STATEMENT OF
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BEFORE THE SUBCOMMITTEE ON
DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON UNDER-PERFORMING VA REGIONAL OFFICES
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INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss issues related to the performance of Department of Veterans Affairs (VA) Regional Offices (VAROs) as identified in reports by the Office of Inspector General (OIG). The reports include audits of the programs and operations of the Veterans Benefits Administration (VBA) as well inspections conducted in individual VAROs. I am accompanied by Mr. Brent Arronte**,** Director, Benefits Inspection Division, in Bay Pines, Florida.

BACKGROUND

Delivering timely and accurate benefits and services to the millions of veterans who provided military service to our Nation is central to VA's mission. VBA, specifically the Office of Field Operations, is responsible for oversight of the nationwide network of 57 regional offices that administer a range of veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs will pay out over $72 billion in claims to veterans and their beneficiaries in fiscal year (FY) 2012, and comprise approximately half of VA's total budget.

For years, however, the disability compensation claims process has been the subject of concern and attention by VA leadership, Congress, and veteran service organizations, due in part to long wait times for benefits and services and the large backlog of claims pending decisions. VA also faces challenges improving the accuracy of disability claims decisions.

As part of our oversight responsibility, we conduct inspections of VAROs on a 3-year cycle to examine the accuracy of claims processing and the management of Veterans Service Center (VSC) operational activities. After completion of our inspection, we issue a separate report to each VARO Director of the results. In their responses to our reports, VARO Directors have concurred with our recommendations for improving the operations of their specific VARO. Recently, we issued a summary report of the results of our inspections conducted at 16 VAROs from April 2009 through September 2010 (*Systemic Issues Reported During Inspections at VA Regional Offices*, May 18, 2011). This summary report included four recommendations. The Acting Under Secretary for Benefits concurred with all recommendations.

Since September 2009, we have consistently reported the need for enhanced policy guidance, oversight, workload management, training, and supervisory review to improve the timeliness and accuracy of disability claims processing and VARO operations. Of those 16 VAROs inspected from April 2009 through September 2010, the Jackson, Mississippi, VARO (70 percent) had the highest level of overall compliance with VBA policy in the areas that we inspected while the Anchorage, Alaska, and Baltimore, Maryland, VAROs had the lowest (7 percent).

Our statement today will focus on the summary report as well as nationwide audits of related areas such as mail processing and fiduciary management to promote broad improvements in VBA programs and operations.

DISABILITY CLAIMS PROCESSING

Our inspections of 16 VAROs from April 2009 through September 2010 disclosed multiple challenges that management teams face in providing timely and accurate disability benefits and services to veterans. We focused our efforts on several specific types of disability claims processing, including temporary 100 percent disability evaluations, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI). In total, we projected that VARO staff did not correctly process 23 percent of approximately 45,000 claims from April 2009 through September 2010. We found that the Wilmington VARO had the highest accuracy rate (89 percent) for claims processing, whereas the San Juan VARO had the lowest (59 percent). However, we did not review temporary 100 percent evaluations processing at these VAROs.[1] If we had, these VAROs' accuracy rates could have been much lower, given the high number of errors we typically have identified in processing this type of claim.

Temporary 100 Percent Evaluations

In January 2011, we projected VBA did not correctly process temporary 100 percent evaluations for about 27,500 (15 percent) of 181,000 veterans (*Audit of 100 Percent Disability Evaluations*, January 24, 2011). We reported that since January 1993, VBA has paid veterans a net $943 million without adequate medical evidence. If VBA does not take timely corrective action, it could overpay veterans a projected $1.1 billion over the next 5 years. The Under Secretary for Benefits agreed with our seven report recommendations for implementing training and internal control mechanisms to improve claims processing timeliness. To date, VBA has implemented two recommendations, and plans to implement the remaining five recommendations by September 30, 2011.

We followed up on these audit results during our VARO inspections. We found VARO staff incorrectly processed 82 percent of the temporary 100 percent disability evaluations we reviewed, resulting in approximately $82 million in overpayments to veterans. About 42 percent of the improper payments were due to human errors. These errors occurred when VARO staff did not input reminder notifications in VBA's electronic system to request reexaminations of these veterans as required by VBA policy.

[1] In September 2009, we included the review of temporary 100 percent claims to our protocols because it is a high risk area.

Traumatic Brain Injury

From April 2007 through FY 2009, based on outpatient screening of veterans requesting VA health care treatment following military service in Operation Enduring Freedom and Operation Iraqi Freedom, VA determined that over 66,000 could possibly have TBI. Of those identified through the screening, VA ultimately confirmed that 24,559 had sustained TBI; claims processing workloads corroborated that amount.

Our VARO inspections showed that staff had made errors in 19 percent of the TBI claims we reviewed. Most of the errors related to either VA medical examiners providing inadequate TBI medical examination reports on which to base disability claims decisions, or Rating Veterans Service Representatives (RVSRs) not returning these inadequate reports to the hospitals for correction as required. RVSRs often did not return the inadequate reports due to pressure to meet productivity standards. A common scenario in TBI claims processing involved veterans who had TBI-residual disabilities as well as co-existing mental conditions. When medical professionals did not ascribe the veterans' overlapping symptoms to one condition or the other as required, VARO staff could not make accurate disability determinations. RVSRs' difficulty in following complex TBI claims evaluation policies also contributed to the TBI claims processing errors.

Post-Traumatic Stress Disorder

VARO staff did not correctly process 1,350 (8 percent) of approximately 16,000 PTSD claims completed from April 2009 through July 2010. Approximately 38 percent of the errors were due to staff improperly verifying veterans' alleged stressful events, a requirement for granting service connection for PTSD. VARO staff lacked sufficient experience and training to process these claims accurately. Additionally, some VAROs were not conducting monthly quality assurance reviews. For these reasons, veterans did not always receive accurate benefits.

Effective July 13, 2010, VA amended its rule for processing PTSD disability compensation claims. The new rule allows VARO staff to rely on a veteran's testimony alone to establish a stressor related to fear of hostile military or terrorist activity, as long as the claimed stressor is consistent with the circumstances of service. This change significantly reduced processing errors associated with PTSD claims. Prior to the rule change, we identified a 13 percent error rate in PTSD claims processing. From the date of the rule change until September 2010, however, that rate had dropped to 5 percent.

Opportunities to Improve Disability Claims Processing Timeliness

In September 2009, as a result of a nationwide audit, we identified opportunities for VAROs to improve timeliness and minimize the number of claims with processing times exceeding 365 days (*Audit of VA Regional Office Rating Claims Processing Exceeding 365 Days,* September 23, 2009). As of August 2008, VBA had 11,099 claims that had been pending rating decisions more than 365 days. On average, these claims were pending 448 days. A primary cause for the slow claims processing times was VARO workload management plans and VSC staff production credits that were not linked to

timeliness goals, such as the national target to complete claims ratings within 125 days. VSC execution of the workload management plans was also inadequate. Although VBA has performance standards to monitor and evaluate VARO staff performance in elements such as service delivery (accuracy), claims processing, customer service, and workload management, those standards are tied to neither timeliness goals for claims processing phases nor the national target.

In addition, VARO workload management plans did not adequately address ten inefficient VARO practices, such as improperly identifying delayed claims, untimely initial requests for evidence, and untimely follow-up on requests for evidence. These inefficient practices caused claims processing delays averaging between 47 and 224 days. For individual claims, the delays were as long as 817 days (27 months). We projected that the inefficient VARO workload management plans and practices unnecessarily delayed benefit payments totaling about $14.4 million for 3,501 claimants an average of 8 months. This report contained four recommendations to establish goals and revise workload management policy to help improve claims processing timeliness. The Under Secretary for Benefits agreed with our findings and recommendations and VBA implemented all recommendations.

DATA INTEGRITY

Our inspection results showed that VARO staff did not timely control Notices of Disagreements (NODs)—written communication from claimants contesting claims decisions. A NOD is the first step in the appeals process. VARO staff did not input NODs in VBA's electronic system in 7 days for 37 percent of the claims we reviewed, although they generally met VBA's pending timeliness goal of 145 days for NOD processing.

Untimely recording of NODs in VBA's electronic system affects data integrity, misrepresents timeliness in NOD processing, and provides an inaccurate account of the total appeals inventory. Such data integrity issues make it difficult for VAROs and senior VBA leadership to accurately measure and monitor regional office performance. Further, VBA's National Call Centers rely upon this information to provide accurate customer service to veterans regarding their appeals. VARO Directors concurred with our recommendations to train staff to properly identify NODs and establish plans to ensure these disagreements are controlled within VBA's 7-day standard.

MAIL PROCESSING AND CLAIMS FOLDER MANAGEMENT

Timely and efficient mail processing is key to completing claims processing and providing benefits and services to veterans as quickly as possible. In September 2009, as a result of a nationwide audit, we reported that VAROs needed to improve the handling, processing, and protection of claim-related documents, as well as meet mailroom security and other operational requirements *(Audit of VA Regional Office Claim-Related Mail Processing*, September 30, 2009). In FY 2008, VBA placed 82 percent of claims under control (i.e. entered claim information into the electronic application to officially establish a claim) in 7 days or less after receipt; however, it took an average of 32 days to place the remaining 18 percent of claims under control. The

Under Secretary for Benefits concurred with our findings and recommendations for addressing these issues. VBA implemented all recommendations by instituting controls and new policies to improve mail processing and ensure VARO staff do not improperly destroy applications for benefits and other official documentation.

In September 2009, based on another nationwide audit, we reported that VBA had inadequate procedures in place for locating veterans' claims folders (*Audit of VBA's Control of Veterans' Claims Folders*, September 28, 2009). VBA managers did not track the number of lost or rebuilt folders, consistently enforce Control of Veterans Records System (COVERS) policies, and establish effective search procedures for missing claims folders. Misplaced claims folders can cause unnecessary claim processing delays, reduce the time regional office personnel have to spend processing claims, and place additional burdens on the veterans awaiting benefits.

As of February 20, 2009, VBA had assigned about 4.2 million claims folders to regional offices for benefit claims processing and safeguarding. We projected that claims folders for an estimated 437,000 (10 percent) veterans were misplaced. Approximately 296,000 (7 percent) veterans had claims folders at locations different from those shown in COVERS. Of these misplaced claims folders, we projected about 55 percent were in other locations inside the regional office, and the remaining 45 percent were at the VA Records Management Center with no certainty as to why.

We concluded that the remaining 141,000 (3 percent) veterans had claims folders that were lost. Most of the 141,000 lost claims folders were for veterans with denied claims or for deceased veterans with no current payments. VBA officials agreed that some of these folders were lost, but also stated that many may never have existed. However, we discovered evidence in COVERS and the Beneficiary Identification and Records Locator System that the folders did exist and at one time were located at Federal Records Centers, the Regional Management Center, or regional offices. Our report included nine recommendations to improve tracking and accountability for veterans' claims folders. The Under Secretary for Benefits concurred with our findings and recommendations. VBA has implemented seven of the recommendations and plans to implement the remaining two by August 31, 2011.

Our inspections disclosed similar findings with regard to mail processing and claims folder management. We found that 12 (75 percent) of the 16 VARO mailrooms did not always control and process mail according to VBA policy. This occurred because VARO management and staff were generally unaware of mail processing requirements, including accurately and timely date stamping mail received at VA facilities. Further, VARO workload management plans contained unclear mail processing procedures or first-line supervisors did not always follow the guidance delineated in these plans. Consequently, beneficiaries may not have received accurate or timely benefit payments. Our inspections also showed that Triage Team staff improperly managed claims-related mail at 10 (63 percent) of the 16 VAROs inspected. Triage Teams are responsible for reviewing, controlling, and processing or routing all incoming mail received from the VARO mailroom. Untimely control and processing of mail can cause delays in

processing disability claims. Triage Team members did not timely record receipt and process 21 percent of the incoming mail. In addition, staff did not properly use COVERS to track the location of 24 percent of claims-related mail. At one VARO, we found 1,462 pieces of mail waiting to be associated with veterans' claims folders.

INFORMATION SECURITY

Securing veterans' personal information is critical while processing VA benefits and services. Unauthorized release of veterans' personal information can result in compromised data and lost veterans' confidence in VA operations. In September 2009, we reported VARO staff had inappropriately placed some claims-related documents in shred bins *(Audit of VA Regional Office Claim-Related Mail Processing*, September 30, 2009). Our inspections at nine VAROs also showed that VBA's policy for safeguarding veterans' personal information was not being followed. Specifically, we identified 78 instances of improper safeguarding of veterans' sensitive information. While VBA policy requires that supervisors perform routine inspections of workstations, some VAROs were not performing these inspections as directed. Although we found no evidence of improper document destruction, we did find evidence of improper storage of documents and other materials containing PII. We discontinued our review of this topic because the majority of the material found was of relatively low-risk, such as unredacted training materials, and its improper safeguarding did not seem intentional.

FIDUCIARY AND ELIGIBILITY DETERMINATIONS

VA must consider the competency of beneficiaries in every case involving a mental health condition that is totally disabling or when evidence raises a question as to a beneficiary's mental capacity to manage his or her financial affairs, including VA benefits. When a veteran is deemed incompetent, VA appoints a fiduciary, which is a third party that assists in managing funds for an incompetent beneficiary.

Our inspections found staff at seven VAROs unnecessarily delayed making final competency decisions in 54 (34 percent) of 159 cases we reviewed. Delays ranged from approximately 17 to 530 days. VARO workload management plans did not make competency determinations a priority or include measures for oversight of this work. As a result, incompetent beneficiaries received their benefits directly without fiduciaries in place to manage their financial resources. While the beneficiaries were entitled to these payments, fiduciary stewardship may have been needed to ensure effective funds management and the welfare of the beneficiaries. The risk of incompetent beneficiaries receiving benefit payments without fiduciaries assigned to manage those funds increases if staff do not complete competency determinations promptly.

At the time of these inspections, VBA did not have a clear, measurable standard to ensure timely completion of these determinations. Its policy required "immediate" action to make a determination following a beneficiary's due process period. However, VARO managers had different interpretations of "immediate." One VARO Director stated the term "immediate" was unrealistic while four Veterans Service Center Managers defined "immediate" as a period from 3 to 30 days. In response to our recommendation, in May 2011 the Acting Under Secretary for Benefits determined VBA would implement a 21-

day standard to ensure timely completion of competency determinations (*Systemic Issues Reported During Inspections at VA Regional Offices*, May 18, 2011).

In addition to the inaccuracies related to delays in processing competency determinations, VARO staff did not follow VBA policy when determining if beneficiaries were competent to handle VA funds. Staff incorrectly determined beneficiaries were incompetent without adequate medical evidence demonstrating they could not manage their affairs. Additionally, VAROs determined beneficiaries were incompetent without providing the mandatory 65-day due process period for the beneficiaries to provide evidence to the contrary.

Further, in March 2011, we reported VBA improperly managed retroactive and one-time payments of $10,000 or greater awarded to incompetent beneficiaries served by appointed, professional (non-spousal), legal custodians (*Audit of Retroactive and One-Time Payments to Incompetent Beneficiaries*, March 3, 2011). VBA did not effectively ensure these payments valued at $10,000 or greater were effectively coordinated among VBA offices, or that Fiduciary Activities completed required account management and estate protection actions. Fiduciary Activities failed to conduct at least one required account management or estate protection action for 72 (40 percent) of the 180 payments reviewed. VBA used manual notification processes, lacked policies and procedures to perform required program actions, and did not ensure sufficient management oversight. Moreover, Fiduciary Activities either did not provide training specific to the management of retroactive and one-time payments to incompetent beneficiaries, or the training was informal and unstructured. This report included five recommendations for improvements in VBA's Fiduciary Activities. The Acting Under Secretary for Benefits agreed with our findings and recommendations and provided responsive implementation plans.

QUALITY ASSURANCE AND OVERSIGHT

In addition to OIG inspections and audits, VBA has its own processes for assessing the quality of its disability claims processing. Our assessment of VARO management controls found weaknesses associated with correcting errors identified by VBA's Systematic Technical Accuracy Review (STAR) program. Of the 16 VAROs inspected, seven did not follow VBA policy when correcting errors identified by VBA's STAR staff. VARO staff did not properly correct 11 percent of the errors reviewed. However, VSC management erroneously reported to STAR staff that all corrective actions were completed. In all instances, VSC management did not provide oversight to ensure correction of the errors identified.

Further, VARO management did not always conduct complete Systematic Analyses of Operations (SAOs). SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VBA policy requires VSCs annually perform SAOs, covering all aspects of claims processing, including quality, timeliness, and related factors. Our inspections found six (38 percent) of the 16 regional offices did not follow VBA policy to ensure SAOs were timely and complete. We determined 53 (30 percent) of 175 SAOs were untimely and/or

incomplete. VARO management did not provide oversight to ensure SAOs addressed all necessary elements and operations of the VSC. By not completing SAOs as required by VBA policy, management may fail to identify existing or potential problems that could hamper effective delivery of benefits and services to veterans. We recommended VARO Directors develop plans to improve oversight and thereby ensure timely correction of errors identified by STAR staff and the completion of SAOs. The VARO Directors concurred with the recommendations and corrective actions are ongoing.

We noted a correlation between VAROs producing complete and timely SAOs and VSC compliance with other VBA policies. We found that five VAROs, where managers ensured SAOs were timely and complete, were the most compliant in other operational activities we inspected. Conversely, of the six VAROs that had untimely and/or incomplete SAOs, five had the lowest performance in other operational activities, such as claims processing, mail handling, and data integrity. The manager of one of these VAROs considered SAOs to be of little or no value toward improving VARO performance. At five of the six least compliant VAROs, vacancies in senior management positions contributed to delays in completing SAOs and implementing corrective actions. These VAROs had Director or Veteran Service Center Manager positions vacant or filled with temporary staff for periods of 5 months or greater. For example, during the 8-month absence of the Anchorage Veterans Service Center Manager, that office did not have any senior leadership physically in place to manage and oversee operations.

We did not provide a recommendation on this issue. However, VBA would benefit from conducting further analysis on improving the timely selection and replacement of key VARO leadership positions. We will continue to look at the effect of management vacancies on VARO operations during future reviews.

CONCLUSION

VBA continues to face challenges in improving the accuracy and timeliness of disability claims decisions and maintaining efficient VARO operations. Our inspections and audit work repeatedly have shown that VAROs do not always comply with VBA's national policy and struggle with implementing effective workload management plans and clear and consistent guidance to accomplish their benefits delivery mission. Our inspections disclosed a wide disparity between the most and least compliant VAROs in the areas we reviewed. VBA's own oversight and quality assurance processes have not been fully effective in closing this gap and ensuring identification and correction of deficiencies in VARO operations. Prolonged vacancies in the VARO leadership needed to drive internal review and promote performance improvement only exacerbate the situation.

Such claims processing and operational problems result in not only added burdens and delayed or incorrect payments to veterans, they also mean wasted Government funds through improper payments that VBA will not likely recover. While VBA has made some incremental progress through its own initiatives and in response to our prior report recommendations, more remains to be done. We will continue to look for ways to promote improvements in benefits delivery operations during our future VARO inspections and nationwide audits. We will also conduct work in related areas, such as an audit in FY 2012 of VA's efforts to develop and implement the next phase of the Veterans Benefits Management System, which is intended to integrate mission critical applications and facilitate data sharing across the Department. This audit will include examination of project management activities, architectures, and security for the system development effort.

Mr. Chairman, this concludes my statement. We would be pleased to answer any questions that you or other Members of the Subcommittee may have.