

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Department of Veterans Affairs

*Review of  
Alleged Data  
Manipulation  
at VA Regional  
Office Honolulu, HI*

March 26, 2015  
15-00880-157

## **ACRONYMS**

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

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## EXECUTIVE SUMMARY

On October 29, 2014, the Office of Inspector General (OIG) received a request from the Director of the Honolulu VA Regional Office (VARO) asking that the OIG assess alleged data manipulation involving a supervisory employee from that office. Specifically, a Honolulu VARO fact-finding initiative revealed a supervisor improperly removed controls from an electronic record used to identify and process claims without taking the appropriate actions. Additionally, results from their fact-finding indicated this supervisor directed staff to disregard Veterans Benefits Administration (VBA) policy when processing some claims. VBA uses electronic system controls to identify types of claims, and to manage and measure its pending and completed workloads. Generally, such controls should remain in place until VARO staff complete all required actions, including providing notices of benefits decisions to the claimants.

We substantiated the allegation that the supervisor inappropriately removed controls in the electronic record used to track and identify claims related to verifying the status of veterans' dependents without taking proper actions to complete the claims. VARO staff provided us with 147 cases they reviewed where the supervisor took actions to remove controls for benefits claims from April through August 2014. We reviewed 139 of the 147 cases and determined the supervisor inappropriately removed system controls for 100 benefits claims. The remaining eight cases were located at other VA facilities and unavailable at the time of our review. We confirmed these actions pose a major control weakness. We will also review the remaining eight cases once they become available to provide assurance no other control weaknesses exist. Further, we selected and reviewed an additional 48 claims and determined the supervisor inappropriately removed system controls in 43 claims. The supervisor admitted to removing controls from the electronic record but stated it was not his intention to misrepresent data. He indicated he wanted his team to work on the most difficult aspects of their workload and he did not want to provide them with easy work associated with the control he removed. Further, in one instance, we determined the supervisor instructed VARO staff to disregard VBA policy related to a claim involving recoupment of separation pay.

The actions to remove claims from the electronic record misrepresented the VARO's claims inventory and timeliness measures, and impaired its ability to measure and manage its workloads. Further, some veterans may have continued to receive additional compensation for dependents that they were not entitled to receive. The inappropriate actions described in this report undermine program effectiveness. Therefore, we recommended the Honolulu VARO Director take immediate action to correct, as appropriate, all improper actions taken by the supervisor. We also recommended the Director confer with VA Regional Counsel to determine the appropriate administrative action to take, if any, against this employee.

LINDA A. HALLIDAY  
Assistant Inspector General  
for Audits and Evaluations

## RESULTS AND RECOMMENDATIONS

### **Allegation**

### **Did a Honolulu VARO Supervisor Inappropriately Remove Claims Processing Controls?**

On October 29, 2014, the Office of Inspector General received a request from the Director of the Honolulu VARO asking OIG to review alleged data manipulation involving a supervisor from that office. Specifically, VARO management's efforts to fact-find revealed a supervisor improperly removed controls from an electronic record used to identify and process claims without taking the appropriate actions. Additionally, results from their fact-finding indicated this supervisor directed VARO staff to disregard VBA policy when processing some claims.

We confirmed that a Honolulu VARO supervisor inappropriately removed controls in the electronic record used to track claims. Further, in one instance, we determined the supervisor instructed VARO staff to disregard VBA policy related to a claim involving recoupment of separation pay.

### **Background**

In March 2014, the VARO Director's staff began assisting employees with processing dependency verification notifications to veterans. In order to verify the status of veterans' dependents, VBA issues questionnaires to those veterans receiving additional monthly compensation for dependents, such as a spouse or child. As a veteran returns the questionnaire verifying the number of dependents he or she receives compensation for, VARO staff will take the appropriate action to complete the case. If the veteran does not return the questionnaire, VARO staff establish a control in the electronic record to track the claim. Staff then sends notice to the veteran proposing to reduce or discontinue his or her benefits because VBA cannot determine whether the veteran should continue to receive additional benefits for their dependents. VBA uses electronic system controls to identify types of claims, and to manage and measure its pending and completed workloads. Generally, such controls should remain in place until staff complete all required actions.

On October 10, 2014, the VARO Director and an employee assigned to the dependency verification review noticed several controls removed from the electronic record without any action taken on the respective claims. The VARO team evaluated the supervisor's actions and found that he cleared controls for claims without completing the appropriate actions, with the majority of controls cleared in June 2014. The team determined the supervisor incorrectly cleared controls in claims relating to the status of veterans' dependents, making these incomplete claims appear to be completed.

**What We Did**

We conducted a site visit at the Honolulu VARO to assess the merits of the allegation. We obtained and analyzed the results of the VARO's review of what had occurred. We interviewed the employee who was the subject of the allegation, as well as VARO leadership. Further, we reviewed 139 of 147 cases where the supervisor took actions to remove controls for benefits claims to determine whether the actions were appropriate. The remaining eight cases were located at other VA offices and unavailable for review. Although we confirmed these actions pose a major control weakness. We will review the remaining eight cases once they become available to provide assurance no other control weaknesses exist. In addition, we expanded our review to include 48 additional cases to determine whether the supervisor took appropriate actions to clear system controls related to dependency verification.

**What We Found**

We found that a Honolulu VARO supervisor inappropriately removed controls in the electronic record used to track and identify benefits claims without taking proper actions to complete 143 of 187 claims. Further, in one instance, we determined the supervisor instructed VARO staff to disregard VBA policy related to a claim involving recoupment of separation pay.

Of the initial 139 cases reviewed, we determined the supervisor inappropriately removed system controls for 100 benefits claims. We expanded our review to include an additional 48 claims and determined the supervisor inappropriately removed system controls in 43 of these claims. As a result, we confirmed the supervisor improperly removed system controls for benefits claims related to verifying the status of veterans' dependents. If not for our review and the internal review conducted by VARO staff, veterans may have continued to receive benefit payments for dependents to which they were not entitled.

The supervisor also instructed staff to deviate from VBA policy when sending due process letters notifying veterans that their benefits would be reduced if they did not respond with the dependency questionnaires. The supervisor developed due process letters that did not properly inform the veterans what their reduced monthly payment rates would be, as required.

Staff were also instructed by the supervisor to deviate from policy in one case related to the recoupment of separation pay. When a veteran is discharged from service and receives separation pay, VA will recoup the amount of that separation pay before paying the veteran compensation. In this case, the supervisor met a veteran with financial hardship who was having a difficult time paying his monthly rent. The supervisor contacted the veteran's landlord and asked if the landlord would stop eviction proceedings if the supervisor could get the veteran more money to pay his rent.

In order to accomplish this, the supervisor instructed a Veterans Service Representative to modify the veteran's VA disability payments by reducing

the monthly amount of money recouped for his separation pay. This would allow the veteran to receive additional monthly benefits, but would lengthen the time it would take VA to recoup the \$40,000 in separation pay. The proper action should have been to instruct the veteran to submit a request to waive recoupment of his separation pay. As a result, the supervisor made an unauthorized commitment to the landlord that was outside his authority.

We interviewed the supervisor who admitted removing controls from the electronic record. He stated it was not his intention to misrepresent data. He indicated he wanted his team to work on the most difficult aspects of their workload and he did not want to provide them with easy work associated with the control he removed. The supervisor also acknowledged adjusting recoupment of the veteran's separation pay was contrary to VBA policy. He stated he hoped his actions would be viewed as an attempt to assist a veteran in need. The VARO quality review staff became aware of this adjustment and took action to restore the full recoupment amount. Therefore, we will not make a recommendation.

#### **Conclusion**

Based on our interviews and examination of a total of 187 actions, we substantiated the allegation that the supervisor inappropriately removed controls from the electronic systems related to dependency claims. These actions misrepresented the VARO's claims inventory and timeliness measures while impairing the VARO's ability to monitor and manage its workload. If not for our review and the internal review conducted by VARO staff, veterans may have continued to receive benefit payments for dependents to which they were not entitled. Given the nature and seriousness of the supervisor's errors, we believe the VARO needs to take immediate action to fully review and correct, as appropriate, all actions this employee performed to inappropriately remove controls.

#### **Recommendations**

1. We recommended the Honolulu VA Regional Office Director take immediate action to fully review and correct, as appropriate, all improper actions taken by the supervisor.
2. We recommended the Honolulu VA Regional Office Director ensure staff receive training on the proper procedures for processing dependency questionnaires.
3. We recommended the Honolulu VA Regional Office Director confer with Regional Counsel and human resources to determine the appropriate administrative action to take, if any, against this employee.

#### **Management Comments**

The VARO Director concurred with our recommendations. VARO staff took corrective actions on all cases improperly processed, to include the one case that involved separation pay. Further, staff received training related to

processing dependency claims and due process. The supervisor that took the improper actions related to dependency claims resigned his position.

**OIG Response** The Director's comments and actions are responsive to the recommendations.

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

## Appendix A VARO Director's Comments

### Department of Veterans Affairs

### Memorandum

**Date:** February 5, 2015

**From:** Director, VA Regional Office, Honolulu, Hawaii (459/00)

**Subj:** Review of Alleged Data Manipulation at the VA Regional Office, Honolulu, Hawaii

**To:** Western Area Field Director (20F4)

Assistant Inspector General for Audits and Evaluations (52)

1. The following is submitted in response to the Office of Inspector General (OIG), Benefits Inspection Division (BID) draft report.
2. The Honolulu Regional Office (RO) concurs with all the recommendations made by the OIG BID. Attached are the corrective actions taken in response to the OIG's recommendations.
3. We appreciate the recommendations and assistance from the OIG BID. Please let me know if there are any additional questions.

*(original signed by:)*

Tracey A. Betts  
Director

Attachment

**Honolulu Regional Office**  
**Response to Office of Inspector General, Benefits Inspection Division**

**Recommendation 1:** We recommended the Honolulu VA Regional Office Director take immediate action to fully review and correct, as appropriate, all improper actions taken by the supervisor.

**RO Response:** Concur

The Honolulu Regional Office (RO) has taken corrective actions on all cases to include the case which involved severance pay.

**Recommendation 2:** We recommended the Honolulu VA Regional Office Director ensure staff receive training on the proper procedures for processing dependency questionnaires.

**RO Response:** Concur

The Honolulu RO provided training to all Veterans Service Representatives on dependency claims and due process.

**Recommendation 3:** We recommended the Honolulu VA Regional Office Director confer with Regional Counsel and human resources to determine the appropriate administrative action to take, if any, against this employee.

**RO Response:** Concur

The Coach who took these improper actions has resigned.

## Appendix B OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Brett Byrd David Pina Diane Wilson

## Appendix C Report Distribution

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