9

Disability Claims Administration

The Commission examined how the policies and operations of VA disability programs were being implemented in the field. The eight site visits that the Commission conducted in 2006 (Appendix D) and much of the testimony heard at Commission meetings formed the basis for the conclusions in this chapter. During the site visits, the Commissioners focused on operations at the regional offices and medical centers of the Department of Veterans' Affairs (VA) and in components of the Department of Defense (DoD) that interact with VA. The Commissioners also focused on the activities of the clinician–examiners who perform medical and physical evaluations of disabled veterans.

I Filing a Claim or Appeal

I.1 Filing a Claim

VA aims to provide timely and accurate decisions on disability compensation claims. Even so, the Department has experienced long delays and extensive backlogs in processing claims for several years. To help overcome the backlog, VA and DoD established a program in 1998 to help service members initiate a disability compensation claim at their military base prior to being discharged. Called Benefits Delivery at Discharge (BDD), the program is in effect at 140 locations in the United States, Korea, and Germany. It currently operates under a 2004 memorandum of agreement between VA and DoD to create a cooperative separation medical examination process to ease the transition from service to veteran status. The BDD program "enables separating service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation."[1]

Claims for disability compensation are initiated when a veteran files an application, either online or at a regional office. A "specific claim in the form prescribed by the Secretary must be filed in order for benefits to be paid or

[1] IOM, *21st Century, 146.*

furnished to any individual under the laws administered by the Secretary" (38 U.S.C. § 5101[a][2006]). However, any communication or action indicating intent to apply for benefits from a claimant or his or her representative may be considered an informal claim (38 U.S.C. § 1155 [2006]).

Upon receipt of a "substantially complete application" (which includes the claimant's name [veteran or other claimant], his or her relationship to the veteran, sufficient service information for VA to verify the veteran's service and claimed medical condition or conditions), VA will begin to process the claim. In accordance with the Veterans Claims Assistance Act (VCAA) of 2000, VA has a "duty to assist" the claimant. VA must give the claimant written notification of the evidence that is necessary to substantiate the claim. It must also tell the claimant who is responsible (i.e., VA or the claimant) for obtaining that evidence. VA must make reasonable efforts to obtain relevant records not in the custody of the Federal Government, and it must make as many requests as are necessary to obtain relevant records within the custody of Federal Departments or agencies, including the veteran's service medical records and VA records of examination or treatment. However, VA encourages applicants to submit copies of their own medical records in order to expedite the claim (Box 9.1 below).

Box 9.1 Excerpt from VA Publication Explaining the Disability Claims Process

What VA Does after It Receives Your Claim

After VA receives your Application for Compensation, it sends you a letter. The letter explains what VA needs in order to help grant your claim. It states how VA assists in getting records to support your claim. The letter may include forms for you to complete, such as medical releases. They help VA obtain pertinent medical records from your doctor or hospital. You should try to complete and return all forms VA sends within a month. Your claim can often be processed more quickly if you send a copy of your own medical records.

What Records VA Obtains to Support Your Claim

VA then attempts to get all the records relevant to your claimed medical conditions from the military, private hospitals or doctors, or any other place you tell us. The person who decides your claim (called a Rating Veterans Service Representative) may order a medical examination. This examination is free of charge. It is extremely important that you report for your examination at the scheduled time to avoid delaying your claim.

SOURCE: IOM*, 21st Century,* 148.

I.2 Timeliness of Claims Processing

In 2006, it took an average of 177 days to process claims. During that year, VBA regional offices received over 654,000 claims for disability compensation. Just

over 81 percent of these were reopened claims (claims that were initially denied or the veteran was dissatisfied with the disability rating) and the rest were original claims.

Two-thirds of compensation claims made each year are from veterans previously determined to have a service connected disability most of them are veterans of WWII, Korea, and Vietnam. As the population of veterans ages, VBA can expect to see a growing percentage of claims for worsening chronic conditions. As of June 2007, the average processing days had increased to 181.

Figure 9.1 shows the average length of time it takes to adjudicate a rating claim for disability compensation benefits in comparison to the strategic goal.[2]

The development initiation and evidence-gathering phases of disability claims processing take the largest portion of time in the process. The key medical aspects of the disability claims process are:

- development of medical evidence, such as information about degree of impairment, from service showing treatment for claimed disability, from doctors after service linking current disability to service, functional limitation, and disability, which almost always includes a disability examination conducted by a VHA clinician or medical contractor; and

- the rating process, in which the medical evidence is compared with the criteria in the Rating Schedule and a percentage rating is determined.

To analyze the current system for filing a claim (appeals will be addressed separately in this section), the first place to look is the procedure for filing a claim, the forms involved, literature, and so on. When reviewing the present timeline for the timeliness of claims processing, it is evident that the overall process can be reduced if some of the cycles are reduced. The most time-consuming part of claims processing is the time it takes to begin development until the time the development has been received and the claim referred to the rating board for a decision.

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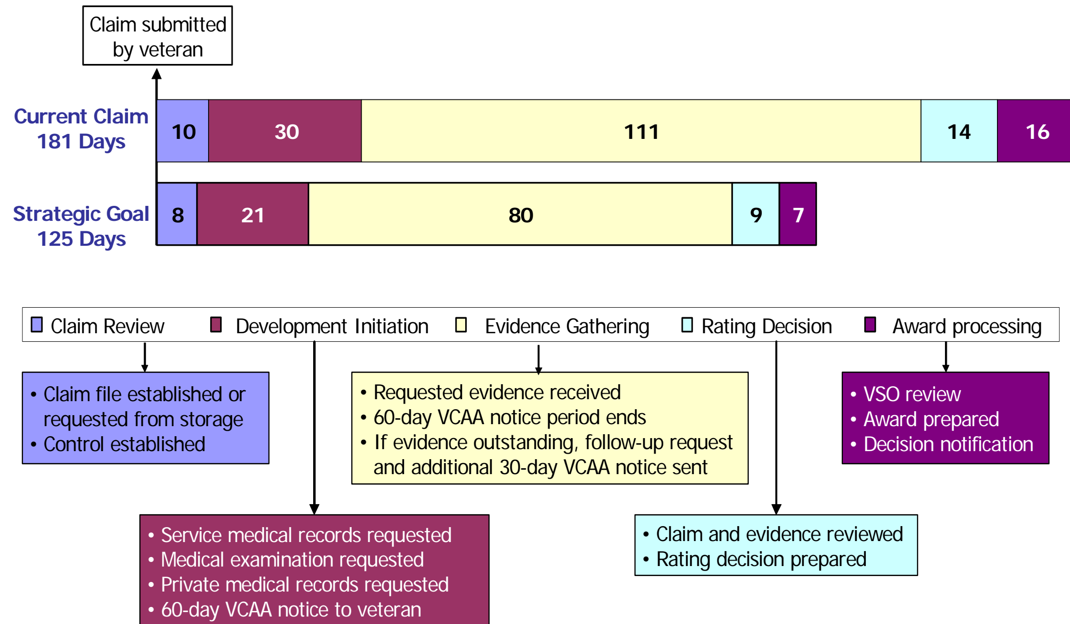
[2] VA, *PA&I Dashboards for FY 2006 (End-of-Month June 2007)*.

Figure 9.1 Disability Claim Timeline (June 2007 Data)



It is noteworthy that most claims filed require VA to further develop evidence when in fact these claimants could have provided VA with more information or evidence from the outset. While most claims are "substantially complete," they fail to address all the areas required to promote a timely decision by VA. For example, the VA may receive a claim from a veteran who is filing for service connection for a knee condition due to an injury in service (nothing additional written on the claim application submitted by the veteran). It would be deemed minimally sufficient to begin development. However, this claim could have been more effective by stating when and where treatment was received in service, and when and where treatment was received after service up to the present time. Even better would have been for the veteran to provide a copy of the information. The veteran, in this case, could have expedited the decision in his claim by furnishing the evidence the VA would have been obligated to obtain for him. He could have also included a statement requesting VA to make a decision on his claim as soon as VA had received all the evidence, adding that he had no additional evidence to submit.

VA regulations require VA to give all veterans 60 days in which to provide any additional evidence. This regulation is VA's interpretation of a reasonable time frame but was not specified by court decisions or statute. A high percentage of cases could be rated earlier if VA had a statement, signed by the veteran, that he or she had no additional evidence to submit and for VA to make a decision on his or her claim as soon as all the identified evidence had been received. Providing information at the time the claim is filed could obviate the need for VA to wait the 60-day period to see if the veteran replies. VA and veterans service representatives often have to call the veteran in many cases to get this information because all the evidence is already on file, but the 60-day time limit for furnishing additional evidence has not yet passed. In a majority of cases, the veteran states he or she has no other information to submit and requests an early decision. This becomes a resource issue, when the very nature of the issue is to improve the timeliness of claims processing. VA could be devoting more time to claims processing if a claim was well documented at time of filing. Having a well-documented claim presented at the beginning of the claims process still significantly reduces the time it takes to decide a claim. It should also be noted that VA will not violate a veteran's right to file a claim or to furnish information. If a veteran does not want VA to make an early decision for any reason, VA will wait for the 60-day time limit to mature. VA's responsibility in this case would be to obtain the service medical records and also to schedule a VA exam if the evidence warranted it.

In the development initiation and evidence-gathering phases, VA cannot proceed without acquiring the evidence that was identified by the veteran. If there has been no reply to prior requests, VA must send a second request for the evidence. Clearly, if this stage could be shortened, the overall claims process would be shortened, and VA would be in a better position to provide timely decisions to veterans and reach their strategic goal of processing disability claims within 125 days of receipt.

Multiple requests are often necessary to obtain needed information. This phase of the claims process is managed by the predetermination team in the Veteran Service Center. The team sets diaries (deadline dates) for receipt of requested information, then determines the need for a VA medical examination to determine current level of disability or to provide a medical opinion as to whether the current disability is related to the veteran's military service (referred to as "medical nexus").

According to VA, "The purpose of compensation and pension (C&P) examinations is to provide the medical information needed to reach a legal decision about a veteran's entitlement to VA monetary benefits based on disability" (Brown, 2003). Obtaining a C&P medical examination is part of VA's duty to assist the applicant. An examination is required:

- when a veteran files a claim for service connection and submits evidence of disability;
- when a veteran asserts a worsened service-connected condition;
- to provide medical nexus;
- to reconcile diagnoses;
- as directed by the Board of Veterans Appeals (BVA); and
- as required by regulation (Pamperin, 2006).[3]

In 2004, VA began fielding online examination templates for each of the Automated Medical Information Exchange worksheets in graphical user interface format. These "intelligent," point-and-click templates are designed to structure the information gathering and reporting process, thus increasing completeness, consistency, and timeliness of examination reports. As of April 2005, a version of each of the automated templates was installed in all examination sites.[4] The templates had been used 290,000 times as of the end of February 2007 and accounted for about 28 percent (21,125 of 75,000) of the C&P examinations performed by VHA that month. Of 102 sites using the templates, 59 completed more than 1,000 in January 2007. According to the director of the Compensation and Pension Examination Program (CPEP), VA is committed to mandating template use, and key stakeholder feedback and refinement activities are underway prior to taking that step.[5] If an examination report does not include sufficiently detailed information to support the diagnoses or about the effects of diagnosed conditions on functioning, the rating veterans service representative (RVSR) is instructed to return the report as inadequate for rating purposes.[6]

After all development actions are complete, the claim is referred to the RVSR for a rating. The RVSR reviews all the evidence associated with the claim, makes decisions on issues raised by the claimant, and identifies any inferred issues that should be addressed. The RVSR documents the rating decision in a standard format, using an automated rating preparation system called Rating Board Automation 2000. After completing the rating decision, the claims folder with the rating is referred to the postdetermination team (PDT) for processing of the decision. Prior to releasing the claims folder and the rating to the PDT, and if the veteran has retained a veteran service organization, one of their representatives will review the rating and initial the rating if they agree. The claims folder and rating then go to the PDT. If the PDT does not agree with the decision, the rating is sent back to the RVSR and both the VSO and RVSR will confer about the rating.

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[3] IOM, *21st Century*, 148.
[4] Ibid., 150.
[5] Ibid., 150.
[6] Ibid., 152.

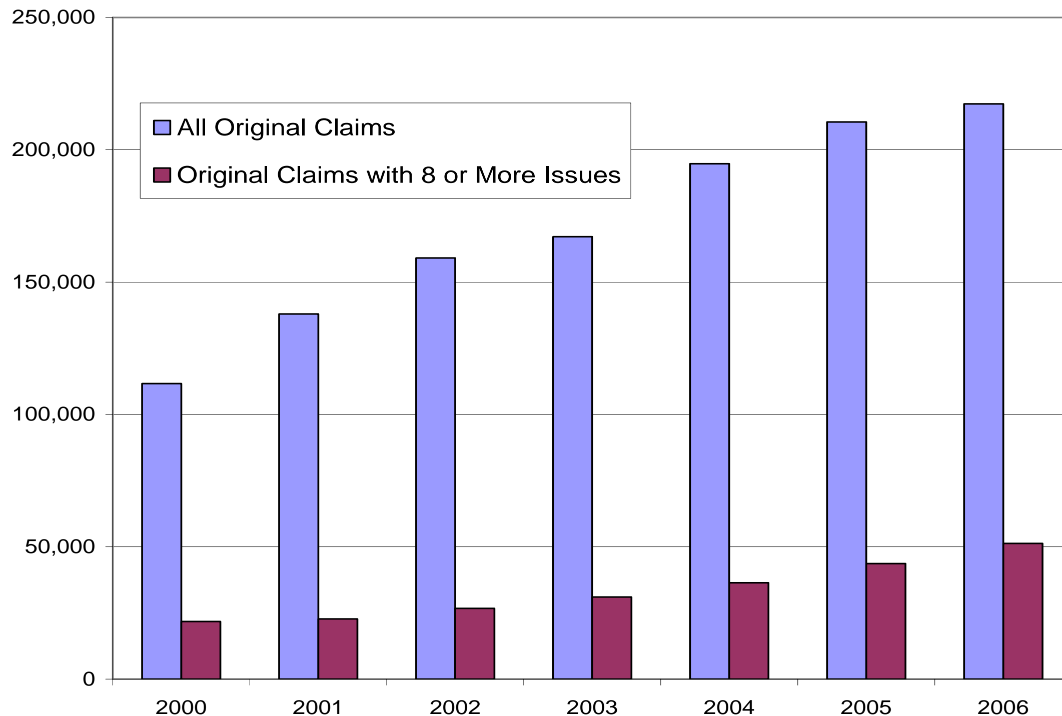
I.3 Volume of Claims

The number of disability claims pending and the time it takes VA to process those claims has been a growing concern among veterans, veterans' service organizations, VA, Congress, and stakeholders. The bar graphs below (Figures 9-2, 9-3, and 9-4) reflect information on original claims received, the number of rating-related claims filed and decided, and the number of claims pending and the number pending more than 6 months, respectively from FY 2000 through FY 2006.[7]

In FY 2006, VA received 806,000 disability-related claims. Most of these (654,000) were claims from veterans for compensation for service-connected injuries and diseases. (The other disability-related claims were for disability pension, dependency and indemnity compensation for survivors, hospitalization reviews, and future examination reviews.) Compared with the FY 2000 workload, this was a 38 percent increase in disability-related claims and a 56 percent increase in compensation claims (VA, 2006). In addition, the number of claims involving eight or more issues (i.e., medical conditions), each of which must be evaluated separately, has more than doubled, from about 21,000 (20 percent of the original claims) in 2000 to about 51,000 (22 percent of original claims) in 2006 (Figure 9.3). This means that the number of rating decisions that must be made was a multiple of the 654,000 disability compensation claims filed in FY 2006.

[7] Ibid., 170-172.

Figure 9.2 Number of Original Compensation Claims from Veterans and Number of Original Compensation Claims from Veterans Containing Eight or More Issues, End of FY 2000–2006

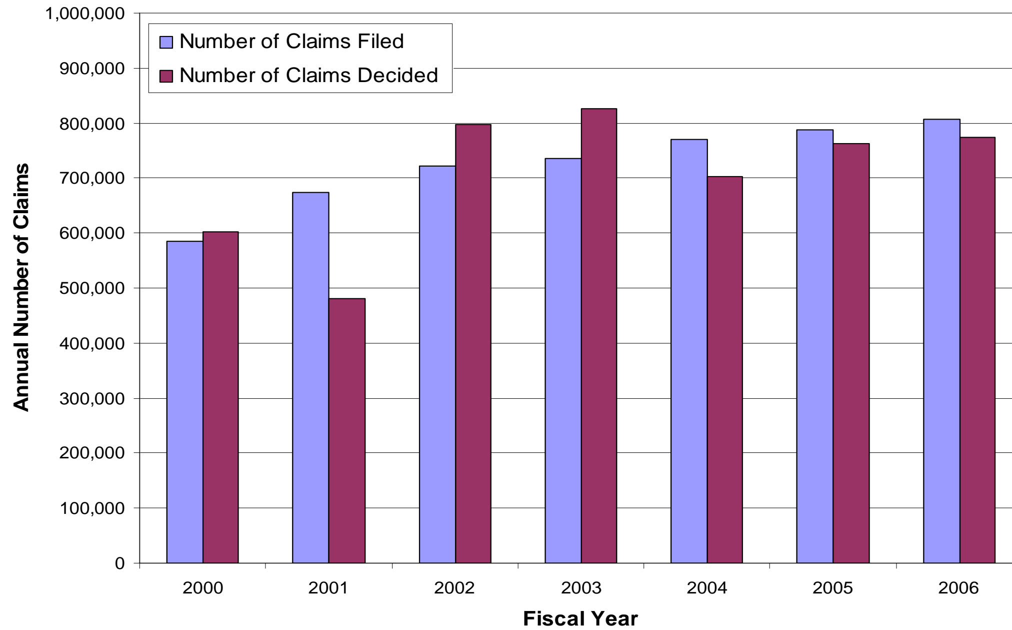


SOURCE: IOM, *21st Century,* 170.

VBA has been unable to track total number of issues adjudicated until recently with the advent of the current tracking system, RBA 2000. According to data provided to the committee by VBA, adjudicators made more than 1.8 million rating decisions on compensation for disabilities during calendar year 2006 while adjudicating 628,000 disability compensation claims, indicating that the average number of issues (disabilities) per claim was just under three.

As the annual number of ratings-related claims filed has increased, so have the number of decisions on rating-related claims (Figure 9.4).

Figure 9.3 Number of Rating-Related Claims Filed and Decided, FY 2000–FY 2006

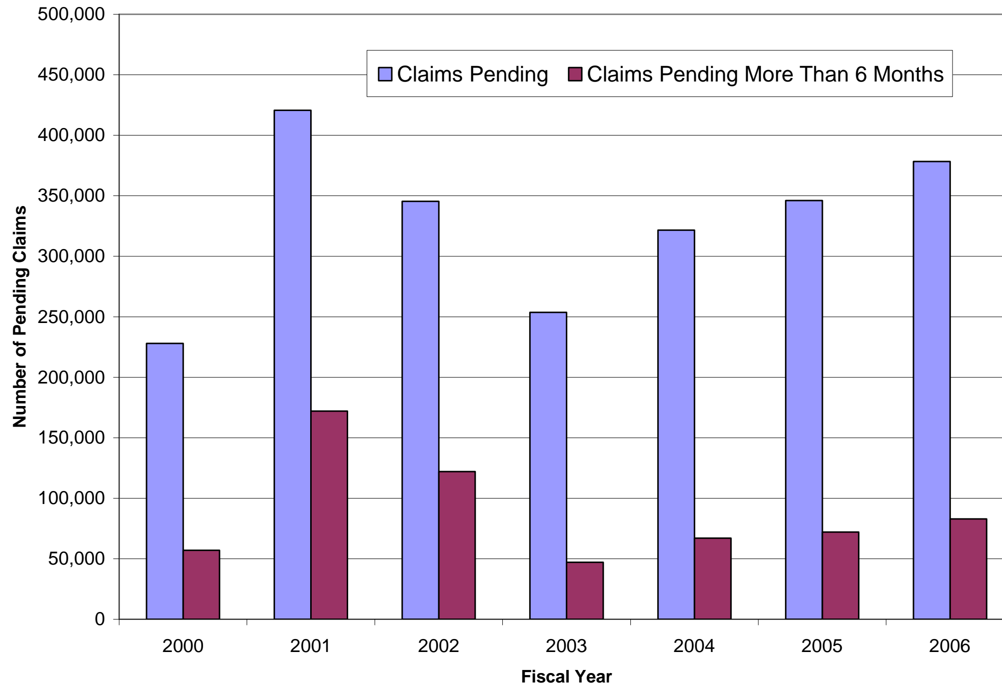


SOURCE: IOM, *21st Century,* 171.

However, new claim receipts continue to exceed case dispositions, resulting in an increasing backlog of pending claims. Nearly 380,000 rating-related claims were pending at the end of FY 2006, compared with 228,000 at the end of FY 2000 (Figure 9.5).[8]

[8] Ibid., 169.

Figure 9.4 Number of Rating-Related Claims Pending and Number Pending More Than Six Months, End of FY, 2000–2006



SOURCE: IOM, *21st Century,* 172.

I.4 Filing an Appeal

A veteran (or other applicant, such as a surviving spouse, child, or parent of a veteran) who disagrees with a VA regional office's decision can file an appeal either to the local regional office (for reconsideration of the original decision) or to the Board of Veterans Appeals (BVA). If the veteran chooses to appeal to the regional office, but is still dissatisfied with the decision, he or she may then appeal to a local decision review officer (DRO), stationed at the regional office. If the appeal is still not satisfactorily resolved, the veteran may appeal to BVA.

If still dissatisfied, the veteran has additional appeals (in sequential order) to:

- the U.S. Court of Appeals for Veterans Claims;
- the U.S. Court of Appeals for the Federal Circuit; and
- the U.S. Supreme Court.[9]

Although a veteran can appeal for any reason, issues frequently appealed include disability compensation, pension, education benefits, recovery of overpayments, and reimbursement for unauthorized medical services. The two most common appeals are made by veterans who feel that (1) the VA regional

[9] Ibid., 157.

office denied them benefits for an impairment (i.e., it was declared not to be service connected) that they believe began while they were in service, and (2) the severity rating assigned to the impairment was too low and an increase in the rating level is warranted.[10]

I.4.A Appeal Steps

To begin the appeal process, a veteran files a written notice of disagreement with the field office (regional office or medical center) from which the disputed decision was issued. For most compensation cases, the appeal must be filed within 1 year from the date of the decision. If more than one claim is at issue (e.g., a claim for compensation based on an orthopedic condition and a claim for compensation on a respiratory condition), the notice of disagreement must be specific about which issue or issues are being appealed. If a veteran is appealing to the regional local office (rather than BVA), he or she may choose to have the case handled in the traditional appellate review process (in which an RVSR handles the appeal) or to have the file reviewed by a decision review officer (DRO). DROs provide a second (*de novo* or a brand new decision, rather than reviewing the prior decision) review of an appellant's entire file, and they can hold a personal hearing about an appellant's claim. DROs are authorized to grant the contested benefits based on the same evidence in the claim folder that the local office used to make the initial decision. After completing any additional development or proceedings, the RVSR or DRO (as appropriate) sends the veteran either a favorable decision on all issues, or a statement of case explaining the reasons for the decision not to allow the appeal (this may include granting one or more of the appealed issues), along with VA Form 9, the substantive appeal form, which the veteran may use to ask for a BVA review of the decision. VA Form 9 must be filed within 60 days of the mailing of the statement of case, or within 1 year from the date VA mailed its decision, whichever is later. (The 60-day period for filing a substantive appeal can be extended for "good cause.")

On Form 9, the veteran states the desired benefit, notes perceived mistakes in the statement of case, and comments on anything with which he or she disagrees. If the veteran submits new evidence or information with the substantive appeal, such as records from recent medical treatments or evaluations, the VA local office prepares a supplemental statement of case, which is similar to the statement of case, but addresses the new information or evidence submitted.

The local VA office sends a letter to the veteran who files an appeal to BVA when the claims folder is transferred to BVA in Washington, DC. Generally, the

[10] Ibid., 157-158.

appellant has 90 days (from the date of the letter) or until BVA decides his or her case, whichever comes first, during which to submit more evidence, request a hearing, or select or change a representative.

At personal hearings, appellants meet with either a DRO at the regional office or a BVA member (at BVA hearings). Personal hearings are informal. Appellants in most areas of the country can choose to hold a BVA hearing. The most common BVA hearing is where the appellant is at the regional office and the member of BVA travels to the regional office. This is called a travel board hearing. The appellant can also go to Washington and have a hearing with the member of BVA at the BVA office in Washington, DC. Some regional offices are also equipped to hold BVA hearings by videoconference with the appellant at his or her regional office and the board member in Washington, DC, which is considered the most expedient choice.[11]

After the hearing, a BVA board member will review a transcript of the hearing and the appellant's file and make a decision either allowing or denying the case. Appeals may be dismissed in certain limited circumstances. However, if BVA cannot make a final decision, it may remand the case (i.e., send the claim back to the Appeals Management Center or regional office, depending on workload) for additional development and a new determination. If after completing the additional development, the local office is again unable to allow the claim, it returns the case to BVA for a final decision.[12]

I.4.B Board of Veterans' Appeals

BVA is a quasi-judicial, organizationally independent component of VA that reports directly to the VA Secretary and makes final agency decisions with respect to claims for veterans' benefits. BVA reviews all appeals for entitlement to veterans' benefits on behalf of the VA Secretary, including appeals involving claims for service connection, increased disability ratings, individual unemployability, pension, insurance benefits, educational benefits, home loan guaranties, vocational rehabilitation, and dependency and indemnity compensation, and also determinations of duty status, marital status, dependency status, and effective dates of benefits.

The law requires BVA to decide cases on a "first come, first served" basis. To do that a docket number in the order in which the substantive appeal is received. An appellant may file a motion to advance the case if he or she believes that his or her appeal should be decided sooner than the appeals of others.

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[11] Ibid., 159.
[12] Ibid., 159.

BVA decides cases *de novo* (that is, it makes a brand new decision, rather than reviewing the prior decision), so it gives no deference to the regional office decision being appealed. Decisions are based only on the law, VA's regulations, precedent decisions of the courts, and precedent opinions of VA's general counsel. BVA performs an analysis of credibility and probative value of evidence and considers all potentially applicable provisions of law and regulations. Final decisions must include:

- findings of fact;
- conclusions of law;
- analysis of the reasons and bases for the decision on each material issue of fact and law; and
- an order granting or denying the appeal.[13]

In the event that an appellant is dissatisfied with a final BVA appeals decision, he or she has several options:

- accept the decision and take no further action, in which case the decision becomes final;
- go back to the regional office and with new and material evidence, try to reopen the claim;
- file a motion for reconsideration or to vacate (i.e., an attempt to have the same body withdraw or modify its decision) with BVA;
- re-review the case because there was a clear and unmistakable error in the BVA decision; or
- file an appeal with the U.S. Court of Appeals for Veterans Claims.

I.4.C U.S. Court of Appeals for Veterans Claims

If BVA denies requested benefits, or it grants less than the maximum benefit available under the law, and the appellant decides to appeal to the U.S. Court of Appeals for Veterans Claims (CAVC), he or she must file the appeal within 120 days after BVA mailed its decision. Unlike BVA, CAVC does not receive new evidence. CAVC considers only:

- the BVA decision;
- briefs submitted by the appellant and VA;
- oral arguments, if any; and
- the case record (the entire claims folder) that VA considered and that BVA had available.

[13] Ibid., 159-160.

In cases decided on merit (cases not dismissed on procedural grounds), the court may (1) reverse the BVA decision (i.e., grant contested benefits); (2) affirm the BVA decision (i.e., deny contested benefits); or (3) remand the case back to BVA for rework.[14]

I.4.D U.S. Court of Appeals for the Federal Circuit and the U.S. Supreme Court

Under certain circumstances, an appellant or VA who disagrees with a decision of the Court of Appeals for Veterans Claims may appeal to the U.S. Court of Appeals for the Federal Circuit and then to the Supreme Court of the United States.

The court reviews the same record that was considered by BVA; that is, the court does not receive new evidence nor does it hold a trial. Appellants themselves or their lawyers or approved agents may serve as representatives before the court; however, the court directs whether oral argument is held. Either the appellant or VA may appeal a decision made by the U.S. Court of Appeals for Veterans Claims to the U.S. Court of Appeals for the Federal Circuit, and may seek further review in the Supreme Court of the United States.

The number of appeals pending and the time it takes VA to process those appeals has been a growing concern for decades among veterans, veterans service organizations, VA, Congress, and others associated with the appeals process. The bar graphs below (Figures 9-6 through 9-10) reflect information on appeals received, pending, and decided from FY 2000 through FY 2006.[15]

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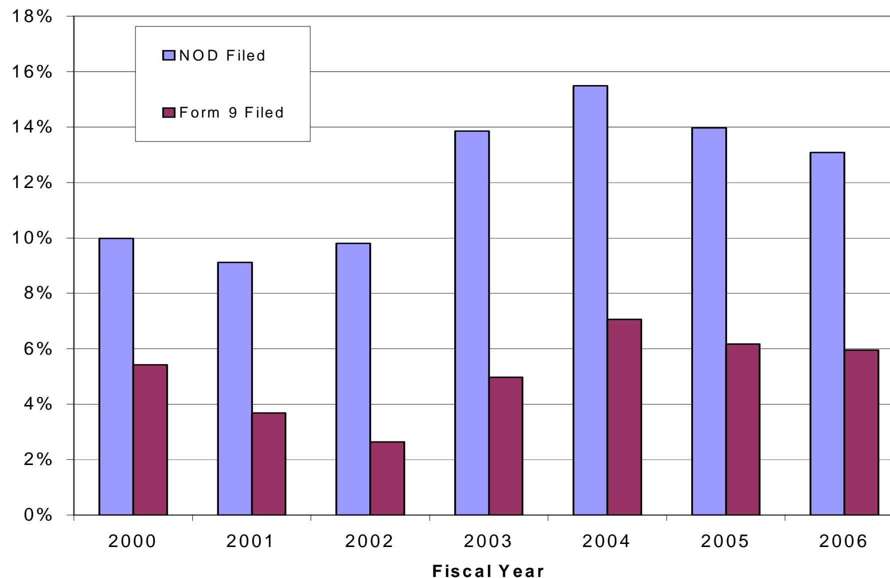
[14] Ibid., 164.
[15] Ibid., 143–148.

Figure 9.5 Rate of Appeals (Notices of Disagreement), FY 2000–FY 2006

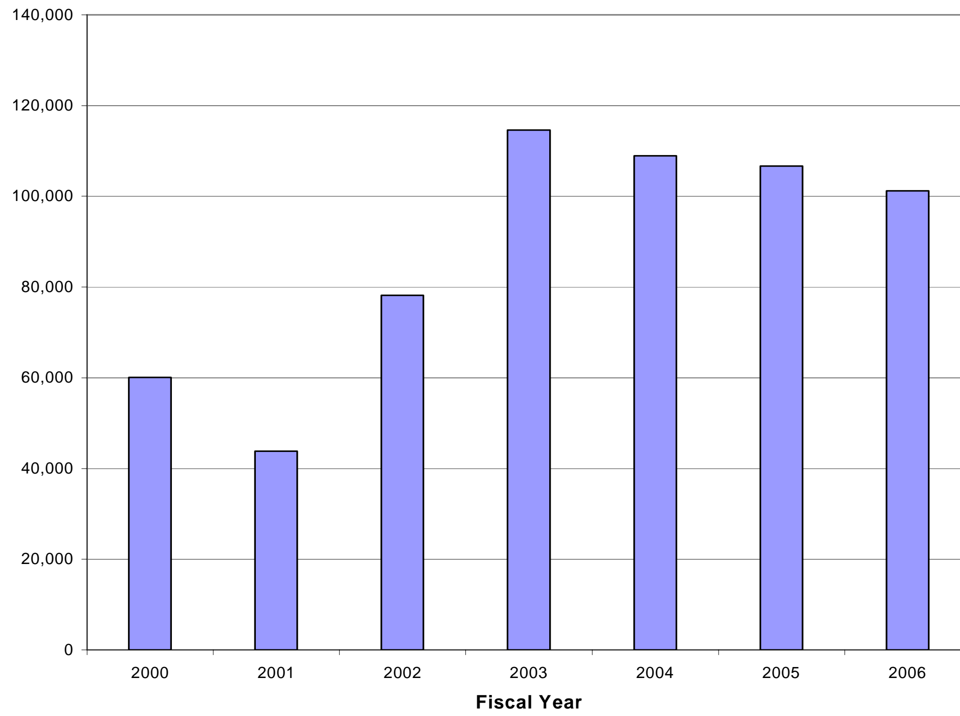


SOURCE: IOM, *21st Century,* 175.

Many notices of disagreement are resolved by the regional office or when the appellant does not pursue the appeal, but the number of formal appeals was still higher in FY 2006 than in FY 2000. Appellants filed 46,100 formal appeals in FY 2006 compared with 32,600 formal appeals in FY 2000. The annual number of BVA decisions, however, has not increased. As a result, the number of cases pending at BVA at the end of FY 2006—40,265—was almost double the number at the end of FY 2000. This does not include the substantial number of appeals being worked on by the appeals teams in regional offices and the Appeals Management Center, which had been established by the Veterans Benefits Administration (VBA) in 2003 to consolidate expertise in processing remands from BVA (Figure 9.8).[16]

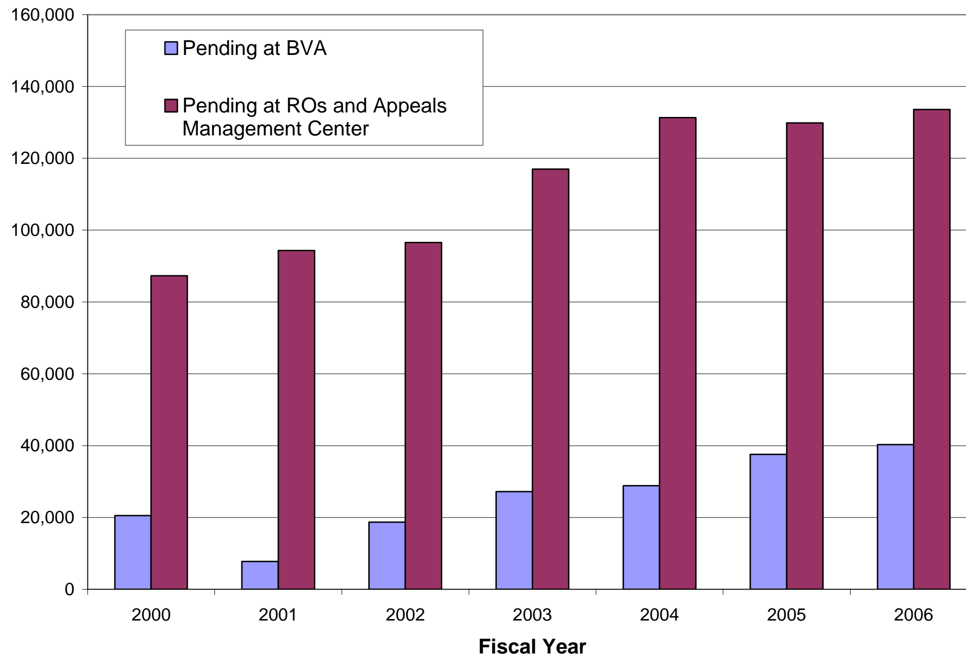
[16] Ibid.*,* 174.

Figure 9.6 Number of Appeals (Notices of Disagreement), FY 2000–FY 2006



SOURCE: IOM, *21st Century,* 175.

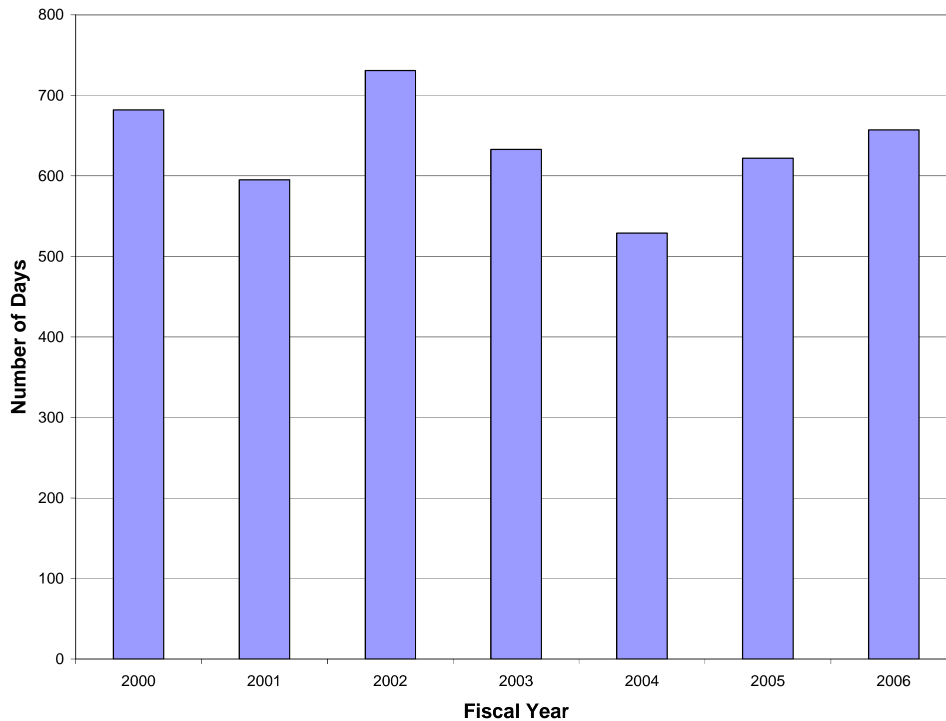
Figure 9.7 Number of Appeals Pending at BVA and at Regional Offices (ROs) and the Appeals Management Center, FY 2000–FY 2006



SOURCE: IOM, *21st Century,* 176.

The average number of days it took to resolve appeals, either by the Veterans Benefits Administration or the Board of Veteran Appeals, was 657 days in FY 2006. This continued a steady increase since FY 2003, but was better than the 731 days it took in FY 2002 (Figure 9.9).

Figure 9.8 Average Number of Days to Resolve Appeals (i.e., Appeals Resolution Time), FY 2000–FY 2006



SOURCE: IOM, *21st Century,* 177.

Note: Appeals resolution time is a joint BVA-VBA measure of time from receipt of notice of disagreement by VBA to final decision by VBA or BVA. Remands are not considered to be final decisions in this measure. Also not included are cases returned as a result of a remand by the U.S. Court of Appeals for Veterans Claims.

Most appeals (72 percent in FY 2006) are resolved without a hearing before BVA. In FY 2006, 22,000 cases were resolved at the field office level after the notice of disagreement was received but before a formal appeal was filed on VA Form 9. In 42,200 cases, the appellant decided not to appeal further after reading the field office's statement of the case. Another 11,000 were resolved at the field office level after Form 9 was submitted. That left 29,000 appeals, of which BVA resolved 25,000 and remanded 4,000 to the field offices for further development.[17]

BVA decided 39,100 cases specifically involving disability compensation in FY 2006. It upheld the field office denials 46 percent of the time, reversed the field office decision on one or more of the issues 20 percent of the time, and

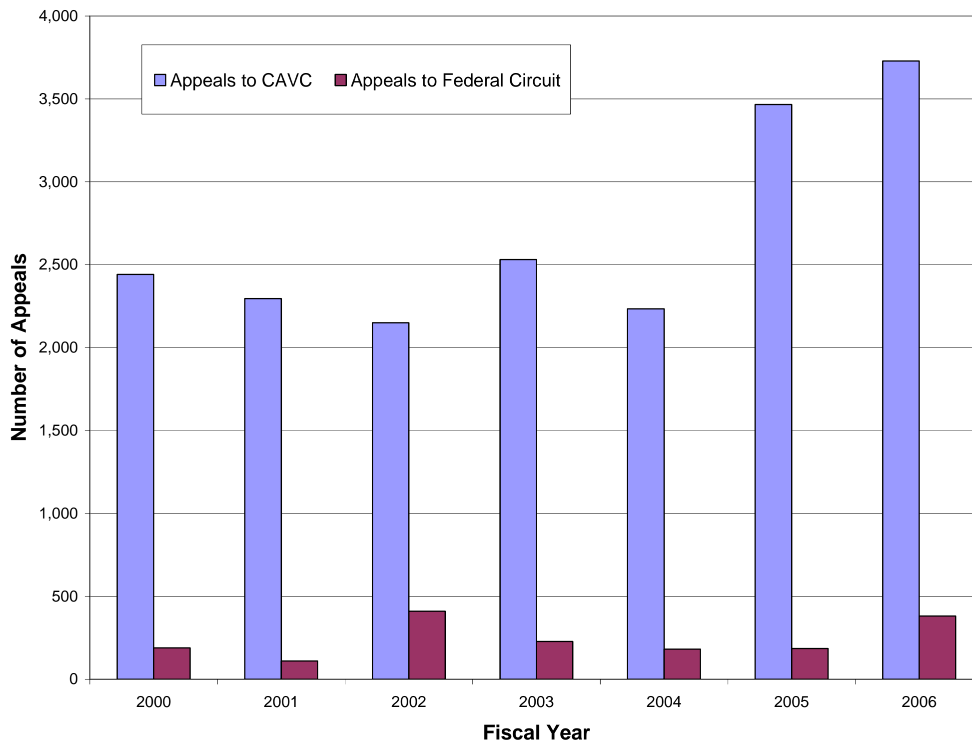
[17] Ibid.*,* 174.

remanded the case to the originating field office 32 percent of the time for further development of one or more issues.[18]

The number of appeals to the U.S. Court of Appeals for Veterans Claims averaged between 2,000 and 2,500 a year before FY 2005, when it jumped to 3,500 (Figure 9.10). The Court of Appeals for Veterans Claims received 3,700 appeals in FY 2006. This court affirmed the BVA decision in full or in part in 11 percent of the cases in FY 2004, 16 percent in FY 2005, and 25 percent in FY 2006. During the same 3 years, the same court reversed the BVA decision or remanded the case for further development 50–60 percent of the time.[19]

There were 382 appeals to the Federal Circuit Court in FY 2006, the highest since FY 2002, when 410 appeals were filed (Figure 9.10).

Figure 9.9 Annual Number of Appeals of BVA Disability Decisions to the Courts, FY 2000–FY 2006



SOURCE: IOM, *21st Century,* 178.

[18] Ibid., 174-176.
[19] Another 25–35 percent were dismissed on procedural grounds.

I.4.E Remands and Timeliness

Remands are of concern because not only do they increase the time it takes for a decision on the individual veteran's claim by at least a year, they also increase the overall workload and slow the resolution of appeals of other appellants. By law, BVA must decide on appeals in the order in which they were entered on the docket. If BVA remands a case to the regional office, and that case is subsequently returned to BVA for a decision, which happens about 75 percent of the time, the returned case takes precedence over appeals currently before BVA. During FY 2006, BVA remanded 32 percent (12,500) of the cases it decided. At the end of FY 2006, 16 percent (21,200 of 133,600) of the rating-related claims pending at regional offices and the Veterans Benefits Administration's Appeals Management Center were remands. If, as expected, 75 percent of the remands are returned to BVA after further development, they will constitute 30–40 percent of the 35,000–40,000 cases decided by BVA each year (in FY 2006, for example, BVA received 14,400 remands returned by the Appeals Management Center and regional offices for decision, equal to 37 percent of BVA decisions that year (Figure 9.11).[20]

The percentage of BVA dispositions remanded jumped from 30 percent in FY 2000 to 49 percent in FY 2001. In 2002, in response to a recommendation of the 2001 Claims Processing Task Force, BVA established an evidence development unit to develop evidence needed to make a final decision or correct a procedural error in cases that otherwise would have to be remanded. The remand rate fell to about 15 percent "within a matter of months".[21]

When evidence development by BVA was barred by the U.S. Court of Appeals for Veterans Claims, the Veterans Benefits Administration created the Appeals Management Center in July 2003 to specialize in developing the cases that have been remanded by BVA and reviewing the regional office.[22]

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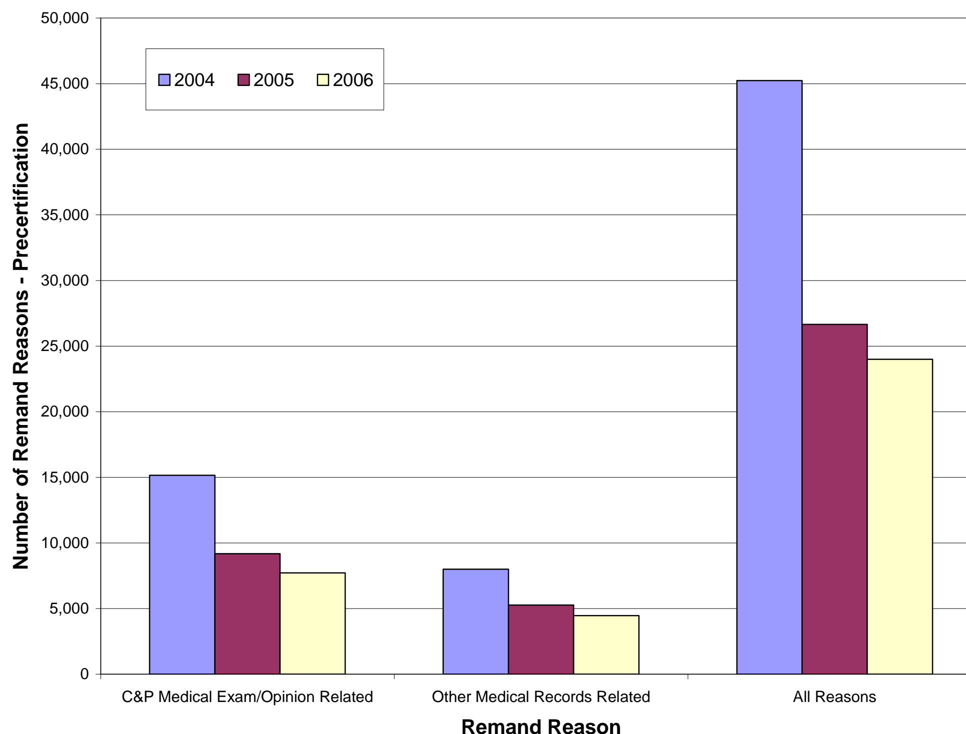
[20] IOM, *21st Century,* 177-178.
[21] Ibid., 178.
[22] Ibid., 178-179.

Figure 9.10 Number of Remands by Reason, FY 2004–FY 2006



SOURCE: IOM, *21st Century,* 180.

Note: Other medical records include military service, VA, and private medical records that should have been requested but were not, or if requested but not forthcoming, were not followed up. Nonmedical reasons for remands have to do with duty to notify (lack of, incorrect, or inadequate notices to appellants), duty to assist (not obtaining nonmedical service and other records), and due process (not following procedural rules).

I.5 Reports that Have Evaluated the Claims and Appeal Process

I.5.A Report of the President's Commission on Veterans Pensions (Bradley Commission)

The 1956 Bradley Commission noted that "(t)imely and adequate assistance must be provided to alleviate the war-incurred handicaps of servicemen as soon as possible after separation.[23] Furthermore, "(t)he timely assistance that was provided to World War II and Korean conflict veterans was a major step toward the solution of the veterans' problem—a problem that faced this country after each preceding conflict but remained unsolved until World War II."[24]

[23] President's Commission, *Report*, 11.
[24] Ibid., 29.

I.5.B Report of the Veterans' Claims Adjudication Commission (VCAC)

The Veterans' Claims Adjudication Commission (VCAC) noted that the VA claims and appeals system is "perceived as inefficient, untimely, inaccurate, and so on."[25] The commission looked to Congress to "decide whether the existing benefits, concomitant processing system, and the level of performance, is proximate to what it wants and intends."[26] The commission analyzed pending and completed original and reopened disability compensation claims and pending appeals.

One of the noteworthy findings was the length of time it took VA to develop a claim. Based on a random sample of claims from six regional offices, for original claims it took, on average, 23 days from date of receipt until the regional office's first request for development information. The regional offices' elapsed time for development was 107 days, on average. The average time from completion of development to regional office decision was 80 days. For repeat claims, it took regional offices, on average, 48 days from date of receipt until the first request for development information. Elapsed development time was 73 days. The average time from completion of development to regional office decision was 95 days.[27]

VCAC found that regarding timeliness of a request for evidence, most veterans responded to requests for information timely or not at all. Veterans did not respond 35.1 percent of the time (13 cases). In 75 percent (15 of 20) of the remaining cases, the veteran responded in 30 days or less.

Third-party requests, such as private physician reports and VA medical records, were also received on time, with 73.7 percent (14 of 19) received in 30 days or less. The commission found in receiving comments from veterans that "[t]he claims application process is very complex and frustrating to veterans. The application form is in need of serious revision both for ease of use by veterans and by adjudication division employees. Veterans need more information about what evidence is required to support a claim and how to get it. They also need better information about the steps in the claims process, how long an average claim should take, and how long their claim will take if different from the average."[28] As with many reports on claims processing, the commission encouraged strong VA–veteran service organization partnerships. They noted case management to be "a promising claims-processing technique.

[25] VCAC, *Report*, 26.
[26] Ibid., 26-27.
[27] Ibid., 65.
[28] Ibid., 127.

VCAC said "A fully documented claim presented to VA can be readily decided. Some regional offices have agreements with veterans service organizations under which a well-documented claim presented to the regional office will be adjudicated immediately. These agreements demonstrate the mutual benefits of building partnership between claimants, representatives, and VA."[29]

The VCAC held a focus group meeting of VA employees. "Employees said veterans do not know what happens to their claims because VA does not explain the application process well. One employee said he did not understand the process, so how could a veteran?"[30] VA employees reported that veterans who were assisted in filing a claim or appeal by either a VA benefits counselor or a veterans service representative filed better, well-documented, claims. They acknowledged the value of service representatives.

VCAC's major findings and recommendations for the claims and appeals process were:[31]

- it involves too many handoffs at the initial adjudication level;
- it lacks clear and definitive rules that can be fairly and efficiently applied to the processing of the vast majority of cases;
- it fails to provide meaningful due process to claimants by not making them partners in the adjudicative process;
- it imposes time-consuming and labor-intensive redundancies, such as, the notice of disagreement and statement of the case prior to the filing of a formal appeal;
- it blurs accountability due to ill-defined jurisdictional lines and failure to use the results of actual adjudications for quality control and employee rating purposes; and
- it generally fails to treat the claims and appeals process as a continuum that should narrow and sharpen issues as a claim proceeds through the process, rather than expanding and obfuscating them.

VCAC also recommended "replacing the notice of disagreement with a formal appeal and eliminating the statement of the case; shortening the appeal period to 60 days; expanding the role of the hearing officers to make it the mandatory first step in the appeal process."[32]

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[29] Ibid., 204.
[30] Ibid., 137.
[31] Ibid., 181.
[32] Ibid., 185.

Filing an appeal on a VA decision is not difficult and the process is well documented. What is not easy or well understood is why it takes so long to resolve that appeal. The delay in processing appeals is well known to all associated with the appeals process. At the regional office level, the appeals process is very tedious and utilizes many resources that could be processing claims. VCAC discussed appeals processing in great detail. A notice of disagreement with a regional office decision initiates the appeals process. A statement of the case is usually issued by the regional office, and the veteran is requested to file a substantive appeal if he or she is not in agreement with the original decision. The veteran is asked if he or she would like to have a decision review officer (DRO) review the case and is also given the opportunity to have a hearing with the DRO. The DRO will issue a decision, and if the decision is unfavorable, the veteran can continue the appeals process and the case will ultimately be sent to the Board of Veterans Appeals (BVA).

I.5.C Report of the VA Claims Processing Task Force

This 2001 Task Force recommended ways to improve the timeliness of claims and appeals processing. One of their recommendations was to "Revise the operating procedures in *Veterans Benefits Administration Manual* (M21-1): Evidence requested from a claimant, private physician, or private hospital must be received within 30 days."[33] Regional offices allow claimants 60 days from the date of request to submit requested evidence.

Reducing the time limit to submit evidence from 60 to 30 days will significantly assist the Veterans Benefits Administration in meeting their processing goal of 100 days. Under VA regulations, a claimant has 1 year from the date of request of the information in which to submit that evidence. Therefore, the date of entitlement is still protected by the "1-year rule" so veterans will not be harmed by this recommended change.[34]

For appeals, the Task Force recommended changing processes to "Require that BVA process the current workload of appeals, including development of appeals, rather than issuing remands. The Veterans Benefits Administration should return BVA remands for priority processing. Priority should be given to working the approximately 1,800 cases that were remanded prior to FY 1998."[35]

Acceptance of new evidence should occur only at the BVA level. Cases should not be remanded because of new evidence subsequent to the date the appeal was sent to BVA. An organizational realignment is required by the Veterans

[33] VA Claims Processing Task Force. *Report*. Washington, DC: VA, 2001, 32.
[34].Ibid., 33.
[35] Ibid. , 34.

Benefits Administration to support the BVA remand and decision process. The Veterans Benefits Administration should place an appeal decision-processing unit within BVA to support the appeals process and to reduce, if not eliminate, remands. Establish a method of accountability for BVA in developing cases for decision rather than returning the appeals to the regional offices. Continue to track errors that result in remands for cause and report on the type and rate of errors to the originating office for quality and retraining purposes. Transfer responsibility for processing Veterans Health Administration (VHA) appeals and remands in an expeditious manner to VHA.

Training was recommended for regional office claims development staff in records retrieval. The training should focus on identifying key veteran service information to aid the searcher, and the availability of certain service information in VA systems. The training must strongly emphasize the need to address all issues in the initial request to the National Personnel Record Center.[36]

I.5.D Report by the Institute of Medicine

Veterans deserve a claims process that is efficient and fair. They should not have to wait long for decisions on disability compensation and other benefits. The decisions should accurately determine eligibility to minimize the number of false negatives (veterans incorrectly denied benefits) and false positives (veterans granted benefits for which they are not eligible). Veterans with similar levels of disability should be treated the same even if they are dealing with different regional offices. And if they appeal, they should receive an accurate decision within a reasonable amount of time.[37]

The VA claims process has long struggled with timeliness, accuracy, and consistency. The importance of adequate medical examinations in achieving timeliness, accuracy, and consistency has been recognized since the early 1990s. But, the most important factor affecting VA's ability to produce timely, accurate, and consistent decisions is the disability claim workload.[38]

I.5.E Report by The CNA Corporation

The CNA Corporation (CNAC) was tasked with comparing the VA Disability Compensation Program with other federal disability programs and to explore lessons learned from other disability programs. The analysts interviewed VA staff and reviewed reports from the Government Accountability Office (GAO), VA Office of the Inspector General, Commission site visit summaries, and congressional testimony. CNAC reported processing claims for disability compensation took an average of 177 days in FY 2006. Accuracy and consistency were reviewed and reported as 86 percent of decisions reviewed. It

[36] Ibid., 47.
[37] IOM, *21st Century*, 166.
[38] Ibid., 166.

was noted that decision making was accomplished at 57 regional offices all across the country. One of the findings from the raters and veterans service organization survey was that it was often time consuming to receive evidence, thus contributing to the delay in providing timely decisions to veterans. CNAC reported VA compared favorably with other federal programs except in the area of timeliness. They also noted training and turnover are key to the success of any claims program.

I.6 Perspectives on Claims and Appeals from Commission's Site Visits

During site visits, the Commission heard from Veterans Service Center employees. Employees provided the Commission teams with a perspective on their operational challenges to include the difficulty in creating Veterans Claims Assistance Act (VCAA) letters, demands for productivity, the need for training, high turnover rates and the time it takes to train new raters, communication with veterans service organizations and examiners, frivolous claims, and the development of claims with multiple conditions or issues. VA raters said that templates should be made mandatory at all VA locations where compensation and pension examinations are conducted. All site visits included town hall meetings, which afforded the Commissioners a chance to meet and hear from veterans about some of the issues that were important to them. One of the most common complaints was the difficulty in filing and understanding claims and appeals. Veterans found the process too complex and frustrating.

One program from the site visits that merits consideration as a best practice is the Washington Department of Veterans Affairs (WDVA) Claims Quality Assurance (QA) initiative. WDVA demonstrated an innovative, performance-based system developed to measure and improve the quality of claims submitted to VA by veteran service officers in the state.

In 2005, WDVA filed 9,933 claims for benefits on behalf of veterans in the state of Washington. (The majority of the claims work performed by the WDVA is accomplished through contracts with the major veteran service organizations.) Just prior to initiating the Claims QA program, WDVA conducted a random sampling of these claims using the new system's performance measures and scoring. The claims in the preprogram sample scored a 48 percent "batting average" in quality of claims submitted. One year after the introduction of the Claims QA process, another random sample was taken and scored. The new system demonstrated a significant improvement in quality of claims submitted with a measured score of 79 percent.

The tangible results of this QA program are greater veteran satisfaction and generally higher ratings. Other benefits noted: veterans are assisted in a more professional, timely manner. Unsubstantiated claims are weeded out early in the process. VA receives substantially completed claims. VA ratings are generally issued in less than 100 days, thus helping the Veterans Benefits Administration (VBA) meet its timeliness goals. Fewer appeals are required. Training needs are identified and addressed, resulting in better trained service officers. The ability to track and demonstrate service officers' proficiency enhances partnerships with veterans and VA. Because the system tracks the tax-free VA compensation payments flowing into the state economy, the information has helped to justify additional state funding of veteran programs. WDVA also believes the program enhances Washington's national reputation for care of veterans and their families.

I.6.A Findings

I.6.A.a Claims Process

The claims process is extremely complex and often not understood by veterans, some of the veterans service representatives, and by many VA employees. Many studies have been completed on timeliness of claims processing, included the ones noted in this report, yet, the delays continue and the frustrations mount for all involved in the process of filing and adjudicating claims and appeals. Most claims filed with the VA are not well documented. Well-documented claims will improve the timeliness of the claims process by reducing the need for development. VA should educate veterans, veterans service representatives, and VA employees about the necessity of filing well-documented claims. In addition, reducing the period of time VA will wait for a response from veterans and medical facilities from 60 days to 30 days will allow VA to improve the timeliness of the claims process because it allows VA to make a decision after the 30-day wait period has expired or would allow VA to follow up after 30 days, rather than 60 days, on a request for evidence or information, all depending on the evidence needed to process the claim. An extension could be granted upon request.

Another benefit for veterans would be to change the commencement date for the period of payment to the effective date of the award. Presently, payment of benefits may not be made for any period prior to the first day of the calendar month following the month in which the award became effective (38 U.S.C. § 5111 [2006]). For example, in a case where the veteran is retired on July 31, 2007, the effective date of the award, by rating, is August 1, 2007. Present law prohibits payment from the effective date and requires VA to make the award from September 1, 2007, and the first payment will not be received until October 1, 2007. A panel of newly discharged veterans reported to the

Commission that it was often difficult to make ends meet because of the delay in the initial payment of VA compensation benefits.

I.6.A.b Appeals Process

The Social Security Administration (SSA) discusses appeal periods in SSA Publication No. 05-10041: "If you wish to appeal, you must make your request in writing within 60 days from the date you receive our letter. We assume you receive the letter five days after the date on the letter, unless you can show us you received it later."[39] Under SSA procedures, if a person appeals a decision, the appeal goes forward to a higher level and the original decision maker does not see the case again.

Appeals processes and procedures have become more time consuming than the initial claims decision process. Improvements to the present appeals process will result in more timely decisions for veterans. One of the key points to make on appeals cases is the need to make a quick decision based upon the evidence of record. The longer appeal cases are pending, the greater the likelihood that new evidence or new claims will be introduced, further complicating and delaying the appeals process.

Recommendation 9.1

Improve claims cycle time by

- **establishing a simplified and expedited process for well-documented claims, using best business practices and maximum feasible use of information technology; and**
- **implementing an expedited process by which the claimant can state that the claim information is complete, and waive the time period (60 days) allowed for further development.**

Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.

Recommendation 9.2

Change the commencement date for the period of payment to the effective date of the award.

Recommendation 9.3

[39] SSA, *Publication No. 05-10041ICN.*

Reduce the appellate workload by focusing on improved accuracy in the initial decision-making process, enhance the appeals process by ensuring adequate resources to dispose of existing workload on a timely basis, and deploy technology for transferring electronic records between field offices and the Board of Veterans Appeals.

II Duty to Assist

II.1 Issue

After the *Morton* decision in 1999, Congress reaffirmed the long-standing principle that the Secretary of Veterans Affairs has an obligation to assist veterans in filing and prosecuting their claims (*Morton v. West*, 12 Vet. App. 477 [1999], *opinion withdrawn,* 14 Vet. App. 174 [2000]). VA has a statutory duty to inform the veteran about what is necessary to substantiate his or her claim and to assist the veteran in obtaining the necessary substantiating evidence for the claim.

The Commission investigated whether the current duty to assist laws are appropriate or if veterans, their legal representatives, or both should be responsible for developing supporting evidence from private sources for their own claims. The Commission also studied how VA's duty to assist affects departmental resources, claims backlog, and remand rates, as well as whether VA should clarify what is meant by "sufficient evidence."

In 38 U.S.C. § 5103A [a][1] [2006] the Secretary of Veterans Affairs is required to make reasonable efforts to assist a claimant in obtaining evidence necessary to substantiate a claim for a benefit under a law administered by the Secretary." However, the Secretary "is not required to provide assistance to a claimant under this section if no reasonable possibility exists that such assistance would aid in substantiating the claim" (38 U.S.C. § 5103A [a][2] [2006]). The Secretary can "defer providing assistance…pending the submission, by the claimant, of essential information missing from the claimant's application" (38 U.S.C. § 5103A [a][3] [2006]).

In regards to the Secretary assisting a veteran in obtaining records, the Secretary "shall make reasonable efforts to obtain relevant records (including private records) that the claimant adequately identifies to the Secretary and authorizes the Secretary to obtain" (38 U.S.C. § 5103A [b][1] [2006]). If the Secretary has difficulties in obtaining relevant records, the Secretary "shall notify the claimant that the Secretary is unable to obtain records with respect to the claim" (38

U.S.C. § 5103A [b][2] [2006]). The Secretary currently has the responsibility to aid in obtaining records for compensation claims including "the claimant's service medical records… [and] other relevant records pertaining to the claimant's active military…service" (38 U.S.C. § 5103A [c][1] [2006]).

In their 1956 report to the President, the Bradley Commission did not discuss the duty to assist, focusing on the disability ratings system and the philosophy involved in compensation for service-connected disabilities related to military service.

VCAC recommended that "Congress needs to attend to the concept of "duty to assist," either by providing specific definitions or codifying the court's rulings.[40] In discussing 38 U.S.C. §§ 5106, 5107(a), VCAC said,

> Although the first sentence [of section 5107(a)] has been interpreted as imposing an almost open-ended duty to assist on the Secretary to develop evidence for the claimant pertinent to the claim, the statute does not say this at all. It says that the Secretary shall assist the claimant in developing the facts pertinent to the claim. Presumably, if Congress had meant "evidence," it would have said "evidence." Logically and legally, evidence and facts are two different things. The facts pertinent to the claim are the issues to be evaluated in the context of the criteria for entitlement; evidence is the material necessary to establish those facts as true. The only specific statutory exception applies to pertinent information (evidence) in the possession of a Federal Department or agency. Thus, a literal reading of the statute requires the Secretary to assist the claimant in identifying the facts that must be established, but the burden of submitting evidence to establish those facts remains with the claimant.[41]

VCAC also emphasized the importance of a VA and veterans service organization (VSO) partnership by stating that "VA's claims-processing system does not make effective, systematic use of the accumulated knowledge and communication base embodied by VSO representatives. "VCAC suggested that VA regulations concerning VSO representation should be restudied and modified to set out specific roles, responsibilities, and limitations of the representative so that VSO support of the claims process may be maximized as the proposed partnership is formulated. They explained that a fully documented claim presented to VA can be readily decided. In fact, they noted that some regional

[40] VCAC, *Report*, 6.
[41] Ibid., 190.

offices have agreements with VSOs under which a well-documented claim presented to the regional office will be adjudicated immediately. For VCAC, such agreements demonstrated the mutual benefits of building partnerships between claimants, representatives, and VA.

The Veterans' Claims Adjudication Commission (VCAC) believed that well-informed claimants and their representatives, acting in partnership with VA, are in an excellent position to know whether duty to assist and, indeed, all due process requirements have been followed in adjudicating their claims. By making these judgments a routine part of the claims process, VCAC believed that procedural issues associated with adversarial paternalism could be minimized."[42]

A July 1999 decision made by the U.S. Court of Appeals for Veterans Claims (CAVC) caused a dramatic transformation in the way VA could assist veterans and dependents develop claims (*Morton v. West*, 12 Vet. App. 477 [2006], *opinion withdrawn,* 14 Vet. App.174 [2006]). This change made the claims process much more legalistic and severely restricted VA's discretion in effectuating development of claims. This change also led to an onslaught of challenges to the court's interpretation of the scope and timing of the VA's "duty to assist" and "well-grounded" claim requirement by VSOs and other veterans' advocates.

After the *Morton* ruling, the VA could not assist the claimant or order medical or psychiatric examinations until the claim was "well-grounded," meaning supported by evidence sufficient to convince a fair and impartial individual that a claim is plausible, or, in the CAVC's parlance, "meritorious on its own or capable of substantiation." The court opined that 38 U.S.C. 5107(a) reflects a statutory policy that implausible claims should not consume the limited resources of VA. *Morton* was extremely significant because it demonstrated (and ultimately transformed) the inextricably intertwined nature of the two doctrines: the veteran's duty to submit a well-grounded claim and VA's duty to assist.

In November 2000, Congress enacted the Veterans Claims Assistance Act of 2000 (VCAA) (Pub. L. No. 106-475, 114 Stat. 2096). The law, commonly referred to as the "duty to assist law" legislatively overturned the ruling in the *Morton* decision. This act would "reaffirm and clarify the duty for the Secretary of Veterans Affairs to assist claimants for benefits under laws administered by the Secretary, and for other purposes. Further, the new statute amended 38 U.S.C. §§ 5102, 5103 and added the new sections 5100 and 5103A, expanding VA's duty to assist claimants in several respects. Specifically, 38 U.S.C. § 5103A (a) imposes on VA a duty to assist a claimant by making reasonable efforts to assist

[42] Ibid., 204.

him or her in obtaining evidence necessary to substantiate a claim for benefits. Other provisions outline the details of providing such assistance in obtaining information, evidence, and records from government and private sources; of informing the claimant if VA is unable to obtain pertinent evidence; and of providing a medical examination or medical opinion when necessary to resolve the claim. Congress specified in detail the various ways in which the Secretary is to perform his duty to assist regarding provision of diagnostic medical evaluations. Section 5103A (d), which is captioned "Medical Examinations for Compensation Claims," states:

(1) In the case of a claim for disability compensation, the assistance provided by the Secretary under subsection (a) shall include providing a medical examination or obtaining a medical opinion when such an examination or opinion is necessary to make a decision on the claim.

(2) The Secretary shall treat an examination or opinion as being necessary to make a decision on a claim for purposes of paragraph (1) if the evidence of record before the Secretary, taking into consideration all information and lay or medical evidence (including statements of the claimant)

(A) contains competent evidence that the claimant has a current disability, or persistent or recurrent symptoms of disability; and

(B) indicates that the disability or symptoms may be associated with the claimant's active military, naval, or air service; but

(C) does not contain sufficient medical evidence for the Secretary to make a decision on the claim.

In July 2000, the Congressional Budget Office estimated the costs of proposed legislation (H.R. 4864, which later became the Veterans Claims Assistance Act) at $4 million in 2001 and $7 million to $8 million annually thereafter.[43]

In their 2002 report, GAO found that the Veteran Benefits Administration (VBA) regional offices were not consistent in how they were complying with the VCAA.[44]

GAO noted that the VCAA requires VBA to take four steps when assisting a veteran. VBA must:

1. notify claimants of the information necessary to complete the application,
2. indicate what information not previously provided is needed to prove the claim…,

[43] Congressional Budget Office, *Cost Estimate of H.R. 4864*.
[44] GAO, *VBA's Efforts*, 2.

> 3. make reasonable efforts to assist claimants in obtaining evidence to substantiate claimants' eligibility for benefits…, and
>
> 4. inform claimants when relevant records are unable to be obtained.[45]

GAO found that although VBA had given guidance to the regional offices on how to apply the VCAA, results of accuracy reviews completed in VBA's central office showed that regional offices lacked consistency in compliance with the law.[46] GAO concluded that VBA had provided guidance to its regional offices on how to implement the VCAA. However, despite the efforts of the VBA central office, results from VBA's accuracy reviews indicate a decrease in rating accuracy due to noncompliance with VCAA requirements.[47] GAO recommended that if VBA continued to experience significant problems with implementing the VCAA, the Secretary of Veterans Affairs should direct the Under Secretary for Benefits to identify the causes of the VCAA-related errors so that more specific corrective actions may be taken.[48] VA concurred with the GAO recommendation.

Although the Veterans' Claims Assistance Act (VCAA) has aided the veteran during the claims process, it has substantially added to the workload of VBA. After the passage of the law, "claims must now be developed and evaluated under the expanded procedures required by the VCAA."[49] Additionally, VBA reported that it has had more case files to review as a result of the VCAA. In FY 2001, "VBA received about 95,000 more claims and produced about 120,000 fewer claims decisions" than in the prior year. In FY 2001, 674,219 claims were received compared to 578,773 from the prior year, and 481,117 claims were completed in FY 2001 compared to 601,451 from FY 2000.[50] VBA decided to undertake a review of cases that had been dismissed because they were not well grounded per the *Morton* decision's interpretation of the statutes. However, VBA claimed that this larger case load could also be attributed to other factors, such as the "addition of diabetes as a presumptive service-connected disability for veterans who served in Vietnam."[51] In addition to increased workload, there were also increased costs associated with the VCAA as estimated by the Congressional Budget Office. VBA needs to continue to make progress in reducing delays in obtaining evidence, ensuring that it will have enough well-trained staff in the long term, and implementing information systems to help improve claims-processing productivity.[52]

[45] Ibid., 4.
[46] Ibid., 2.
[47] Ibid., 16.
[48] Ibid., 16.
[49] Ibid., 11.
[50] Ibid., 10.
[51] Ibid., 11.
[52] Ibid., 14.

In his July 2005 presentation to this Commission, the Under Secretary for Benefits for the Department of Veterans Affairs, discussed the Veterans Claims Assistance Act, stating

> one of its central provisions clarified and enhanced VA's "duty to assist" veterans with their disability claims. In my opinion, this was a proper and well-conceived law that addressed a deficient process under which VA had been adjudicating claims. It made our adjudicators absolutely responsible for helping each individual veteran know what to do, what is needed to substantiate his or her claim, how to respond, and what we will do to assist him or her. It is also an example of a law which…. has been inordinately difficult to properly execute.[53]

The Under Secretary further stated that

> as a result of VCAA, and the accelerating influx of claims, Secretary Principi convened the Claims Processing Task Force in May 2001. His charge was to "recommend specific actions that the Secretary (of Veterans Affairs) could initiate, within his own authority, without legislative or judicial relief, to reduce the current veterans' claims backlog while processing claims more rapidly."[54] The objective of our Task Force (whose chairman later became the Under Secretary) recommendations in October 2001 was to improve the efficiency and effectiveness of VBA claims processing.[55]

In speaking about the workload for disability claims, the Under Secretary stated

> the number of disability claims received each year has likewise dramatically increased (578,000 in 2000; 771,000 in 2004; about 800,000 projected by the end of FY 2005). A further very real and complicating factor in our process is the number of disabilities (referred to as "issues") veterans are now presenting in each claim. About a decade or so ago, we had 2.5 issues per claim. Today we are seeing higher numbers of "issues"—in many cases, over 10 issues per claim. Across the country, we have seen as many as 40 to 50 issues per claim.[56] Through the implementation of the Claims

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[53] Cooper, *Statement before the Commission*, 2005.
[54] Ibid.
[55] Ibid.
[56] Ibid.

> Processing Task Force recommendations, I believe VBA has laid the basic groundwork that will work to improve consistency in our claims decisions. As previously mentioned, we have made all regional offices similar, if not identical, in organizational structure, work process, and IT application.[57]

In December 2005, The American Legion testified before the House Committee on Veterans Affairs regarding challenges and opportunities facing VA's disability claims processing in 2006. The American Legion testified that although the VCAA was good in intent, VA failed to fulfill the aim of the legislation. The law was meant to aid veterans by informing them of the evidence and information necessary for VA benefits. The law "is a departure from long-standing adjudication policies and procedures, which did not adequately inform and assist individuals with their claims."[58]

II.2 Findings

The goal for the processing of veterans' claims for disability compensation benefits is to have all the evidence necessary to grant the claim at the earliest possible opportunity, ideally at the time the claim is presented to the VA. Whenever a claim is presented to the VA that is not complete, development required to complete the claim delays adjudication.

The Benefits Delivery at Discharge (BDD) program is a good example of meeting the needs of veterans. All the evidence is on record to allow VA to adjudicate the claim before the service member is discharged from active duty. If the service medical records are not sufficient to adjudicate the claim, an examination is conducted and a decision is rendered, all prior to the discharge of the service member from active duty.

Whenever duty to assist becomes a factor in the processing of a claim, the adjudication of the claim must be delayed until legal and procedural requirements are met. VA is, and should be, responsible for notifying a veteran of the evidence necessary to successfully prosecute his or her claim. Reasonable time limits for submitting evidence are necessary, but the current arbitrary allowance of 60 days in every case may not be warranted. Revisiting the intent of Congress as to who should be responsible for obtaining evidence, VA or the veteran, may allow for an opportunity to improve execution of the duty to assist principle and allow for faster claims processing.

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[57] Ibid.

[58] Mooney, *Challenges and Opportunities*, 2005.

During site visits, the Commission received numerous complaints that the duty to assist letters were not easily understood by veterans, were too "legalistic," and were too long. Complaints were also received that incomplete letters were mailed to claimants and that additional original development was done when a new issue was added to the claim. The claims process should be examined by all stakeholders with the focus on the quality and timeliness of the development process. VA, the Veterans Claims Adjudication Commission, GAO, and the American Legion, all cited above, have recognized the need to improve the duty to assist requirement. Reviewing the language in development letters to make them easier to understand, both by VA employees and the veteran, and reviewing who is responsible for obtaining which types of evidence (VA or the veteran) would improve the current duty to assist process.

Recommendation 9.4

VA should review the current duty to assist process and develop policy, procedures, and communications that ensure they are efficient and effective <u>from the perspective of the veteran.</u> VA should consider amending Veterans Claims Assistance Act letters by including all claim-specific information to be shown on the first page and all other legal requirements would be reflected, either on a separate form or on subsequent pages. In particular, VA should use plain language in stating how the claimant can request an early decision in his or her case.

Recommendation 9.5

VBA regional office staff must receive adequate education and training. Quality reviews should be performed to ensure these frontline workers are well versed to rate claims. Adequate resources must be appropriated to hire and train these workers to achieve a manageable claims backlog.

III Delayed Payments

An obstacle to the financial well-being of veterans and an effective transition from the military to civilian life is the current statutory requirement that disability compensation payments cannot be paid from the effective date of entitlement, but rather must be delayed until the first day of the second month after the payments are entitled. This requirement was enacted as a budget-saving provision in the Omnibus Budget Reconciliation Act of 1982 (Public Law 97-253, § 401, 96 Stat. 763, 801). It applies even to individuals filing a claim within 1 year

of date of entitlement or date of discharge whose entitlement date is the day after the date of discharge. While this restriction might seem reasonable from the standpoint of reducing costs, it means that service members do not receive any disability benefits for up to two months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. Before this statutory change, the veteran would have received disability benefits from the effective date of August 3. Because veterans—especially those who are unable to work—still have to provide for themselves and their families, the Commission recommends that this statutory requirement be changed.

IV Program Operations Comparison

The Commission was required to evaluate and assess comparable disability benefits provided to individuals by the Federal Government, State governments, and the private sector. The Commission relied upon a study conducted by GAO and requested a comparison of other programs by CNAC.

IV.1 GAO Highlights

In April 2006, GAO published "Disability Benefits: Benefits Amounts for Military Personnel and Civilian Public Safety Officers Vary by Program Provisions and Individual Circumstances." This report compared the service-connected disability benefits provided to military personnel with the benefits provided for line of duty injuries to civilian public safety officers at the Federal, State, and local level. The report focused on the benefits provided for three main categories of disability: (1) temporary disability, (2) permanent partial disability, and (3) permanent total disability. There were seven main areas of consideration: (1) line of duty injuries, (2) continuation of pay, (3) temporary disability retirement benefits, (4) permanent partial benefits, (5) return to work, (6) inability to work, and (7) total disability.

After conducting their analysis, GAO concluded that a general observation cannot be made concerning which governmental body consistently provides more compensation. Instead, the GAO report recommends observing this issue through a different prism. Their analysis indicates that the variation in benefit packages is dependent on a program's specific provisions and the individual circumstances of the service member. Therefore, there are cases where the benefits provided to a service member are greater and vice versa. For example, if an individual is unable to work due to a line of duty injury or illness, VA compensation payments for veterans are based on the disability rating, regardless of salary level. In contrast, compensation payments for selected civilian public safety officers are based on salary level, regardless of disability. As

a result, veterans with more severe injuries and lower wages will be compensated at a higher rate by VA. However, other veterans who have less severe injuries and higher wages will be compensated lower by VA.

GAO found that in situations pertaining to issue over line of duty, continuation of pay, and temporary disability retirement, service members receive more compensation. All programs reviewed by the GAO provide benefits to replace a portion of lost wages for individuals in the line of duty up until the time the injury is determined to be permanent and/or the individual can return to duty. However, service members are treated differently than public service officers. GAO compared the program provisions that govern service member line of duty injury to those that govern most civilian public service officers and found that injured service members are more likely to qualify as line of duty injured. This is because service members are on duty 24 hours a day, 7 days a week. In addition, continuations of pay provisions for service members are generally more flexible. Finally, the starkest difference between service members and public safety officers is the fact that service members are eligible to receive access to temporary disability retirement benefits.

IV.2 CNAC Highlights

CNAC was tasked to compare VA's disability compensation program with other federal disability compensation programs. This was done to develop recommendations that could be made by the Commission to VA to improve its operations. CNAC's analysis of VA's program operations can be found in Chapter 6, "Compensation, Survey Results, and Selected Topics," of this report.

CNAC compared the VA system to Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Federal Employees' Workers' Compensation Act, Federal Employee Retirement System, Civil Service Retirement System, and the Disability Evaluation System. To complete its comparative analysis, CNAC completed two tasks. First, it identified the major criticism of operations in VA's disability program. This included the following: (1) basic performance measures, (2) physical consolidation of offices, (3) balancing quality and quantity in employee performances, (4) training, (5) staff turnover, and (6) claimant representation. Second, it determined whether VA could address some of the criticisms using "lessons" from other federal disability compensation programs.

In respect to the criticism concerning basic performance measures, CNAC looked at three variables: consistency, accuracy, and timeliness. CNAC discovered that VA does not have a current measure of consistency. However, they recognized that none of the other federal disability compensation programs

have applied the necessary elements for measuring consistency. CNAC determined that the recommendations made by GAO concerning consistency were not in place in any federal program. GAO recommended including the following components in assessing consistency: (1) the use of multivariate regression analysis examining disability decisions along with controlling factors to determine whether the decisions are consistent, and (2) an in-depth independent review of a statistically valid group of case files to determine what factors may contribute to inconsistencies. CNAC recommended that one way to reduce inconsistency in disability programs would be to implement physical consolidation. At the moment, VA and SSA already have taken some steps to consolidate elements of the disability claims processing, but CNAC found that more should be done.

In respect to the criticism concerning basic performance measures, CNAC discovered that VA's accuracy rate in 2006 was 88 percent, which CNAC compared to SSDI (96 percent). CNAC concluded that this discrepancy is most likely the result of differences between the programs and their requirements for processing a claim. For example, VA has to rate the severity of a disability, which creates more potential for error than the yes-or-no disability decision required for SSDI. To improve the accuracy rate, CNAC recommends that VA adopt SSA's focus on the most error-prone cases. The VA's Systematic Technical Accuracy Review (STAR) program would need to be expanded. CNAC believes this would result in a great improvement in accuracy for VA claims processing.

In respect to the criticism concerning basic performance measures, CNAC discovered that compared to other disability program's VA's timeliness performance is poor. The average time for VA to complete a claim in FY 2006 was 177 days, which does not include appeals. In contrast, the average SSDI claim took 88 days in FY 2006, and the Federal Employee Retirement System, Civil Service Retirement System's average is 38 days. CNAC could not determine the exact cause for the poor performance, except that differences exist because of VA's complicated disability decision-making process, staffing shortages, low productivity, or some unknown factors. Also, the differences across programs in the work required to process a claim make it difficult to pin down the cause. CNAC makes note of VA's attempt to fix the problem by utilizing "Tiger Teams" to deal with cases that are designated as high priority at any given time. This program has been successful, but CNAC finds that this is no surprise considering that the "Tiger Teams" are made up of the most experienced staff. This emphasis makes it impossible for VA to replicate due to its staff shortage. One recommendation CNAC made is for VA to study SSA's Quick Disability Determination process. This involves the use of predictive models to identify cases with high probability of being granted benefits and then trying to act on those cases within 20 days.

In respect to the criticism concerning balancing quality and quantity in employee performance, CNAC discovered there exists a perception that VA emphasizes quantity over quality. In a national survey, 80 percent of raters said having enough time to process a claim was one their top three challenges. They were also asked to rate the availability of time to decide a claim, 54 percent of raters said availability of time was fair or poor. It can be argued that this creates incentives for RVSRs to make decisions that are not always fully backed by evidence, which leads to more appeals, and remands, and increases backlogs in the system. CNAC's interviews with VA staff and review of congressional testimony convinced it that there are well-defined standards for both quantity and quality of employee performance. CNAC also found that VA is not the only disability program facing issues over balance. SSA disability evaluations have indicated that employees also felt the emphasis on productivity had a negative impact of accuracy.

In respect to training, CNAC concluded that the criticism is unfounded. In relation to other disability programs, VA's level of standardization of training is unmatched. In addition, CNAC discovered that the other disability programs do not have formal evaluations of their training. CNAC believes that the VA's training difficulties are made exponentially worse because staff feel a need for more training and that training seems to be sacrificed to meet work quotas. This emphasis has encouraged a high staff turnover at VA. The quality of claims is lessened since inexperienced individuals are taking over for experienced raters. Surprisingly, CNAC found that VA's attrition rate was 15 percent for FY 2000, which was lower than the federal average of 17 percent. But, CNAC concluded that comparisons with other Federal agencies are irrelevant. The complicated nature of VA's work demands it spend vast amount of resources training its employees. When an experienced employee leaves, the consequences ripple more across VA than at most other Departments.

In respect to the criticisms concerning claimant representation, CNAC discovered that there is wide variation amongst veteran service organizations concerning the quality of training that accompanies each representative. There are some representatives who are highly qualified while others are not. The reason for the variability is that accreditation of each representative is made by the veterans service organizations. With few exceptions, most federal disability programs do not have involvement in external representation for claimants.

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