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BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON

"VA'S DEVELOPMENT AND IMPLEMENTATION OF POLICY INITIATIVES"

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Chairman Bost, Ranking Member Esty, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the programs and operations of the Veterans Benefits Administration (VBA). We recently made changes to our oversight model for VBA to allow us to better review national policy changes and focus on their high-impact programs and operations. Aside from reporting on specific problems and providing targeted solutions to VBA, we have emphasized identifying the underlying root causes of issues that have negatively impacted current programs and future initiatives. Among other causes, we have identified program leadership and governance as common deficiencies. We are committed to uncovering the source of problems that put taxpayer dollars and veterans' benefits at risk of fraud, waste, and abuse or that undercut the quality and timeliness of services to veterans and their families.

We believe that recent VBA initiatives and policy changes were well-intentioned to expedite the benefits process. Our recent reviews and audits, however, have revealed that VBA's emphasis on efficiency has affected its ability to review and process claims accurately. Our reports identified recurring deficiencies, such as the lack of adequate controls and information technology functionality, that resulted in the inefficient delivery of services and inaccurate benefits rendered to veterans.

Background

The OIG is committed to conducting effective oversight of VA programs and operations through independent audits, inspections, reviews, and investigations. VBA is responsible for delivering approximately $100 billion in federally authorized benefits and services to eligible veterans, their dependents, and survivors.

In October 2017, the OIG implemented a new national inspection model for VBA oversight. Previously, the OIG largely conducted oversight through inspections of VBA's 56 regional offices. Under the new model, the OIG now conducts nationwide audits and reviews of high-impact programs and operations within VBA. The purpose of these audits and reviews is to

- Identify systemic issues within VBA that affect veterans' benefits and services,
- Determine the root causes of identified problems, and
- Make useful recommendations to drive positive change across VBA.

Since October 1, 2017, the OIG has published 15 oversight reports related to VBA.[1] In these reports, the OIG made 55 recommendations to VBA for improvement,[2] and identified nearly $278 million in potential monetary benefits. VBA has generally concurred with our recommendations and provided acceptable action plans. It must now follow through with the difficult work of implementation if they are to carry out their responsibilities effectively and be good stewards of taxpayer dollars.

Recent OIG Oversight Reports

We want to highlight four recently-issued reports related to the OIG's oversight of VBA that we believe are illustrative of our efforts:

- *Unwarranted Medical Reexaminations for Disability Benefits*
- *Denied PTSD Claims Related to Military Sexual Trauma*
- *Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits*
- *Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis (ALS)*

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[1] *Audit of VBA's National Pension Call Center*, November 1, 2017; *Review of Claims Processing Actions at Pension Management Centers*, November 1, 2017; *Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, VA*, December 5, 2017; *Audit of Vocational Rehabilitation and Employment Program Subsistence Allowance Payments*, March 15, 2018; *Review of Timeliness of the Appeals Process*, March 28, 2018; *Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact*, May 2, 2018; *VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017*, May 15, 2018; *Unwarranted Medical Reexaminations for Disability Benefits*, July 17, 2018; *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, August 21, 2018; *Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits*, August 21, 2018; *Accuracy of Effective Dates for Reduced Evaluations Needed Improvement*, August 29, 2018; *VA Policy for Administering Traumatic Brain Injury Examinations*, September 10, 2018; *Review of Accuracy of Reported Pending Disability Claims Backlog Statistics*, September 10, 2018; *Timeliness of Final Competency Determinations*, September 28, 2018; *Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis*, November 20, 2018.

[2] As of November 19, 2018, 35 of the 55 recommendations (64 percent) remain open/not fully implemented.

In these four reports, the OIG made a total of 14 recommendations to the Under Secretary for Benefits and identified about $187 million in potential monetary benefits. The reports' findings identify a number of systemic problems that VBA needs to address:

- Deficient control activities
- Inadequate program leadership and monitoring
- Lack of information technology system functionality
- Unintended impacts of the National Work Queue

Unwarranted Medical Reexaminations

The OIG conducted a nationwide review to determine whether VBA staff required veterans with disabilities to be subjected to unwarranted medical reexaminations. According to VBA policy, medical reexaminations can be requested when there is no qualified exclusion from reexamination. A qualified exclusion could include, for example, a disability that is permanent and not likely to improve, a disability without substantial improvement over five years, and updated medical evidence in the claims folder sufficient to continue the current disability evaluation without additional examination. If not subject to exclusion, reexaminations may be requested when there is a need to verify the continued existence, or current severity, of a disability. VBA policy also requires staff to exercise prudent judgment in determining the need for reexaminations by requesting them only when necessary and making every effort to limit those requests.

The OIG reviewed a statistical sample of 300 cases with reexaminations from March through August 2017 and found that VBA staff requested unwarranted medical reexaminations in 111 cases. Based on this sample, the OIG estimated that VBA staff requested unwarranted reexaminations in 19,800 of 53,500 cases. As a result, the OIG projected that VBA spent about $10.1 million on these unwarranted reexaminations. The OIG further estimated that VBA would waste an additional $100.6 million over the next five years unless it ensures that staff only request medical reexaminations when necessary. The OIG made four recommendations for (1) establishing internal controls to ensure that a reexamination is necessary, (2) prioritizing the design and implementation of system automation to minimize unwarranted reexaminations, (3) enhancing VBA's quality assurance reviews of requested reexaminations, and (4) conducting a focused quality improvement review of cases with unwarranted reexaminations to understand and redress the causes of avoidable errors. The Under Secretary for Benefits concurred with the recommendations and provided acceptable action plans.

Denied Military Sexual Trauma-Related Claims

The OIG conducted a nationwide review to determine whether VBA staff correctly processed claims related to veterans' military sexual trauma (MST) in accordance with VBA procedures prior to denying the claims. Some service members are understandably reluctant to submit a

report of MST, particularly when the perpetrator is a superior officer. Service members may also have concerns about the potential for negative performance reports or punishment for collateral misconduct. There is also sometimes the perception of an unresponsive military chain of command. If the MST leads to posttraumatic stress disorder (PTSD), it is often difficult for victims to produce evidence to support the occurrence of the assault. VBA policy, therefore, requires staff to follow additional steps for processing MST-related claims so veterans have additional opportunities to provide adequate evidence.

VBA reported that it processed approximately 12,000 claims per year over the last three years for PTSD related to MST. In fiscal year 2017, VBA denied about 5,500 of those claims (46 percent). The review team assessed a sample of 169 MST-related claims that VBA staff denied from April through September 2017. The review team found that VBA staff did not properly process veterans' denied MST-related claims in 82 of 169 cases. As a result, the OIG estimated that VBA staff incorrectly processed approximately 1,300 of the 2,700 MST-related claims denied during that time (49 percent).

The OIG made six recommendations to the Under Secretary for Benefits including that VBA review all approximately 5,500 MST-related claims denied from October 2016 through September 2017, take corrective action on those claims in which VBA staff did not follow all required steps, assign MST-related claims to a specialized group of claims processors, and improve oversight and training on addressing MST-related claims. The Under Secretary concurred with the recommendations and has already taken steps to address them. The Under Secretary recently stated that VBA was increasing its focus on MST claims by updating required training for claims processors, as well as adding more quality and accuracy reviews of MST claims. The Under Secretary also stated that, in FY 2019, VBA will review every denied MST-related claim decided since the beginning of FY 2017.

Intent to File Submissions

The OIG conducted a nationwide review to determine whether VBA staff assigned correct effective dates for compensation benefits with submissions of an intent to file (ITF). Before March 24, 2015, VBA could grant entitlement to benefits as early as the date of receipt of an informal claim as long as a formal claim was submitted within one year of the date VBA sent the claimant the application form. However, to standardize its claims process, VBA removed the informal claims from its regulations and replaced them with the ITF process. With the new process, claimants can submit an ITF electronically, by mail, or by calling a VBA representative. The submission date of an ITF is important because VBA may use the ITF's date of receipt as the effective date for paying benefits.

From March 24, 2015, through September 30, 2017, VBA reported receiving more than 1 million claims using ITF submissions. The OIG reviewed a statistical sample of 300 claims with ITF submissions during this period and found that VBA staff incorrectly assigned effective dates in 56 cases. Based on this sample, the OIG estimated that 22,600 of the 137,000 cases (17 percent)

completed during this period had incorrect effective dates assigned. The OIG estimated that these errors resulted in an estimated $72.5 million in inaccurate benefits payments to veterans—of which about 97 percent were underpayments. Most of the errors occurred during the initial period of ITF implementation, and the OIG found that VBA made significant improvements over time. VBA has since reduced the number of incorrectly dated claims to 4 percent. The OIG recommended that the Under Secretary for Benefits prioritize the modernization of the ITF system and consider integrating ITF submissions into the Veterans Benefits Management System (VBMS), VBA's electronic claims processing system. The OIG also recommended a special review of veterans' claims with ITFs submitted during the initial implementation period. The Under Secretary concurred with the recommendations and provided acceptable plans for implementation.

Amyotrophic Lateral Sclerosis Claims

The OIG conducted a nationwide review to determine whether VBA accurately decided veterans' claims involving service-connected Amyotrophic Lateral Sclerosis (ALS). VA describes ALS, commonly referred to as Lou Gehrig's disease, as a rapidly progressive neurological disease that attacks the nerve cells responsible for directly controlling voluntary muscles. Because a statistical correlation was found between military service activities and the development of ALS, VA established a presumption of service connection in 2008. As a result, veterans who develop the disease during service, or any time after separation from military service, generally receive benefits if they had active and continuous service of 90 days or more. Although VBA prioritizes claims for veterans with ALS, staff must also accurately decide these claims because it is a serious condition that often causes death within three to five years from the onset of symptoms.

The OIG reviewed a statistical sample of 100 veterans' case involving service-connected ALS from April 2017 through September 2017. The team found that VBA staff made 71 errors involving 45 veterans' ALS claims. We then projected that 430 of 960 total ALS veterans' cases had erroneous decisions.

For example, rating personnel incorrectly decided ALS claims related to one or more of the following categories:

- special monthly compensation benefits
- evaluations of medical complications of ALS
- effective dates
- benefits related to adapted housing or automobiles
- inaccurate or conflicting information in decisions
- proposals to discontinue service connection

These errors resulted in estimated underpayments of about $750,000 and overpayments of about $649,000 over a six-month period. The OIG estimated that VBA could make an estimated

$7.5 million in underpayments and $6.5 million in overpayments over a five-year period if VBA staff continue to make errors at the rate identified in this review. Also, VBA staff generally did not tell veterans about special monthly compensation benefits that may be available. The Under Secretary for Benefits agreed to implement the OIG's two recommendations to implement a plan to improve and monitor decisions involving service-connected ALS and to provide notice regarding additional special monthly compensation benefits that may be available.

Systemic Issues

Within just these four reports, the OIG identified common systemic issues that contributed to the troubling outcomes detailed in their findings. As mentioned earlier, these include deficient control activities, inadequate program leadership and monitoring, a lack of information technology system functionality, and the unintended impacts of VBA's National Work Queue implementation.

Deficient Control Activities

The Comptroller General is required by the United States Code to issue standards for internal control in the federal government.[3] The Government Accountability Office (GAO) *Standards for Internal Control in the Federal Government* provides the overall framework for establishing and maintaining an effective internal control system. It further defines control activities as the actions that management establishes through policies and procedures to achieve objectives. In all four reviews, the OIG determined that inadequate control activities contributed to the deficiencies identified.

VBA currently requires an additional level of review for some types of complex claims, such as traumatic brain injury cases, but does not require this additional level of review for MST-related claims. The OIG determined that an additional level of review for MST-related claims would serve as a control activity to ensure VBA staff processes claims in accordance with applicable regulations.

We reported in our ALS work that VBA policy requires an additional level of review for decisions involving higher levels of special monthly compensation. The OIG identified errors in 25 ALS decisions despite having additional reviews by rating personnel or VA regional office managers. The OIG determined VBA should implement a plan to improve the decisions and additional reviews of claims involving ALS and monitor these claims to ensure staff demonstrate proficiency.

In the ITF review, errors generally occurred because the ITF process was new and had a six-month implementation and delivery period. VBA did not take the time to set up adequate standard operating procedures before implementing the new initiative. The OIG determined that

[3] Section 3512 (c) and (d) of Title 31

errors generally occurred due to inadequate procedural guidance that lacked specific details for locating electronic ITF submissions within VBMS. Since nationwide implementation of the ITF process, VBA has taken steps to improve its control activities, which has resulted in improved accuracy.

We found in the unwarranted reexaminations review that VBA policy requires a pre-exam review of the veteran's claims folder before requesting that a veteran appear for a medical reexamination to determine whether it is needed. The pre-exam review should be completed by a rating veterans service representative and would serve as a control activity to prevent unwarranted reexaminations. However, VBA management routinely bypassed the pre-exam review, which contributed to the significant number of unwarranted reexaminations ordered by VBA staff.

Inadequate Program Leadership and Monitoring

One of the key requirements set forth by federal internal control standards is program monitoring. Management should establish and operate activities to monitor the internal control system and evaluate needs, as well as remediate identified internal control deficiencies in a timely manner. In two of the four reviews, the OIG determined that inadequate program monitoring was a contributing factor to the problems identified.

VBA's quality assurance programs consist of the Systematic Technical Accuracy Review (STAR) team nationally and the Quality Review Teams (QRT) at each VA regional office. During the MST review, the OIG determined that the STAR team stopped conducting special focused quality improvement reviews of MST-related claims in December 2015. VBA managers stated that they reallocated resources toward other areas because the error rate declined for MST-related claims from 2011 to 2015. However, since the volume of MST-related claims is less than other types of claims, many of these claims do not appear in the typical samples reviewed by STAR and QRT staff, who therefore lacked proficiency. The OIG concluded, and VBA agreed, that special focused reviews should be reinstated and targeted feedback and training provided to claims processors.

In the unwarranted reexaminations review, the OIG determined that VBA's quality assurance processes did not measure whether VBA employees requested reexaminations only when necessary. VBA also stated that the quality assurance division had not conducted any trend analysis or special focused quality improvement reviews of the reexamination process. VBA agreed with the need for modifying the quality review processes to include a review of reexaminations and with conducting a special focused quality improvement review in this area.

Lack of Information Technology System Functionality

The OIG identified issues that can be traced to a lack of information technology system functionality. For example, VBA could add features to VBMS to prevent scheduling reexaminations in cases that meet the exemption criteria. Specifically, VBMS could issue an

alert if a claims processor tries to request a reexamination for a veteran that meets exception criteria. Implementing this strategy would help prevent errors and reinforce training by providing immediate feedback to staff.

VBMS contains ITF data; however, the system lacked the functionality to assist rating personnel when assigning effective dates for benefits based on ITFs. More than two years after the implementation of ITF, in June 2017, VBA updated VBMS. Additional modernization of functionality within VBMS could further improve accuracy of assigning effective dates related to ITF submissions. The OIG recommended that VBA prioritize the design and implementation of system automation reasonably designed to minimize these issues.

Unintended Impact of National Work Queue

VBA's National Work Queue (NWQ) distributes claims daily to each VA regional office based on factors such as workload capacity, national claims processing priorities, and special missions. While the NWQ is designed to create efficiencies, it has created other unintended consequences. In 2016, when VBA implemented the NWQ, it no longer required VA regional offices to use specialized staff to process claims that VBA designated as requiring special handling, which included MST-related claims. As a result, all claims processors became responsible for a wide variety of claims, including MST-related claims. However, many claims processors did not have the experience or expertise to process these types of claims. This was a contributing factor to VBA staff incorrectly processing almost half of veterans denied MST-related claims. The Under Secretary for Benefits has agreed to reinstate specialized teams to process these claims.

Ongoing OIG Oversight

In addition to the recently completed oversight, the OIG continues to work on matters designed to improve the delivery of benefits to veterans and their families, including several ongoing nationwide reviews to identify systems-level barriers to effective and efficient implementation efforts.

For example, in August 2018, the OIG initiated a review related to the Decision Ready Claims (DRC) program. VBA established the DRC program to streamline claims processing and improve timeliness. Like the ITF process, VBA prioritized the DRC program and implemented it within about six months. VBA piloted the program in May 2017 and implemented it nationally in September 2017. As of October 2018, VBA's self-reported data shows that DRC cases have been completed in an average of about 15 days. However, the number of claims submitted through the program has fallen far short of what VBA initially anticipated. As a result, the OIG initiated a review to determine whether VBA effectively planned and implemented the program. The OIG anticipates publishing the final report for this review in early 2019.

In May 2018, the OIG also initiated a review related to canceled contract medical examinations. VBA requests Compensation and Pension medical exams from a Veterans Health Administration (VHA) clinician, or through one of the Medical Disability Examination contract vendors. Exam

cancellations can delay veterans' claims, waste appropriated funds, and increase VBA's workload because they duplicate the exam request process. Exam cancellations can also cause an adverse decision on veterans' claims. The OIG anticipates publishing the final report for this review in early 2019.

Conclusion

VBA attempts to quickly implement programs and policies and reduce claims backlogs have resulted in unintended consequences. These include sacrificing accuracy for timeliness, rolling out national initiatives after small and short pilot programs, and other efforts to meet the changing and growing demands for benefits and services. The OIG's efforts to identify important systemic issues and focus on high-impact programs and initiatives will help limit those unintended consequences, and better position VBA to provide service to veterans and their families in the most effective and efficient manner possible.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.