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BEFORE THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS,
US HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
"IS THE VETERANS BENEFITS ADMINISTRATION PROPERLY PROCESSING
AND DECIDING VETERANS' CLAIMS?"
JULY 23, 2024

Chairman Luttrell, Ranking Member Pappas, and members of the Subcommittee, thank you for the opportunity to testify on the independent oversight conducted by the Office of Inspector General (OIG) on VA's quality assurance and training programs related to providing disability compensation benefits to eligible veterans. The OIG is committed to conducting work that results in evidence-based findings and practical recommendations to help the Veterans Benefits Administration (VBA) promptly and accurately provide veterans with the benefits and services they have earned. To that end, the OIG works diligently to ensure every report issued is fair and balanced, and serves as a road map for VA leaders to make program and process improvements across the nation.

Disability compensation is a tax-free monetary benefit paid to veterans with disabilities that are the result of a disease or injury incurred or aggravated during active military service. As of December 31, 2023, more than 5.7 million veterans were receiving these benefits.[1] VBA has established a multifaceted quality assurance program to help identify and eliminate barriers to making timely, accurate, and consistent decisions on disability compensation claims. Its training program is meant to adequately prepare new and current employees to address the complexity of the claims process, particularly given the increased workload from the PACT Act, and to inform all claims personnel of constantly changing policies, procedures, and guidance.[2] Both the quality assurance and training programs have had considerable challenges in meeting their objectives, as evidenced by the OIG reports

[1] VA, "VA Benefits & Health Care Utilization," www.va.gov/vetdata/docs/pocketcards/fy2024q1.pdf.

[2] The PACT Act refers to the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics Act of 2022, Pub. L. No. 117-168, 136 Stat. 1759.

discussed below. Given the impact on veterans when benefits are delayed or decided in error, the OIG remains vigilant in its oversight of various aspects of these programs.

DEFICIENCIES IN VBA'S QUALITY ASSURANCE AND TRAINING PROGRAMS

The OIG acknowledges that VBA has improved its quality assurance review process by implementing action plans associated with OIG report recommendations, including those made in response to the oversight reports issued in 2020 through 2022 described later in this statement. However, the OIG continues to identify deficiencies with VBA's quality assurance and training processes related to disability compensation claims. The following four reports provide examples of errors and weaknesses that can affect whether veterans receive the prompt and accurate payments they are due. These highlighted reports focus on (1) processing errors VBA personnel made on veterans' individual unemployability claims, (2) inconsistencies implementing changes to the disability rating schedule, (3) issues with claims automation, and (4) unwarranted medical reexaminations for veterans.

VBA Personnel Made Errors When Processing Veterans' Claims for Individual Unemployability Benefits

When a veteran is unable to secure and maintain "a substantially gainful occupation" because of service-connected disabilities, VA policy states that the veteran should be rated totally disabled—also referred to as total disability based on individual unemployability (TDIU).[3] The OIG conducted a review to determine if claims processors were following policies and procedures to accurately decide veterans' claims for TDIU benefits.[4]

In the resulting July 2024 report, the team found VBA employees did not consistently follow policies and procedures when processing these claims, leading to errors and improper payments to veterans.[5] The team estimated, based on two statistical samples, that these claims processing errors resulted in $84.7 million in underpayments and at least $9.8 million in overpayments during the review period from

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[3] VA Manual 21-1, part 8, sub. 4, chap. 3, sec. A, topic 1.a, "Establishing Entitlement to TDIU" and topic 2.b, "Definition: Substantially Gainful Employment," July 29, 2021.

[4] VA OIG, *VBA Needs to Improve Accuracy of Decisions for Total Disability Based on Individual Unemployability*, July 17, 2024

[5] Both underpayments and overpayments are considered improper payments. The Office of Management and Budget defines federal payments as improper when they are paid in the incorrect amount, paid to an ineligible recipient, or issued without adequate supporting documentation. Office of Management and Budget, "Requirements for Payment Integrity Improvement," app. C in OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, March 5, 2021.

May 1, 2022, to April 30, 2023.[6] The OIG made seven recommendations to help VBA improve the accuracy of TDIU claims decisions. These recommendations included updating guidance, enhancing information systems, improving training, and evaluating workload distribution. All recommendations remain open, and the OIG will continue to assess VBA's corrective actions until adequate documentation has been presented to demonstrate sufficient implementation.[7]

Disability Rating Updates Were Not Consistently Applied

VBA uses the VA Schedule for Rating Disabilities (the rating schedule) to determine monthly compensation to eligible veterans for service-connected disabilities based on documented medical severity. In 2021, updates were made to the rating schedule for the musculoskeletal body system. The OIG performed a review to assess the effectiveness of VBA's implementation of the rating schedule changes for hip and knee replacements.

The report on the review's findings, published in February 2024, found an estimated 38 percent of claims had an improper payment during the review period.[8] VBA paid an estimated $3.3 million in total improper payments for hip and knee replacement claims—including both underpayments and overpayments for these claims. VBA concurred with the OIG's four recommendations, with two focusing on inadequate quality assurance (monitoring) and training processes.[9] Specifically, the OIG called on VBA to develop implementation procedures to include monitoring the accuracy of claims processing when rating schedule revisions are made. The OIG also recommended VBA supplement training on the rating schedule updates and include how to apply the changes to help assure claims processors' comprehension. The recommendations remain open at this time.[10] The OIG will track VBA's progress through its recommendation follow-up process.[11]

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[6] The OIG team reviewed a random sample of 120 granted individual unemployability claims and 80 denied claims that were completed from May 1, 2022, to April 30, 2023.

[7] At quarterly intervals commencing 90 calendar days from the report issue date, the OIG sends a follow-up status request to the action office asking for an implementation status report. The OIG follow-up staff generally will provide VBA 30 calendar days to respond.

[8] VA OIG, *Rating Schedule Updates for Hip and Knee Replacement Benefits Were Not Consistently Applied*, February 21, 2024.

[9] The other two recommendations address issues unrelated to quality assurance and training.

[10] VA's action plans included target completion dates for recommendation 3 as May 31, 2024, and was yet to be determined for recommendation 4.

[11] The OIG made its first follow-up status request for this report on May 21, 2024. VBA provided their status update to the OIG on July 3, 2024, and the documentation provided is currently being reviewed.

Improvements Are Needed to Claims Automation

Anticipating a surge in disability benefits claims resulting from passage of the PACT Act, VBA launched a project to automate the processing of certain hypertension (high blood pressure) claims.[12] The project automates evidence-gathering tasks including extracting blood pressure readings and hypertension-related medication data from VA treatment records. These are compiled into a summary sheet, uploaded to the veteran's electronic claims folder, and used as evidence to decide the claim.

The OIG carried out a proactive review to determine whether the project supported accurate decisions on veterans' claims while also improving processing timeliness and reducing manual effort. In September 2023, the OIG published a report detailing deficiencies with the automation project.[13] The team found the summary sheets did not provide accurate and reliable evidence, which resulted in inaccurate decisions on veterans' claims. The OIG made four recommendations to VBA, including implementing an improved quality assurance process and monitoring the results to ensure the accuracy of hypertension summary sheets and final decisions.[14] All recommendations remain open at this time.[15]

Veterans Were Required to Attend Unwarranted Medical Reexaminations

To ensure veterans' monthly compensation benefits are consistent with their levels of disability, VBA requires reexaminations for veterans when there is a need to verify the continued existence or the current severity of a disability. VBA's policy is to only request reexaminations when mandated by law, or if necessary, before reducing a veteran's disability rating due to improvements in the disability. While required reexaminations are important to make sure that taxpayer dollars are spent appropriately, unwarranted reexaminations are a waste of funds, could cause undue hardships for veterans, and reduce the efficiency and timeliness of claims processing.

The OIG conducted a review to determine whether VBA staff followed procedures when requesting medical reexaminations. The subsequent March 2023 report found practices inconsistent with procedures and that VBA had opportunities to reduce unwarranted reexaminations.[16] When VBA staff complete rating decisions on veterans' claims for benefits, they may establish approximate reexamination control dates in the electronic system. A control date is the month and year when the

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[12] The automation project focused on claims that include a request for an increased rating for hypertension.

[13] VA OIG, *Improvements Needed for VBA's Claims Automation Project*, September 25, 2023.

[14] The other three recommendations deal with issues unrelated to quality assurance and training.

[15] VBA provided their most recent status update to the OIG on July 16, 2024, and the documentation provided is currently being reviewed

[16] VA OIG, *Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits*, March 16, 2023.

claim is due for review. Based on a statistical sample review, the team estimated staff *erroneously established a control date* for future reexaminations in 66 percent of cases (3,149 of 4,754), including cases in which disabilities were permanent and not likely to improve. This occurred, in part, because VBA did not require staff to cite objective evidence for why reexaminations were needed.

VBA's policy was for a "locally designated claims processor with expertise in review examination ordering" to determine whether reexamination is still needed once the related control date is reached.[17] However, VBA did not define or provide criteria for the expertise needed to process these claims. The team reviewed a separate statistical sample of claims with control dates that had come due and estimated claims processors requested unwarranted reexaminations at that time in about 44 percent of cases (9,733 of 22,534).

VBA concurred with the report's three recommendations, which included VBA updating its training materials and ensuring claims processors meet all training requirements related to establishing and ordering medical reexaminations.[18] All recommendations remain open until VBA provides documentation of sufficient progress to demonstrate adequate implementation.[19]

PRIOR OIG REPORTS ON VBA QUALITY ASSURANCE

Concerns with the accuracy and timeliness of claims processing are not new. From 2020 through 2022, the OIG completed six nationwide reviews that focused on various components of VBA's quality assurance review program.[20] This statement highlights three reports from that series that focus on the accuracy of decisions for veterans' disability compensation claims:

- The first report examines reviews by VBA's national quality assurance program, referred to as the Systematic Technical Accuracy Review (STAR) program.[21]

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[17] VA Manual 21-1, "Control of Future Examinations," updated September 15, 2021, sec. IV.ii.1.B, topic. 1.d. The February 2019 version of the manual placed this information in sec. III.iv.3.C, topic 2.d.

[18] The other two recommendations address concerns unrelated to quality assurance and training.

[19] VBA provided their most recent status update to the OIG on April 11, 2024. The team is communicating with VBA to obtain the necessary evidence to assess closure of the recommendations.

[20] VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*, July 22, 2020; VA OIG, *Deficiencies in the Quality Review Team Program*, July 22, 2020; VA OIG, *Site Visit Program Can Do More to Improve Nationwide Claims Processing*, August 18, 2020; VA OIG, *Greater Consistency Study Participation and Use of Results Could Improve Claims Processing Nationwide*, September 29, 2020; VA OIG, *The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings*, May 18, 2021; VA OIG, *The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing*, August 9, 2022.

[21] VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*.

- The second publication assesses the quality review teams at each of VBA's 57 regional offices.[22]
- The third report summarizes the systemic issues identified during the OIG's prior reviews.[23]

To better understand who is responsible for implementing the OIG recommendations related to VBA's quality assurance review program, it is useful to know the governance structure of responsible offices and individuals. The program relies on two offices within VBA—the Compensation Service and the Office of Field Operations. The Compensation Service, led by an executive director, administers the quality assurance review program and assesses claims processing accuracy nationwide. The Office of Field Operations, headed by a deputy under secretary, directs VBA's district and regional offices and is responsible for ensuring claims processing personnel follow quality assurance procedures. Field Operations is also tasked with taking corrective actions on deficiencies identified during quality assurance reviews. It is vital for these two offices to effectively coordinate and communicate to help the quality assurance program achieve its mission, goals, and responsibilities.

The STAR Program Did Not Adequately Identify and Correct Claims-Processing Deficiencies

The STAR program is one element of VBA's multifaceted quality assurance review program to support the provision of disability compensation benefits in a timely and accurate manner. The program is intended to provide quality review and analyses of all factors involved with processing a specific claim. STAR analysts perform quality reviews on individual, randomly selected claims from across the country to identify processing deficiencies and provide feedback to claims personnel to improve decision-making. VBA uses the results of these publicly reported reviews to estimate claims processing accuracy nationally and for each regional office. The OIG conducted this review to determine whether the STAR program performed accurate quality reviews of claims decisions, had adequate procedures to ensure corrective actions were implemented timely and correctly, and provided feedback to managers and staff to increase the accuracy of claims decisions.

The OIG found in its 2020 report that the STAR quality review process needed improvement, and VBA did not take sufficient actions to make certain the program fully identified deficiencies in the claims process and provided meaningful feedback to regional office employees.[24] STAR analysts generally detected benefit entitlement errors but did not place as much emphasis on finding procedural deficiencies. A benefit entitlement error occurs when a claims processor takes an action that violates

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[22] VA OIG, *Deficiencies in the Quality Review Team Program*.

[23] VA OIG, *The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings*.

[24] VA OIG, *The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims-Processing Deficiencies*.

current regulations or other directives and affects the outcome or has the potential to affect the outcome of a veteran's claim, such as an overpayment or underpayment. Procedural deficiencies also involve a violation of regulations or directives; however, they do not directly affect a veteran's benefits. An example of a procedural deficiency would be establishing an unnecessary medical examination, which could delay benefits decisions. The review team determined there was no formal secondary review process for procedural deficiencies. With this lack of emphasis on procedural deficiencies, VBA may not have complete data on whether employees are properly processing and deciding veterans' claims. The deputy under secretary interviewed by the OIG team stated that identifying these deficiencies is important to help drive operational decisions, such as determining whether additional training is needed for VBA's claims processors. Moreover, in response to the related report recommendation, VBA agreed that some procedural errors have the potential to affect benefits.

The OIG team examined a statistical sample of 100 claims. Of those, an estimated 55 percent had benefit entitlement errors that were identified by STAR analysts that could affect veterans' disability compensation payments and procedural deficiencies. Problems were also noted with the process for correcting errors that resulted in delayed and inaccurate actions, as well as outdated feedback from reviews being provided to VBA personnel that did not enhance the quality of claims decisions.

The six recommendations have been closed based on documentation provided by VBA. They addressed improving and formalizing the processes for secondary reviews and training, including remediating identified deficiencies; increasing claims processing accuracy; enhancing the emphasis on procedural deficiencies; tracking corrective actions; and consistently providing data and feedback to regional offices.

Deficiencies in the Quality Review Team Program

Another OIG oversight report examined quality review teams at each regional office that are responsible for evaluating the accuracy with which VBA staff process compensation claims, identifying any trends in errors committed by claims processors, providing training and mentoring on addressing error trends, and reviewing the performance of individual employees. Quality review team specialists perform reviews of compensation claims that have been processed by other employees. The OIG's work focused on whether specialists executed accurate quality reviews, regional office managers appropriately decided requests for reconsideration of errors identified, and employees initiated timely action to correct identified claims processing errors based on established standards.

Among the findings presented in this 2020 report was that the specialists responsible for identifying claims processing errors missed them in approximately 35 percent of quality reviews completed during

the review period.[25] Furthermore, the process by which these specialists assess one another's work was inadequate to detect errors missed during the initial quality review. Performance reviews of specialists also did not ensure they had the competency needed to detect errors. Without accurate quality review data, VBA cannot fully assess whether employees are making the correct decisions on veterans' claims.

The OIG team also estimated that during the review period, regional office managers inappropriately overturned specialists' determinations that errors were made about 50 percent of the time when claims processors requested a reconsideration of the identified mistakes. Finally, VBA had not established adequate oversight or accountability for assuring the prompt correction of claims processing errors. The OIG estimated that during the review period about 45 percent of identified errors were not corrected within established timelines and about 18 percent were not corrected at all.

The OIG made five recommendations to VBA that were all closed in response to documentation that satisfactory steps for improvement had been completed. These included assessing the peer review process, sampling non-error quality reviews, revising the specialist performance review and error reconsideration processes, and improving the monitoring of error correction timeliness.

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

An OIG report issued in 2021 summarized systemic weaknesses found in the oversight and accountability of VBA's quality assurance review program.[26] Although the program routinely identified claims processing deficiencies and communicated results to internal and external stakeholders, the Office of Field Operations did not ensure regional office employees took adequate corrective actions to redress the deficiencies identified. For example, regional office managers did not follow up with employees to make certain that they corrected errors in a timely manner that were identified by STAR and quality review team personnel. This systemic weakness in oversight and accountability by the Office of Field Operations put veterans at risk of not receiving accurate decisions and the benefits for which they were eligible.

VA submitted sufficient evidence of implementing the report's single recommendation for its closure. VBA carried out an action plan to strengthen oversight of quality assurance by improving the Office of Field Operations' monitoring of errors identified during quality reviews to confirm identified deficiencies were being adequately addressed.

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[25] VA OIG, *Deficiencies in the Quality Review Team Program*. If an employee disagrees with an error cited by a quality review team specialist, they have the option to request reconsideration.

[26] VA OIG, *The Office of Field Operations Did Not Adequately Oversee Quality Assurance Program Findings*.

CONCLUSION

One of the critical foundations of accountability for any program is effective quality assurance to detect and resolve issues. The OIG has found that VBA needs to improve the execution of its quality assurance review program so that eligible veterans receive the disability compensation benefits they are due. While VBA has made progress by carrying out action plans to address oversight report recommendations for improvement, there is more work to be done. The OIG acknowledges that VBA personnel face significant difficulties in processing often complex claims. These challenges are exacerbated by constantly changing policies and processes, increasing workloads, as well as tight timelines. This state of constant change reinforces the OIG's calls for VBA to provide its employees with accurate, timely, and effective training. The OIG remains committed to conducting independent oversight and providing practical recommendations to help improve the accuracy of decisions involving veterans' disability compensation claims, with ongoing projects focused on such areas as PACT Act claims accuracy, staffing, and more effective training for claims processors and medical examiners.

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