	Event
June 22, 2021	The POM area manager emailed the VISN 7 business health program manager to discuss the Birmingham mail situation. He explained, "all of the stations outside of Birmingham, excluding Tuscaloosa, are either still sending the unsorted mail to the POM teams locally or sending the unsorted mail [to] Birmingham." The VISN 7 business health program manager sent the facilities' list of concerns to the POM area manager. Concerns included confusing instructions on multiple addresses to send mail, limited staffing, and increased volume of work. The VISN 7 business health program manager also sent an email to community care and Health Administration Services managers in VISN 7 regarding the new mail process: "I know you all have shared your concerns about this new process, but the sites are going to need to find a way to address the mail that is being received."
June 22, 2021	The Atlanta VA HCS chief of supply chain management emailed the Atlanta VA HCS associate director to inform him of a request for two additional staff. The Atlanta VA HCS associate director responded on June 28, 2021, to "go ahead and request."
June 23, 2021	The POM program management officer of the Southeast Region responded to the list of concerns provided by the VISN 7 business health program manager. Specifically, the POM program management officer stated that the mail instructions contained multiple addresses because there are specific addresses for certain documentation, as required by the Office of Community Care. In response to concerns about limited staffing and increased work volume, the POM program management officer stated that mail function is an "integral part of Community Care" and that "As has been proven by the sorting of the mail, the bulk of the mail is directly belonging to the VAMC [medical center] Community Care related to coordination of care for the previously approved care in the community."
August 9, 2021	The POM area manager emailed the VISN 7 business health program manager, indicating that he was still getting questions about the mail instructions—so he explicitly added addresses for appeals. The VISN 7 business health program manager asked about training that the POM area manager said he could provide. The POM area manager responded by adding an additional training document that would answer her question and added that he did "not believe actual training in a group setting is necessary as this is pretty simple stuff once you see the identification examples."
September 16, 2021	The Atlanta VA HCS chief of supply chain management emailed an Atlanta VA HCS human resources officer requesting an update to additional mailroom staff and stated, "We need to get this mail processed and out of the basement and have a plan to process this mail in the future."

Source: OIG analysis of communication between VHA personnel.

Appendix B: Prior Related VA OIG Reports

Four OIG reports published between 2019 and 2021 have drawn attention to how VA processes medical records and claims, including handling incoming mail.

Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records (June 17, 2021)

The OIG evaluated whether VA's community care staff accurately uploaded records for non-VA medical care to veterans' electronic health records. The audit team found that staff at six of the seven VA medical facilities reviewed did not always index or categorize these records accurately. Inaccurate indexing of medical records poses a risk to veteran care and increases the burden on the VHA staff who locate and correct the errors, reducing their time for other tasks. These errors occurred, in part, due to inadequate procedures, training, quality checks, and quality assurance monitoring, and a lack of local facility-level policies.

The OIG recommended the under secretary for health improve non-VA medical records scanning and indexing by ensuring VHA facilities create and fully implement standard operating procedures. These procedures should clearly define responsibilities for Health Information Management Service and community care staff and the procedures for accurately scanning, importing, and indexing non-VA medical records. The OIG also recommended the under secretary ensure that Health Information Management Service leaders provide or formally delegate training, quality checks, and quality assurance monitoring for facility community care staff responsible for medical record management.[38] As of March 2022, both recommendations remained open.

VHA Did Not Effectively Manage Appeals of Non-VA Care Claims (November 21, 2019)

The OIG conducted this audit to determine whether appeals of non-VA care claims decisions were effectively managed and processed. The OIG found significant deficiencies with the Office of Community Care POM directorate's handling of appeals of non-VA care claims decisions, including that POM did not know the extent of unprocessed appeals that were unaccounted for and stored in file cabinets, boxes, and bins at POM facilities. The audit team visited 10 POM facilities—out of more than 80 total—and identified, in conjunction with POM staff, more than 8,800 other potential appeal documents in file cabinets, boxes, cubicles, and mail rooms that POM staff had not accounted for. The review team concluded VHA and the POM directorate failed to effectively oversee appeals management and processing before and after

[38] VA OIG, Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records, Report No. 19-08658-153, June 17, 2021.

implementation of a new appeals law. VHA did not effectively prepare for the new appeals process and faces significant challenges in identifying and processing appeals.

The OIG made eight recommendations to improve appeals management, including ensuring that incoming appeals go to facilities that will process them and that POM updates communications to direct claimants to submit appeals to its facilities with designated appeals-processing staff.[39] As of December 2, 2020, all recommendations had been closed.

Health Information Management Medical Documentation Backlog (August 21, 2019)

This audit focused on determining if VHA medical facilities were scanning and entering medical documentation into patients' records accurately and in a timely manner. The OIG found limited VHA monitoring and oversight created backlogs that put the continuity of patient care at risk. This occurred because staff did not scan documents and enter them into the electronic medical records in a timely manner. The audit found that as of July 19, 2018, VA medical facilities had a cumulative medical documentation backlog of paper documentation that measured approximately 5.15 miles high and contained at least 597,000 individual electronic document files dating back to October 2016. Staff also did not always perform appropriate reviews and monitoring to assess the overall quality and legibility of scanned documents. The report also concluded that staffing shortages contributed to the backlogs.

The OIG made nine recommendations, including for VHA to define and promptly reduce backlogs; to account for scanning demand in staffing decisions; and to develop monitoring roles, controls, and procedures.[40] As of January 25, 2022, all recommendations had been closed.

Non-VA Emergency Care Claims Inappropriately Denied and Rejected (August 6, 2019)

In response to a congressional request, the OIG conducted this audit to determine whether processors of non-VA emergency care claims inappropriately denied or rejected the claims.

The audit team conducted an accuracy review of claims for emergency medical care obtained outside VA and found that 31 percent of denied or rejected non-VA emergency care claims—with an estimated billed amount of $716 million—were inappropriately processed from April 1 through September 30, 2017, creating the risk of undue financial burden to an estimated 60,800 veterans. The review revealed that some of those denied and rejected claims should have been approved. The OIG concluded there was a significant risk that some of the errors identified

[39] VA OIG, VHA Did Not Effectively Manage Appeals of Non-VA Care Claims, Report No. 18-06294-213, November 21, 2019.

[40] VA OIG, Health Information Management Medical Documentation Backlog, Report No. 18-01214-157, August 21, 2019.

in this audit resulted from pressure to meet production targets, insufficient quality assurance of claims processing accuracy, and incentives associated with meeting production targets.

This audit also identified issues with mail processing, which can cause inappropriate denials and leave veterans in the dark regarding the status of their claims. The review found a significant backlog in mail processing that created a risk that veterans would not be informed of a claims decision or would be informed too late to resubmit or appeal. Backlogs at three facilities showed stacks of unsent claims decision letters printed between one and two months before the OIG site visits. The outgoing mail typically included claim rejection and denial letters that needed time-sensitive responses, such as updating claim information or appealing a denial.

The OIG made 11 recommendations, including the need for VHA to develop and implement clearly defined controls to ensure facilities routinely communicate backlogs of incoming mail to leaders, and timely communication of claims decisions to veterans and providers and what actions the veteran may take in response.[41] As of October 1, 2021, all recommendations had been closed.

[41] VA OIG, Non-VA Emergency Care Claims Inappropriately Denied and Rejected, Report No. 18-00469-150, August 6, 2019.

Appendix C: Scope and Methodology

Scope

The review team performed work from September 2021 through January 2022. The review included evaluating the mail backlog at the Atlanta VA HCS since November 2020. The team conducted site visits to the Atlanta VA medical facility in Decatur, Georgia, on September 24, September 27, September 28, and October 13, 2021. The team also visited the Summit Building in Atlanta, Georgia, on October 15, 2021.

Methodology

The review team conducted on-site observations, interviewed employees of the Atlanta VA HCS, POM, and VISN 7, and reviewed documentation and communications related to the mail backlog from 2020 to 2021. The review team conducted site visits to the Atlanta VA medical facility for several days to observe the progress of the mail processing and scanning and to interview HCS leaders.

The team interviewed the VISN 7 business health program manager and the following individuals from the Atlanta VA HCS:

- Ann Brown, Director
- Dr. Lance Davis, Deputy Director
- Gerald DeWorth, Associate Director
- Dr. Melissa Stevens, Deputy Chief of Staff
- chief health administrator
- deputy medical administrative officer
- supervisor, Medical Records Release of Information
- chief of Supply Chain Management
- deputy chief of Supply Chain Management
- chief, Health Information Management Service
- chief, Ambulatory Care
- mailroom clerk
- material handler
- interim chief of Primary Care

The team also interviewed personnel from the Office of Community Care's POM directorate, including a program management officer and the regional officer for POM Region 2. POM personnel process community care provider claims and report to the Office of Community Care, not a VA medical facility.

The review team examined documentation that included emails from the facility and POM personnel dating back to 2020; shipping receipts for mail sent from the Atlanta VA medical

facility to the Birmingham POM office; logs of processed mail created by Atlanta VA HCS staff; and logs of information about checks for payment from March, April, May, and September 2021.

Fraud Assessment

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

- reviewing hotline complaints,
- interviewing staff to assess the accuracy of the backlog timeline, and
- conducting multiple site visits to observe the progress of opening, sorting, and distributing the mail.

The OIG did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

The team did not rely on computer-processed data for this review.

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 D: Mail Instructions

INSTRUCTIONS: STATION 508/ATLANTA VAMC POM MAIL

Please find below instructions for mail addressed to Payment, Operations and Management (POM) and how it should be sorted:

INTER-FACILITY

HIMS [Health Information Management Service]:

- Send all medical records that come in without claims (UB04 or CMS 1500) to HIMS.
- Send all medical records that are 500 pages or more to HIMS and separate the claim. Put the claim in the package to go to Tampa.

AGENT CASHIER:
Send all refund checks to the Agent Cashier.

OUTSIDE OF THE ATLANTA VAMC

TAMPA:

- Send all claims (UB04 and CMS 1500) with medical records that are 500 pages or less to the address listed below.
- Send all claims (UB04) ONLY that have medical records that are 500 pages or more to the address listed below.
- Send all ADA American Dental Association claims to the Tampa address listed below.

Mailing address:

VHA Office of Community Care
P.O. Box 30780
Tampa, FL 33630-3780

BIRMINGHAM:
Pharmacy Reimbursement:
This would be any documentation that a Veteran is requesting reimbursement for a prescription from a non-VA pharmacy in the community.

Release of Information Form 21-4142
Send to the address listed below.
Other mail: Is anything that comes in that is not listed, please send to the address listed below. Example, if you receive a Veteran's bill for services rendered at a non-VA hospital in the community.
Mailing address:

Birmingham VAMC
VHA Office of Community Care – Delivery Operations
700 19th St S
Birmingham, AL 35233

SALEM:
Please send all Appeals to the address listed below. This would include VA Form 20-0996, and VA Form 10182 and you may receive some handwritten letters from Veterans appealing a claim.
Mailing address:

OCC POM VISN 5/6 Appeals
1988 Roanoke Boulevard
Salem, VA 24153

If you have any questions or concerns about the mail, please reach out to [contact removed] the Supervisor or [contact removed] the Lead for POM.

Figure D.1. *Mail instructions provided by POM area manager to Atlanta VA HCS deputy director on November 16, 2020.*
Source: Atlanta VA HCS staff.

Appendix E: VA Management Comments, VISN 7 Director

Department of Veterans Affairs Memorandum

Date: February 14, 2022

From: Director, VA Southeast Network (VISN 7) (10N7)

Subj: Draft Report: Atlanta VA Medical Center's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims

To: Under Secretary for Health, Office of the Under Secretary for Health (10)

1. I have had the opportunity to review the Draft Report: Atlanta VA Medical Center's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims.

2. I concur with the action plan and ongoing implementation for recommendations 1-3.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

The OIG removed point of contact information prior to publication.

(Original signed by)

Benita Miller for David M. Walker, MD, MBA

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Veterans Integrated Service Network (VISN) Action Plan

Atlanta VA Medical Center's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims

(OIG 2021-03916-AE-0191)

Recommendation 1. Ensure the Atlanta VA Medical Center develops and implements a plan for the routine proper and prompt processing of mail. That plan should include adequate staffing of the mailroom and sufficient training for mailroom personnel.

VHA Comments: Concur

The Atlanta VA Health Care System (VAHCS) developed a new mail processing policy to ensure the routine proper and prompt processing of mail on October 14, 2021 (MR-20-001). VAHCS currently has four mail clerks, which have all been trained according to the new mail processing policy. Additionally, the mail clerk position was changed and upgraded from a General Schedule (GS) 4 to GS 5 position to align with the complexity of new duties. VAHCS is also currently hiring one additional GS 5 and one GS 6 Mail Clerk Lead to further ensure adequate staffing for the routine proper and prompt processing of mail. All incoming mail is being tracked daily and tracking of all Payment Operations and Management mail is broken out and annotated on a daily report with disposition of that mail.

Status: Open Target Completion Date: May 2022

ATTACHMENT

Recommendation 2. Assist the Atlanta VA Medical Center in taking steps when appropriate to recoup monies owed from expired checks that were identified in the mail backlog.

VHA Comments: Concur

The Atlanta VAHCS has processed all checks that were identified in the mail backlog and returned all expired checks to the appropriate vendors for reissuance. Fifty four percent of new replacement checks have been returned to the facility for reimbursement. The Atlanta VAHCS has contacted the appropriate vendors and initiated the bill of collection process for non-received checks to ensure receipt of all replacement checks.

Status: Open Target Completion Date: May 2022

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended
OIG Note: The embedded supporting documentation was not appended in this report.

Appendix F: VA Management Comments, Deputy Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: March 14, 2022

From: Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, Atlanta VA Medical Center's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims (2021-03916-AE-0191) (VIEWS 6828941)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report Atlanta VA Medical Center's mail backlog. The Veterans Health Administration (VHA) concurs with the recommendations and provides action plans for recommendations 3, 4, and 5. Action plans for recommendations 1 and 2 are provided by the VISN 7 Director.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, MD

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Atlanta VA Medical Center's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims

(OIG 2021-03916-AE-0191)

Recommendation 3. Assess the negative effects of this mail backlog on veterans, community care providers, and other parties, and where possible take steps to remedy those effects.

VHA Comments: Concur

The Atlanta VA Health Care System (VAHCS) conducted a review of all medical records to assess for any negative health care effects on veterans. The review was performed by licensed independent practitioners. All abnormal findings, mammography findings and deaths received a second-level review by VA physicians and a third-level review by an external physician. The Atlanta VAHCS Quality Management staff are currently conducting a quality review of the medical records of all abnormal findings, all deaths and ten percent of the remaining episodes of care to validate integrity of the review process. Action will be taken as appropriate to remedy any abnormal findings and to communicate with any effected veterans.

The Atlanta VAHCS conducted a review of inquiries and complaints received from Veterans and community care providers related to billing and claims to assess any financial impact and complete service recovery. The Atlanta VAHCS and Payment Operations Management (POM) are collaborating to identify any potential concerns from community providers on all claims. Any identified negative effects will be remedied.

Status: In Progress Target Completion Date: May 2022

Recommendation 4. Determine if unprocessed mail backlogs exist at other VA medical facilities.

VHA Comments: Concur

The Assistant Under Secretary for Health for Operations will direct the Veterans Integrated Service Networks (VISNs) to determine if unprocessed mail backlogs exist at their VA medical facilities and ensure the routine proper and prompt processing of mail.

Status: In progress Target Completion Date: April 2022

Recommendation 5. Develop procedures and controls to make certain that medical facility personnel taking over POM on-site mail processing have the necessary resources and expertise to accomplish this work accurately and within prescribed timelines.

VHA Comments: Concur

VHA's Office of Community Care (OCC) recognizes the importance of having a comprehensive procedure when transitioning mail processing responsibilities to VA Medical Center (VAMC) personnel. In November 2021, a site-by-site tracking system and dashboard was implemented to allow for improved oversight of these transitions. To improve the procedure and to ensure facility personnel taking over VHA OCC POM on-site mail processing have the understanding needed to identify resources and the expertise to accomplish the work, a transition memorandum will be implemented. The memorandum will include an attachment with the standard operating procedure with detailed instructions for sorting and distribution of mail received, so onsite VAMC staff are prepared for mail processing duties. This memorandum will notify

VISN or VAMC leadership that POM is centralizing and vacating the current site, that POM personnel will no longer be on-site to process mail and that functions previously completed by POM personnel and that those tasks will now be assumed by VAMC personnel. POM will confirm the delivery of the memorandum and POM mail standard operating procedures to VISN and/or VAMC leadership at facilities assuming these responsibilities.

Status: In Progress Target Completion Date: May 2022

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

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	Daniel Morris, Director Cherelle Claiborne Katherine Clay Karen Myers Michael Schlitz
Other Contributors	Glenn Dawkins Michael Martin Rashiya Washington

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