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STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORAILS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairman Bost, Ranking Member Esty, and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify regarding the Department of Veterans Affairs (VA) development and implementation of policy initiatives and the reasons for the challenges identified in three recent VA Office of Inspector General (OIG) Reports.

Mr. Chairman, as you may know, DAV is a congressionally chartered national veterans' service organization of more than one million wartime veterans, all of whom were injured or made ill while serving on behalf of this nation. To fulfill our service mission to America's injured and ill veterans and the families who care for them, DAV directly employs a corps of more than 260 National Service Officers (NSOs), all of whom are themselves wartime service-connected disabled veterans, at every VA regional office (VARO) as well as other VA facilities throughout the nation. Together with our chapter, department, transition and county veteran service officers, DAV has over 4,000 accredited representatives on the front lines providing free claims and appeals services to our nation's veterans, their families and survivors.

We represent over one million veterans and survivors, making DAV the largest veterans service organization (VSO) providing claims assistance. This testimony reflects the collective experience and expertise of our thousands of dedicated and highly trained service officers.

DAV is deeply concerned over the findings of significant deficiencies in three VA OIG reports from July and August of this year. As revealed by these reports, the reasons for these substantial errors can be broken down into three main categories: training; IT systems development and resources; and quality review. As we will conclude, these deficiencies could be mitigated with the adoption of a VBA-wide strategic formula for application prior to implementation of any new changes, processes, benefits or IT systems.

"UNWARRANTED MEDICAL REEXAMINATIONS FOR DISABILITY BENEFITS"

On July 18, 2018, VA OIG published its findings on "Unwarranted Medical Reexaminations for Disability Benefits". The OIG team reviewed a statistical sample of 300 cases with reexaminations from March through August 2017 and found that employees requested unwarranted medical reexaminations in 111 cases. Veterans Benefits Administration (VBA) employees requested reexaminations for veterans whose cases qualified for exclusion from reexamination for one or more of the following reasons:

- Over 55 years old at the time of the examination, and not otherwise warranted by unusual circumstances or regulation;
- Permanent disability and not likely to improve;
- Disability without substantial improvement over five years;
- Claims folders contained updated medical evidence sufficient to continue the current disability evaluation without additional examination;
- Overall combined evaluation of multiple disabilities would not change irrespective of the outcome of reexamining the condition;
- Disability evaluation of 10 percent or less;
- Disability evaluation at the minimum level for the condition.

The three main reasons for the requested unwarranted examinations were lack of pre-examination reviews, lack of system automation and inadequate quality assurance reviews.

Lack of Pre-Examination Reviews

VBA policy requires a pre-exam review of the veteran's claims folder prior to requesting that a veteran appear for a medical reexamination to determine whether the reexamination is needed. It was estimated that 15,500 of 19,800 unwarranted reexaminations (78 percent) lacked a pre-exam review. Determining the necessity of a reexamination was a Ratings Veterans Representative Specialist (RVSR) responsibility, however, in 2017, this task was removed from RVSR performance standards as they do not receive work credit for this function. It has been assigned to Veterans Representative Specialists (VSRs). Bypassing the pre-exam review caused unwarranted reexaminations because VSRs lacked the training and experience needed to determine whether a reexamination is warranted. Similarly, 14 of the 24 VSRs interviewed told the review team that they were unfamiliar with the criteria for determining whether a reexamination was necessary. In addition, managers with Compensation Service's Quality Assurance Program indicated there would be fewer unwarranted reexaminations if RVSRs reviewed cases before VSRs request reexaminations.

Lack of System Automation

VBA did not invest in developing alternative internal controls to make up for the lack of a pre-exam review, such as information system automation. Veterans Benefits Management System (VBMS) automation to address pre-examination review, is scheduled for FY 2019 or later. However, VBA did not maximize any of their electronic automation systems to help prevent employees from requesting unnecessary reexaminations.

Inadequate Quality Assurance Reviews

VBA's quality assurance program measures claims processing accuracy for each VARO and for individual employees and provides feedback and training. The program consists of the Systematic Technical Accuracy Review (STAR) office and the Quality Review Teams (QRT). Neither the STAR office nor the QRT measured whether VBA employees requested reexaminations only when necessary or whether they conducted pre-exam reviews. The Deputy Under Secretary for Field Operations and the Director of Compensation Service both agreed with the need for modifying VBA's quality review processes to include a review of reexaminations, and with conducting a special focused quality improvement review in this area.

Impact of Unwarranted Medical Reexaminations for Disability Benefits

The review team estimated that during the six-month review period, VBA spent $10.1 million on unwarranted reexaminations. It also estimated that VBA would waste $100.6 million on unwarranted reexaminations over the next five years unless it ensures employees only request reexaminations when necessary. The review team estimated that VBA required 19,800 veterans to report for unwarranted medical reexaminations during the review period. Approximately 14,200 veterans experienced no change to their disability evaluations. The reexaminations resulted in proposed benefit reductions for about 3,700 veterans.

Veterans and their families depend on their VA benefit payments to provide a better quality of life. VA has threatened that quality of life by creating unwarranted examinations that possibly led to thousands of veterans having their compensation benefits significantly reduced.

"PROCESSING INACCURACIES INVOLVING VETERANS' INTENT TO FILE SUBMISSIONS FOR BENEFITS"

On August 21, 2018, VA OIG published its findings on "Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits". The OIG review team found that VBA staff did not always assign correct effective dates for compensation benefits with Intent to File (ITF) submissions. VA OIG estimated that 22,600 of 137,000 cases (17 percent) completed from March 24, 2015, through September 30, 2017, had incorrect effective dates assigned for compensation benefits whenever a veteran submitted an ITF.

The OIG review team selected a sample of 300 cases completed from March 24, 2015, through September 30, 2017, to determine the accuracy of effective dates assigned. Most of the errors occurred from March 24, 2015, through July 21, 2016, during the initial ITF implementation period. The OIG estimated that in 15,200 of 35,400 cases (43 percent) completed during that period, rating personnel assigned incorrect effective dates. Most of the errors occurred with electronic ITF submissions.

VBA modified its ITF procedures on July 22, 2016, to include guidance and specific details on how to identify ITFs received electronically or by mail. The OIG review team estimated that in 6,000 of 66,400 cases (9 percent), rating personnel assigned incorrect effective dates. The number of errors decreased significantly during the post-procedure update period ranging from July 22, 2016, through June 12, 2017. Significant improvement was shown following the initial ITF implementation period, with the improper processing of effective dates decreasing from a 43 percent error rate to 4 percent.

The reasons for the ITF processing inaccuracies were summed up as absence of standard operating procedures, inadequate procedural guidance on electronic ITF submissions, deficient and delayed ITF training, quality assurance and VBMS lacked functionality.

Absence of Standard Operating Procedures

When VBA initially implemented the ITF policy, its procedures mainly focused on what to do with an incomplete ITF and how to enter ITF data into VBMS. However, the guidance did not give rating personnel instructions on how to identify the electronic submission of an ITF. The Compensation Service's office of Procedures' lack of standard operating procedures when implementing ITF guidance contributed to a high error rate.

Inadequate Procedural Guidance on Electronic ITF Submissions

VBA's Compensation Service Acting Assistant Director and program analysts for Procedures provided inadequate procedural guidance associated with ITF submissions. The manual procedures in use from March 24, 2015, through July 21, 2016, lacked details on the identification of electronic ITF submissions for rating personnel to correctly assign effective dates, despite numerous updates.

The Acting Assistant Director for Policy stated that the ITF process was not part of the original proposed rule but resulted from negative feedback received from Veterans Service Organizations about the elimination of the informal claim process. Consequently, VBA had to restructure policies, procedures, and claims processing systems within a short time frame.

Deficient and Delayed ITF Training

The OIG reviewed all completed mandatory ITF-related training from March 2015 through March 2017 and determined that the training completed before March 2017 was deficient; because it lacked specific information related to identifying an electronically submitted ITF.

Compensation Service provided the OIG with an instructional video dated March 2015. Although the video provided instructions on how to record the receipt of an ITF in VBMS, it did not show how rating personnel would locate an electronically submitted ITF. Furthermore, a program analyst for Procedures indicated the video was later removed because it was not compliant with accessibility standards. The OIG was unable to substantiate whether any staff were able to view this video because it was no longer available.

Quality Assurance

In March 2016, Quality Assurance conducted a national quality call to inform VBA staff of an error trend with effective dates and ITF. Based on the error trend, Quality Assurance provided explicit instructions on how to identify the presence of an electronic ITF filing in VBMS. It took until July 22, 2016, approximately four months from identification of the error trend, to provide these instructions.

The VBA official reported that the development of mandatory training should ideally occur within a three-month time frame following identification of an error trend, depending on other competing priorities. Mandatory training was created and made available to rating personnel in January 2017. The same official required VARO staff to complete the training by March 31, 2017, a delay of approximately one year following the discovery of the error trend.

Impact of ITF Processing Inaccuracies

Compensation Service's absence of standard operating procedures, inadequate procedural guidance for electronic ITF submissions, deficient and delayed mandatory training, and lack of VBMS functionality resulted in improper payments made to veterans from March 24, 2015, through September 30, 2017.

Of the 22,600 cases with errors, 21,900 (97 percent) resulted in underpayments and represent money that should have been paid to veterans between the correct effective date and the one assigned. On a national level, this resulted in the OIG's findings of an estimated monetary impact of $72.5 million in under payments to veterans and their families.

In many cases, earned benefits from the VA, prevent veterans and their families from being homeless or at-risk of homelessness. Therefore, it is unconceivable that VA would act so slowly to correct their severe under payments. To correct also possible deficiencies and to afford justice to all veterans affected, we recommend that VA review all ITF submissions from March 24, 2015 to the present and correct all under payments.

"DENIED POST-TRAUMATIC STRESS DISORDER CLAIMS RELATED TO MILITARY SEXUAL TRAUMA"

On August 21, 2018, VA OIG published its findings on "Denied Post-traumatic Stress Disorder Claims Related to Military Sexual Trauma". The OIG report team stated that VBA staff did not always follow VBA's policy and procedures, which may have led to the denial of veterans' military sexual trauma (MST)-related claims.

In reviewing the MST-related claims denied by VBA, the review team found that staff did not follow the required claims processing procedures. The most commonly encountered errors in processing were:

- Evidence was enough to request a medical examination and opinion, but staff did not request one;

- Evidence-gathering issues existed, such as VSRs not requesting veterans' private treatment records;
- MST Coordinators did not make the required telephone call to the veteran, or VSRs did not use required language in the letter sent to the veteran to determine whether the veteran reported the claimed traumatic event in service and to obtain a copy of the report; and
- RVSRs decided veterans' claims based on contradictory or otherwise insufficient medical opinions.

The reasons the MST-related claims were incorrectly processed were lack of previous specialization, lack of additional level of review, discontinued special focused reviews and inadequate training.

Need for Specialization

VBA previously implemented the Segmented Lanes model. It had required VSRs and RVSRs on Special Operations teams to process all claims VBA deemed highly complex, as well as sensitive issues such as MST-related claims. The OIG review team concluded that staff on the Special Operations teams developed subject matter expertise on these highly sensitive claims due to focused training and repetition. Under the National Work Queue (NWQ), VBA no longer utilized the Special Operations teams. Under this new model, the NWQ distributed claims daily to each VARO and the VARO determined the distribution of MST-related claims.

As a result, MST-related claims could potentially be processed by any VSR or RVSR, regardless of their experience and expertise. The OIG review team determined VSRs and RVSRs at offices that did not specialize, lacked familiarity and became less proficient at processing MST-related claims.

VARO staff suggested VBA reestablish specialized processing, allowing employees to develop the necessary expertise to ensure consistency and accuracy in processing these sensitive claims. The Deputy Under Secretary for Field Operations agreed that dedicated staff working MST-related claims would help improve the quality of claims processing.

Lack of Additional Level of Review

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. RVSRs, quality review personnel, and supervisors interviewed at the four VAROs visited generally thought an additional level of review would be helpful and could improve accuracy. An additional level of review serves as an internal control and quality check to help ensure:

- Claims processors followed all applicable statutes, regulations, and procedures;
- Evidence of record properly supports the decision; and
- RVSR adequately explained the decision.

The Deputy Under Secretary for Field Operations and Compensation Service Quality Assurance personnel agreed that an additional level of review would help improve the accuracy of processing MST-related claims.

Discontinued Special Focused Reviews

The national Systematic Technical Accuracy Review (STAR) team for Compensation Service and the Quality Review Teams (QRT) at each VARO execute VBA's quality assurance programs. MST-related claims are included in the STAR and QRT claim reviews. However, MST-related claims are only a small percentage of the overall claim volume and are less likely than other claim types to be randomly selected for STAR and QRT reviews. Therefore, STAR and QRT staff did not frequently review them.

STAR staff completed special focused quality improvement reviews of MST-related claims beginning in 2011, based on the deficiencies identified in a 2010 OIG report related to combat stress in women veterans. These reviews continued based on a 2014 Government Accountability Office (GAO) report on MST-related claims that found the problems persisted. Staff performed the reviews twice a year and identified errors like those this OIG review team found, such as missed evidence or markers and failure to request necessary medical examinations.

The STAR office stopped completing special focused quality improvement reviews of MST-related claims in December 2015. VBA's Quality Assurance Officer indicated the STAR office stopped performing special focused quality improvement reviews because it had met the GAO requirement. The Assistant Director of Quality Assurance for Compensation Service also stated that they reallocated resources towards other areas because the error rate declined for MST-related claims from 2011 to 2015.

Given the high error rate identified during its review, the OIG review team determined the STAR office should reinstate special focused quality improvement reviews of MST-related claims.

Inadequate Training

Compensation Service delivered MST training through four modules using VBA's online training management system. The OIG reviewed the four training modules and identified the following issues:

- Consistently referred to a development checklist that was outdated and inaccurate;
- Included erroneous development procedures, such as instructing claims processors to use incorrect medical opinion language;
- Misstated the MST Coordinator's role and responsibilities;
- Did not address how to rate claims where a diagnosis other than PTSD was provided; and
- Included incomplete information regarding what constitutes an insufficient or inadequate examination.

The MST-related claims training was one-time only and there was no requirement for annual refresher training. The Compensation Service Quality Assurance Officer stated that VSRs and RVSRs needed refresher training, and staff at the four VAROs visited, generally agreed it was not adequate. The Director of Compensation Service and Assistant Director of Compensation Service Training agreed that the training needed improvement and indicated that VBA was in the process of creating a new training program. The Deputy Under Secretary for Field Operations stated that training for MST-related claims should be an annual requirement.

Impact of Improperly Adjudicated MST-Related Claims

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 or 49 percent of the 2,700 MST-related claims denied during that time. Due to the severity and volume of these errors, VA OIG recommended that VBA review all denied MST-related claims since the beginning of FY 2017 and reopen the cases with errors to ensure veterans receive accurate claims decisions as well as better customer service.

Those who experience sexual military trauma often suffer in silence. However, nearly 50 percent of those claiming MST-related PTSD have been denied due to VA's own failures. How long will these veterans continue to suffer without justice?

PATTERN OF SYSTEMIC FAILURES

The VA's requesting unwarranted examinations was estimated to require 19,800 veterans to report for unwarranted medical reexaminations during the review period at a cost of over $10 million. The report specifically noted that these were caused by lack of training, lack of automated systems, and no quality review.

VBA's absence of standard operating procedures, inadequate procedural guidance for electronic ITF submissions, deficient and delayed mandatory training, and lack of VBMS functionality resulted in improper payments made to veterans.

49 percent of denied MST-related claims were processed incorrectly and were not processed within VBA's own guidelines and policies. The reasons the MST-related claims were incorrectly processed were lack of previous specialization, lack of additional level of review, discontinued special focused reviews and inadequate training.

The new VA OIG report "Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis" released on November 20, 2018, continues to show these same patterns. The report projected that 430 of the 960 total ALS veterans' cases (45 percent) completed during the six-month review period had erroneous decisions. It was recommended that VBA provide additional training, better quality review and add functionality to VBMS.

RECOMMENDATIONS

As demonstrated, VBA's erratic training, lack of planning for IT systems development and uneven quality review has wasted millions of taxpayers' dollars, as well as underpaid, denied and reduced thousands of veterans. While VA is implementing the recommendations from the VA Office of Inspector General, we believe VA needs to develop proactive measures to lessen these preventable errors in the future.

VA has used production goals and other metrics to drive down the backlogs of claims and appeals and provide timely decisions. However, as noted by the OIG reports, VA is not placing enough emphasis on comprehensive training and quality review. As evidenced, lack of training and improper quality review of claims decisions led to multiple denied claims, reduced benefits, unnecessary examinations conducted, and inaccurate effective dates for claimants.

Training and feedback are instrumental in shifting VA's culture to one primarily driven to achieve quality, rather than merely productivity. After all, proper quality review, training, and feedback will lead to more claims decisions being made right the first time, and thereby lead to a reduction of appeals.

Updated and modern IT is critical to the ultimate success of VBA. Despite past failed attempts to modernize its claims processing systems over the past two decades, VBA made a critical decision to transform its paper-based systems and replace them with streamlined business processes supported by modern IT systems. However, unless VBA is provided sufficient resources to fully implement and program new IT systems at the front end, both productivity and quality will continue to suffer, resulting in more errors and veterans waiting longer to receive their earned benefits.

Over the past several years, VBA has developed and implemented new IT systems to support the transformations, including VBMS, the NWQ, and e-Benefits. Unfortunately, VBA must compete with other offices and agencies within VA for the limited IT funding available each year, delaying development and deployment of critical IT systems and programming. As a result, critical IT systems are rarely fully developed before business process changes are implemented; instead they are phased in over several years, forcing VBA to rely on an inconsistent mix of old and new IT systems, as well as an endless stream of suboptimal "work around" solutions.

While it may be understandable from a purely budgetary view to stretch out development and deployment of new IT systems, it is a failure from a functional perspective. Providing only partial IT solutions inevitably results in a loss of productivity, and often leads to lower quality and less accurate decisions on claims and appeals by veterans. Similar problems caused by inadequately developed technology can be seen in the Vocational Rehabilitation and Employment's (VR&E) $12 million IT debacle and the Education Service's continuing problems in making accurate payments under the new GI Bill program.

As VA is correcting the deficiencies outlined in the OIG reports, we believe that if VA shifts from a reactive position to a preemptive and aggressive approach to future changes and new policies, they can lessen the types of errors noted. VA needs to devote their attention to developing a process to address future changes and potential new policies in advance of the actual changes.

We recommend VBA to create a systematic strategic review process for new policies and initiatives. This could encompass each appropriate VA office potentially impacted by the changes, such as VA Office of Training, VA Quality Assurance and Review, VA IT services including VBMS and NWQ. However to be truly effective, it requires VSOs and other stakeholders, as well as VA's front line subject matter experts including RVSRs and VSRs.

This systematic strategic review process should be focused on vetting new policy initiatives to prevent unintended consequences that can negatively impact veterans and their families. It would be better for VA to invest time and resources preventing these problems from occurring rather than developing "work arounds" and patches after the veterans have already been harmed.

A good example is how VBA, VA Agencies, GAO, VSOs, and stakeholders were all engaged from the beginning in the development of the Appeals Modernization Act (AMA). Before the implementation of the AMA, VBA and BVA have collaborated to develop IT infrastructure, training programs, and quality review. This type of systematic strategic review process will lessen the preventable errors noted by the VA OIG reports.

Mr. Chairmen, this concludes my testimony on behalf of DAV. I would be happy to answer any questions you or other members of the Subcommittees may have.