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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs

MANAGEMENT ADVISORY MEMORANDUM | MEMO #22-01290-237 | DECEMBER 8, 2022

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The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation, except for the standard of evidence collection analysis, or follow-up.

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DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20001

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MANAGEMENT ADVISORY MEMORANDUM

TO: Joshua Jacobs, Senior Advisor for Policy, Performing the Delegable Duties of the Under Secretary for Benefits
Veterans Benefits Administration (20)

FROM: Larry Reinkemeyer, Assistant Inspector General
VA Office of Inspector General's Office of Audits and Evaluations (52)

SUBJECT: VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs

The VA Office of Inspector General (OIG) is issuing this management advisory memorandum because the oversight staff's work has identified issues that warrant Veterans Benefits Administration (VBA) leaders' attention. Since 2018, the OIG has issued at least four reports that demonstrate that VBA personnel made decisions that had adverse effects on some veterans and beneficiaries.[1] The OIG values regular discussions with VBA staff at every level and recognizes that responsive action plans have been submitted for implementing a range of OIG recommendations from these four reports. This memorandum is meant to support and strengthen those efforts by raising awareness about the consequences that processes and procedures can sometimes have on veterans and other beneficiaries.

The OIG's interaction with VBA leaders and staff has demonstrated a steadfast commitment to serving veterans. VBA's well-intentioned focus on solving organizational challenges has, however, resulted in negative consequences for some veterans and their families. These decisions led to improper payments to veterans and their families, violations of veterans' due process rights, disclosure of veterans' personal information, and veterans undergoing unnecessary medical examinations. Taken together, they reflect OIG concerns that warranted this management advisory memorandum. It is also important to publish this reminder given the many challenges that VBA will face as it processes the significant number of complex claims required to implement the PACT Act.

[1] VA OIG, *Exempt Veterans Charged VA Home Loan Funding Fees*, Report No. 18-03250-130, June 6, 2019; VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments*, Report No. 20-03898-236, October 28, 2021; VA OIG, *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters*, Report No. 19-05960-244, November 14, 2019; VA OIG, *Unwarranted Medical Reexaminations for Disability Benefits*, Report No. 17-04966-201, July 17, 2018.

In 2011, the VA Secretary announced the creation of core values and characteristics. They were codified as regulatory guidelines in 2012 and updated to include customer experience principles in 2019.[2] VA codified these I CARE values to ensure they "receive the proper emphasis at all levels within VA, are clearly understood by the workforce, and, most importantly, become an enduring part of the VA culture."[3] The VA Secretary has the authority to prescribe all rules and regulations that are necessary or appropriate to carry out the laws administered by the department consistent with those laws.[4]

These regulations state that VA employees should

- be truly veteran-centric by identifying, fully considering, and appropriately advancing the interests of veterans and other beneficiaries;
- provide the highest standard of care and services to veterans and beneficiaries while managing the cost of its programs; and
- deliver care, benefits, and memorial services to the customer's satisfaction.[5]

At minimum, these four OIG reports demonstrate the consequences of how program changes affect veterans. These reports resulted in 17 recommendations to address specific problems the OIG found with these changes, and no additional recommendations are being made here. However, the OIG is issuing this memorandum to ensure VBA leaders are aware that these reports, when viewed together, suggest that VBA could better institutionalize the application of the I CARE values when making program decisions. By ensuring that the regulatory requirements receive full consideration on all levels of planning, implementing, and overseeing programs, VBA would not only improve outcomes for veterans and their beneficiaries but also advance operations and program efficiency and effectiveness.

VBA Prioritized Improving Processes Rather Than Focusing on Outcomes

When faced with a need for change, VBA's actions to reduce backlogs, expedite processing, and free VBA staff for other priorities have, at times, resulted in poor outcomes for some veterans and beneficiaries.[6]

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[2] 38 C.F.R. §§ 0.601–0.603.

[3] Core Values and Characteristics of the Department, 77 Fed. Reg. 41,273–41,276 (July 13, 2012). These regulations issued by VA in accordance with the rulemaking authority granted by Congress are codified in title 38 of the Code of Federal Regulations and apply to all VA personnel. See appendix A for more details about the I CARE values.

[4] 5 U.S.C. § 301; 38 U.S.C. § 501.

[5] 38 C.F.R. §§ 0.601–0.603.

[6] For more details about VBA's responsibilities, see appendix B. Appendix C provides summaries of the relevant OIG reports.

For example, in *Exempt Veterans Charged VA Home Loan Funding Fees*, although the OIG found that VA processed approximately 3.7 million loans from fiscal year 2012 through 2017, it did not issue loan funding fee refunds to thousands of exempt veterans.[7] VBA was aware that exempt veterans were not refunded home loan funding fees. Nevertheless, VBA focused on other competing priorities, such as addressing appraisal timeliness for pending home loans, and placed the burden on veterans to request a refund.[8] Although increasing efficiency and reducing wait times or backlogs is important in meeting performance goals, this action resulted in burdens on the veterans who were due the home loan funding fees. Veterans were expected to be proactive, meaning that if a veteran did not actively pursue the funding fees due, that veteran would not receive funds to which the veteran was entitled. The OIG acknowledges the importance of these competing priorities articulated by VA, but by requiring a veteran to submit a claim for a refund, VA improperly placed responsibility solely on the veteran to obtain funds that VA has acknowledged were due. Focusing more intensely on veteran-oriented outcomes and rigorously addressing mistakes would have put refunds into the hands of eligible veterans. The OIG is concerned that the attempt to improve overall processing efficiency came at the cost of not providing refunds to some eligible veterans.

In *Improper Processing of Automated Pension Reductions,* the OIG found that VBA automated its process to reduce claims-processing time and free up staff from pension claims.[9] However, instead of including the reasons for the reductions and offering beneficiaries the required due process, VBA proposed the most adverse action possible—the termination of benefits. Additionally, the automated system failed to account for the Supplementary Medical Insurance Benefit, a known medical expense paid for by many beneficiaries, that would have lowered or eliminated pension reductions.[10] Although automating the pension process could result in greater efficiency, veterans should not be negatively affected as a result. VBA's claims processors stated that the automated process provided poor customer service because the notices of proposed adverse action and final decision letters did not provide the information beneficiaries needed to contest the reductions. Although the OIG recognizes that improving claims-processing timeliness and freeing up staff to concentrate on other critical areas are important factors, veterans and beneficiaries were adversely affected.

Similarly, in *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requestors*, the OIG found that, in an effort to reduce a growing

[7] VA OIG, *Exempt Veterans Charged VA Home Loan Funding Fees*.

[8] VA OIG, *Exempt Veterans Charged VA Home Loan Funding Fees*.

[9] VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments.*

[10] VBA Manual 21-1, part 9, sub. 3, chap. 1, sec. G, "Pension - Deductible Medical Expenses," September 15, 2021. Supplementary Medical Insurance Benefit is a Medicare Part B premium that beneficiaries may pay to the Social Security Administration. This premium is a medical expense that can be used to offset beneficiaries' incomes without requiring a submitted medical expense form.

Privacy Act request backlog and improve veterans' access to their records, VA officials knowingly made changes to VBA's Privacy Act release policy. Changes included stopping the redaction of third-party private information, even though VBA was aware of the associated privacy risks.[11] Under the prior policy, such disclosures would likely have been considered a security breach resulting in VA offering credit protection services to affected individuals. In this instance, VBA did not notify stakeholders of these policy changes or the potential risks. The policy changes created an increased risk of identity theft for individuals who may be unaware their information was disclosed in response to Privacy Act requests. VBA prioritized resolving its massive backlog of Privacy Act requests over the risk of identity theft for millions. While VBA's efforts to reduce its growing backlog are important and well-intentioned considerations, veterans were not informed of this disclosure or its risks.

Finally, in *Unwarranted Medical Reexaminations for Disability Benefits*, the OIG found VBA required veterans to report for unwarranted medical reexaminations. This burdened veterans who were obligated to report for examinations, the majority of which resulted in no change to their disability evaluations.[12] These unnecessary examinations occurred because of a lack of pre-examination reviews. VA policy required a pre-examination review to determine whether the reexamination is needed. This review served as an internal control to prevent unwarranted reexamination. However, the OIG team estimated that 15,500 of 19,800 unwarranted reexaminations lacked this review. This occurred because VA regional office managers routed these cases away from decision-making claims processors—who have the knowledge and experience to determine whether examinations are necessary—to employees without that knowledge and experience and directly to a non-decision-making claims processor to schedule the examination. The process was altered because the executive in charge concluded that decision-making claims processors should only complete work directly related to making rating determinations. That alteration addressed a significant consideration, but the implementation resulted in a burden being imposed on veterans to report for unwarranted medical examinations. If VBA had more fully considered the effect of this policy change on veterans, these unwarranted examinations could have been avoided.

Inadequate Controls for Ensuring Accountability, Monitoring, and Communication Contribute to Negative Outcomes

A key factor in improving accountability for achieving VA's mission is to implement an effective internal control system to help VA adapt to shifting environments, evolving demands,

[11] VA OIG, *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters*.

[12] VA OIG, *Unwarranted Medical Reexaminations for Disability Benefits*.

changing risks, and emerging priorities.[13] Internal controls include evaluating performance and holding individuals accountable for their responsibilities; communicating the necessary information to achieve objectives; and establishing and implementing monitoring activities, results evaluations, and deficiency remediation. An effective internal control system, if applied to the four issues that the OIG reviewed in these reports, would have resulted in VBA improving quality reviews, informing veterans when their personal information is released, and overseeing automated processes and correcting any issues before veterans are affected.[14]

A review of the reports showed that VBA did not

- perform adequate quality reviews or effectively hold staff accountable for meeting quality standards,[15]
- communicate with veterans and servicemembers regarding policy changes,[16] or
- ensure automated adjustments were completed correctly or remediate deficiencies that resulted in incorrect benefits paid to veterans and other beneficiaries.[17]

Enforcing accountability, increasing monitoring, undertaking corrective action, and fully communicating with stakeholders would help ensure that VBA fully considers the impact on veterans and other beneficiaries.

VBA Perspective

To gain further insight into the effects of implementing OIG recommendations, the team interviewed VBA officials currently responsible for some of the programs reviewed in previous reports.[18] VBA executive directors acknowledged that everything they do should promote the I CARE values. These executives believe that, strategically, VBA considers the I CARE values

[13] OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, July 15, 2016; GAO, Standards for Internal Control in the Federal Government, GAO-14-704G, September 2014. In accordance with OMB Circular A-123, managers are responsible for establishing and maintaining internal controls to achieve specific objectives related to operations, reporting, and compliance.

[14] GAO, Standards for Internal Control in the Federal Government; VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments*; VA OIG, *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters*; VA OIG, *Unwarranted Medical Reexaminations for Disability Benefits*; VA OIG, *Exempt Veterans Charged VA Home Loan Funding Fees*.

[15] VA OIG, *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters*; VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments*; VA OIG, *Unwarranted Medical Reexaminations for Disability Benefits*.

[16] VA OIG, *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters*.

[17] VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments*.

[18] On April 21, 2022, the team interviewed the acting executive director of the Office of Mission Support, the acting executive director of the Loan Guaranty Service, and the executive director of the Pension and Fiduciary Service.

but also acknowledged that sometimes issues arise that cause VBA to focus narrowly on a specific problem, taking the focus off the I CARE values. Overall, these executives believe that all VBA staff truly care and are doing the best they can to serve veterans. One executive stated further progress is needed in aligning systems and the mindset of VBA staff with the I CARE values, assessing quality, and communicating with all stakeholders.

Conclusion

Previous reports issued by the OIG show that VBA did not always fully consider the effect organizational decisions would have on veterans, beneficiaries, and their families. In the OIG reports reviewed, VBA made changes to its processes and procedures that contributed to a failure to provide refunds to veterans and their families, violation of veterans' due process rights, disclosure of veterans' personal information, and unnecessary medical examinations.

This was partly due to VBA focusing on increasing efficiency without first assessing the full effect on individual veterans or other beneficiaries and partly due to internal control system deficiencies related to accountability, monitoring, and communication. Holistic consideration of outcomes for veterans and beneficiaries, as well as better implementation of controls at an organizational level, could have helped VBA consistently demonstrate compliance with the I CARE values. As VBA prepares to implement the PACT Act, these considerations become even more important.

Requested Action

The OIG requests that VBA inform the OIG what actions, if any, it takes to more systematically assess the impact of proposed actions on veterans, beneficiaries, and their families when planning, implementing, or overseeing programs, projects, and operations.[19]

VBA Response

The senior advisor for policy, performing the delegable duties of the under secretary for benefits, did not concur with the findings of OIG's management advisory memorandum. The senior advisor stated that although VBA concurred, or concurred in principle, with the OIG reports and recommendations referenced within the management advisory memorandum, the senior advisor stated VBA "strongly oppose[s] the implication that VBA did not always fully consider the effect organizational decisions would have on Veterans, beneficiaries, and their families." The full text of the senior advisor's comments appears in appendix D.

[19] This memorandum is addressed to the under secretary for benefits and is directed to anyone in an acting status or performing the delegable duties of the position.

OIG Response

This memorandum gives VBA senior leaders, some of whom are new to their position, an awareness of opportunities to further support and strengthen VBA's commitment to I CARE values. During frequent interactions, OIG personnel have found VBA leaders have shown a steadfast dedication to serving veterans. However, as the memorandum shows, VBA's focus on solving specific organizational challenges sometimes has negative consequences for veterans and their families. The referenced reports from 2018 through 2021 highlight instances in which VBA took actions to achieve greater efficiency at the cost of some negative outcomes for veterans. In some cases, VBA was aware of the risk of adverse consequences for veterans or their families but failed to effectively manage this risk.

Regarding *Exempt Veterans Charged VA Home Loan Funding Fees*, VBA detailed in its appendix D comments that this management advisory memorandum does not fully consider prior VBA report comments on "operational practices, historical context, and leadership decisions" or the many competing priorities and limited resources VBA faced due to unprecedented growth in loan volume and calls as well as system changes. For example, VBA noted that the unprecedented market conditions also "weighed heavily on the leadership decisions made to focus resources on system and process enhancements to improve the accuracy of [Certificates of Eligibility] determinations and benefits delivery." Additionally, VBA noted that it demonstrated commitment to I CARE values by prioritizing and implementing processes that resulted in expanded program access to qualifying veterans with shorter wait times and provided detailed descriptions of those actions and processes in the full text of their appendix comments.

As previously stated, the OIG agrees that VBA leaders and staff have shown a steadfast dedication to serving veterans and acknowledges the progress made in responding to recommendations despite significant challenges. However, as the OIG reported in its June 2019 report on *Exempt Veterans Charged VA Home Loan Funding Fees,* VA processed approximately 3.7 million loans from fiscal year 2012 through 2017 and did not issue loan funding fee refunds to thousands of exempt veterans. Importantly, VBA was aware that exempt veterans were not refunded home loan funding fees. The senior advisor's response elaborated on the issues the OIG identified during that review but provided no additional information to dispute the facts and conclusions of the June 2019 OIG report.[20]

For the report on *Improper Processing of Automated Pension Reductions*, VBA explained that its decisions related to this process demonstrated the I CARE value of commitment and stated it was focused on veterans and beneficiaries to reduce the burden of overpayments. While that is a laudable goal, pension beneficiaries had their benefits unnecessarily reduced without sufficient due process and consideration of the evidence, including the Supplementary Medical Insurance

[20] VA OIG, *Exempt Veterans Charged VA Home Loan Funding Fees*.

Benefit (SMIB). If VBA had provided proper due process, veterans and beneficiaries would have been appropriately informed of all material facts and detailed reasons VBA used for the proposed action. Although VBA's response stated that the SMIB was not yet available "until well into the applicable calendar year and that by processing [cost of living allowance] cases with the calculated [Social Security Administration] rate, VBA is able to reduce the overpayment burden on the Veteran/beneficiary," the Medicare Part B premiums, or SMIB, were released on November 8, 2019, before the next calendar year and before any automated pension reductions had been proposed or processed. Additionally, because this insurance premium offsets any increases in Social Security payments, had VBA's automated process included consideration of the SMIB, it would have lowered or eliminated pension reductions and, in many cases, increased pension payments.[21] VBA discontinued automated final pension reductions, only leaving the proposed adverse action portion, and concurred in principle with the recommendations in the report. Currently, all but one recommendation has been closed.[22]

For *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requestors,* VBA commented that it "did not intentionally put Veteran's information at risk when implementing changes to the Privacy Act release policy" and changed its policy "only after VA's Office of General Counsel determined there was legal support for releasing unredacted records." The policy allowed releasing unredacted records if VBA purposely included the information in the requester's record. The OIG's review of 18 of 30 Privacy Act responses found 1,027 third-party names and social security numbers in records that VBA purposely included in requesters' claims files. The OIG found that VA officials, to reduce a growing Privacy Act request backlog and improve veterans' access to their records, knowingly made changes to VBA's Privacy Act release policy to stop redacting third-party private information, even though VBA was aware of the associated privacy risks. Although the VA Office of General Counsel provided legal support for the disclosure practice, this was despite the risk of substantial harm to third parties whose personal information is included in a veteran's claims file. While VBA's efforts to reduce its growing backlog are important and well-intentioned considerations, that decision resulted in the increased risk of identity theft for millions of people. The senior advisor's response noted that VBA has implemented effective internal controls and ensured veterans' personal information is protected and properly disclosed but provided no additional information to dispute the facts and conclusions of the November 2019 OIG report.[23] The OIG made five recommendations, which were closed as of January 4,

[21] VA OIG, *Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments.*

[22] The recommendation for VBA to review all automatically completed fiscal year 2020 pension reductions based on Social Security cost of living adjustments to ensure regulations and procedures were followed remains open pending completion by VBA.

[23] VA OIG, *Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requesters*.

2021. These recommendations included a commitment from VBA to update their Privacy Act release policy and begin redacting third-party personally identifiable information; to ensure that the Records Management Center complies with the requirements for mailing Privacy Act responses in accordance with VA Directive 6609; and to implement a plan to improve quality reviews and ensure staff are held accountable for the accuracy of their Privacy Act releases. According to their response, VBA has shown progress in addressing these recommendations, such as beginning to revise its Privacy Act release policy to further safeguard veterans' information. Additional measures listed by VBA include modernizing processes related to the Freedom of Information Act and responding to breaches during site visits at the Centralized Support Division.

Regarding *Unwarranted Medical Reexaminations for Disability Benefits*, VBA noted the actions that were taken in response to recommendations made in the OIG report issued in July 2018. At the time this report was issued, and based on the findings of that report, the OIG determined that altering the process for review examinations from having decision-making claims processors conduct a pre-examination review to routing these claims to non-decision-making claims processors to order examinations resulted in veterans reporting for reexaminations that were unwarranted. The process was altered because the executive in charge concluded that decision-making claims processors should only complete work directly related to making rating determinations. Although VBA's reasoning for making this decision is admirable, at the time of the report it resulted in negative outcomes for veterans.[24] The OIG made four recommendations. VBA's response to this memorandum states that it "disagreed with OIG's comment that RVSR employees be required to make the determination on whether a reexamination is necessary to implement the recommendation" and that the "OIG's position to require an RVSR make this determination dictates an assignment of VBA's workload and job responsibilities for VBA employees." However, the July 2018 OIG report only pointed out that changing the responsible party from knowledgeable decision-makers who would conduct a pre-examination review of the evidence to non-decision-making employees without adequate controls, including automation and quality reviews, resulted in unnecessary examinations. The OIG did not recommend any assignment of VBA's workload and job responsibility. The OIG did recommend that VBA establish sufficient internal controls to ensure that reexaminations are necessary before requiring a veteran to report for one, design and implement an automated system to minimize unwarranted reexaminations, enhance quality reviews, and conduct a special focused review to develop a better understanding of the causes of these unnecessary examinations. In fact, VBA concurred with three of these recommendations and concurred in principle with one recommendation. All four of the recommendations have been closed; however, two of four recommendations were

[24] Since this report was published, VBA has instituted new processes to ensure that claims processors do not order unnecessary reexaminations. However, this does not change the result that their initial decision caused veterans to report for unnecessary reexaminations.

closed as unimplemented.[25] These two recommendations will be discussed in an upcoming OIG follow-up report to this initial review.[26]

In sum, the OIG acknowledges and appreciates VBA employees' commitment to veterans. The validity of OIG's recommendations or VBA's responses are not at issue. This memorandum instead is meant to raise VBA leaders' awareness about concerns when viewing past VBA reports taken together and at a higher policy level. With increasing demands and modernization efforts, even greater caution is required in making policy, process, and quality review actions to ensure that efficiencies take into consideration all possible effects on veterans and other beneficiaries.

[25] The unimplemented recommendations relate to establishing internal controls to ensure reexaminations are necessary and conducting a review of claims with unnecessary examinations for data-gathering purposes.

[26] VA OIG, *Unwarranted Medical Reexaminations for Disability Benefits*.

Appendix A: I CARE Values, Core Characteristics, and Customer Service Principles

Core Values (38 C.F.R. § 0.601)

VA's core values describe the organization's culture and character and serve as the foundation for the way VA employees should interact with each other, as well as with people outside the organization. These values also serve as a common bond between all employees regardless of their grade, specialty area, or location. The core values are integrity, commitment, advocacy, respect, and excellence:

- **Integrity.** VA employees will act with high moral principle, adhere to the highest professional standards, and maintain the trust and confidence of all with whom they engage.
- **Commitment.** VA employees will work diligently to serve veterans and other beneficiaries, be driven by an earnest belief in VA's mission, and fulfill their individual responsibilities and organizational responsibilities.
- **Advocacy.** VA employees will be truly veteran-centric by identifying, fully considering, and appropriately advancing the interests of veterans and other beneficiaries.
- **Respect.** VA employees will treat all those they serve and with whom they work with dignity and respect, and they will show respect to earn it.
- **Excellence.** VA employees will strive for the highest quality and continuous improvement and be thoughtful and decisive in leadership, accountable for their actions, willing to admit mistakes, and rigorous in correcting them.

Core Characteristics (38 C.F.R. § 0.602)

Whereas the core values define VA employees, the core characteristics define what VA stands for and what VA strives to be as an organization. These characteristics are aspirational goals that VA wants its employees, veterans, and the American people to associate with VA and with its workforce. These core characteristics describe the traits all VA organizations should possess and demonstrate, and they identify the qualities needed to successfully accomplish today's missions and support the ongoing transformation of VA. VA employees should strive to embody the characteristics of being trustworthy, accessible, quality, innovative, agile, and integrated:

- **Trustworthy.** VA earns the trust of those it serves, every day, through the actions of its employees. VA employees provide care, benefits, and services with compassion, dependability, effectiveness, and transparency.

- **Accessible.** VA engages and welcomes veterans and other beneficiaries, facilitating their use of the entire array of its services. Each interaction will be positive and productive.
- **Quality.** VA provides the highest standard of care and services to veterans and beneficiaries while managing the cost of its programs and being efficient stewards of all resources entrusted to it by the American people. VA is a model of unrivalled excellence due to employees who are empowered, trusted by their leaders, and respected for their competence and dedication.
- **Innovative.** VA prizes curiosity and initiative, encourages creative contributions from all employees, seeks continuous improvement, and adapts to remain at the forefront in knowledge, proficiency, and capability to deliver the highest standard of care and services to all the people VA serves.
- **Agile.** VA anticipates and adapts quickly to current challenges and new requirements by continuously assessing the environment in which it operates and devising solutions to better serve veterans, other beneficiaries, and service members.
- **Integrated.** VA links care and services across the department; other federal, state, and local agencies; partners; and Veterans Services Organizations to provide useful and understandable programs to veterans and other beneficiaries. VA's relationship with the Department of Defense is unique, and VA will nurture this relationship for the benefit of veterans and servicemembers.

Customer Experience Principles (38 C.F.R. § 0.603)

Customer experience is the product of interactions between an organization and a customer over the duration of their relationship. VA measures these interactions through ease, effectiveness, and emotion, all of which impact the overall trust the customer has in the organization:

- **Ease.** VA will make access to VA care, benefits, and memorial services smooth and easy.
- **Effectiveness.** VA will deliver care, benefits, and memorial services to the customer's satisfaction.
- **Emotion.** VA will deliver care, benefits, and memorial services in a manner that makes customers feel honored and valued in their interactions with VA. VA will use customer experience data and insights in strategy development and decision-making to ensure that the voice of veterans, servicemembers, their families, caregivers, and survivors inform how VA delivers care, benefits, and memorial services.

Appendix B: Overview of VBA

VBA is responsible for providing various benefits and services to service members, veterans, and their families. Figure B.1 provides an overview of the four major program offices associated with the four published OIG reports discussed in this management advisory memorandum: the Compensation Service, the Pension and Fiduciary Service, the Loan Guaranty Service, and the Office of Mission Support.

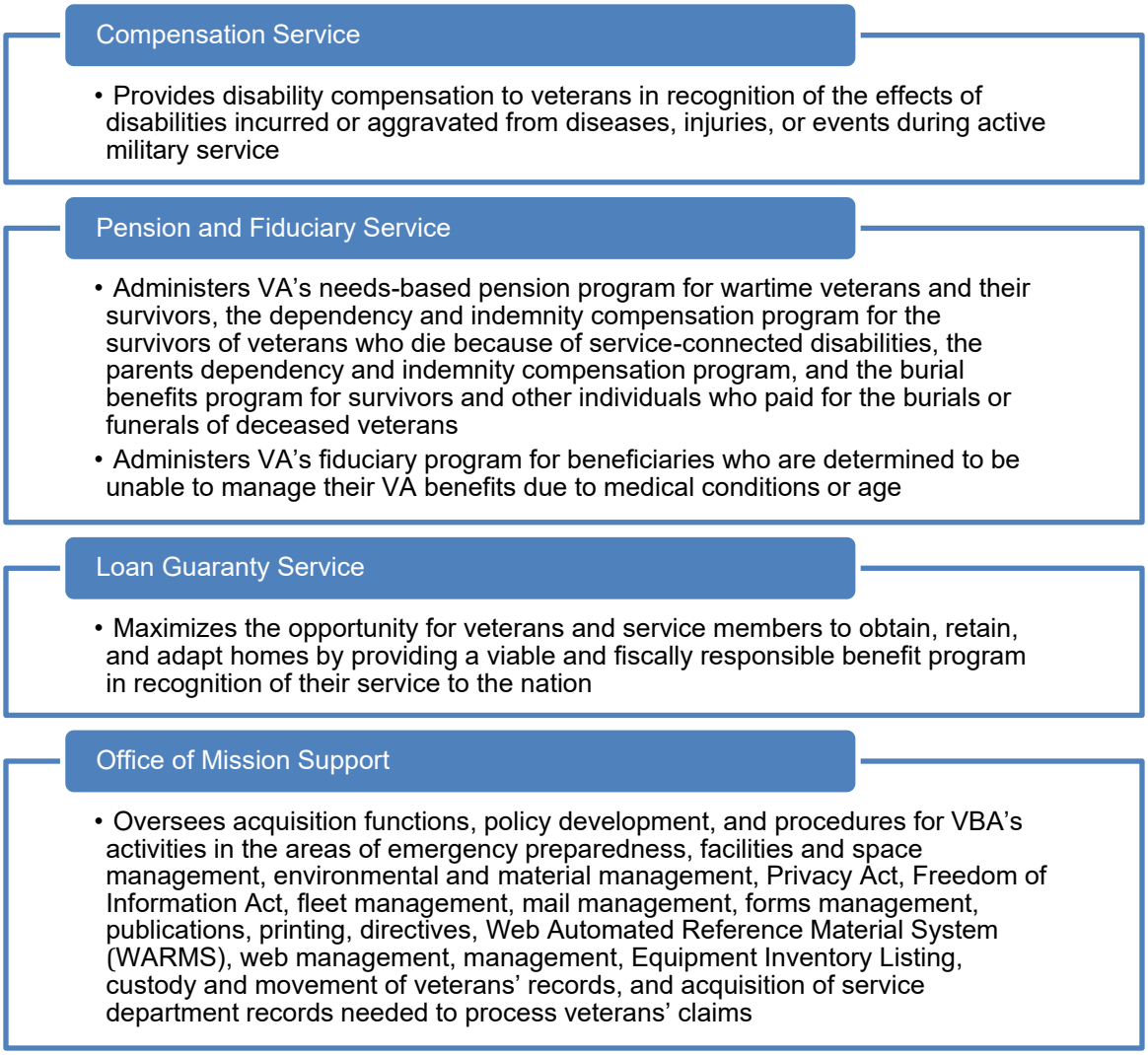

Figure B.1. *Overview of VBA program offices associated with previously published OIG reports. Source: VA OIG analysis of VBA program offices.*

Appendix C: Summary of Relevant OIG Reports

The following OIG reports found VBA's actions had negative consequences for some veterans and other beneficiaries.

Exempt Veterans Charged VA Home Loan Funding Fees
(Published June 6, 2019)

Veterans are generally required to pay a funding fee to VA at loan origination to defray the cost of administering a VA home loan. However, veterans are exempt from paying the funding fee if they are entitled to receive VA disability compensation.

The OIG's review of home loans showed that VA owed refunds to approximately 53,200 exempt veterans for loan funding fee charges totaling $189 million from calendar years 2012 through 2017. VBA's Loan Guaranty Service managers were aware since October 2014 that thousands of exempt veterans may have been charged home loan funding fees; however, VBA did not take adequate actions to ensure refunds were issued. Loan Guaranty Service managers stated they were focused on other competing priorities, such as addressing serial refinancing, a high blocked call rate and long wait times, and appraisal timeliness for pending home loans.

The failure to refund eligible veterans' funding fee charges occurred because of inadequate action taken to refund the inappropriate charges. Also, refunds of loan funding fees did not occur because certificates of eligibility did not reflect the correct exemption statuses for veterans, and there was no automated process to identify exemption status changes. Because inappropriate funding fee charges were not refunded, many exempt veterans may have suffered significant financial losses.

The OIG made five recommendations, which were closed as implemented as of January 23, 2020.

Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments
(Published October 28, 2021)

VBA began automating pension adjustments to decrease the time it takes to process claims, to reduce the backlog, and to free up staff to work on other critical areas. However, the OIG found that the automated process did not give beneficiaries adequate due process and failed to account for known medical expenses that would have lowered or eliminated any automated reductions. Letters sent to beneficiaries did not include all material facts and detailed reasons for the proposed payment reductions and did not meet the basic required elements outlined in VA regulations and procedures. Additionally, the business rules for the automated pension adjustment process did not account for beneficiaries' responses to the letters proposing to reduce

their benefits. Claims processors are required to consider increases in Medicare Part B premiums when determining pension benefits; however, the system's calculations did not include these expenses when reducing payments. If these expenses had been included, the increased premiums could have negated reductions and resulted in higher pension benefits for 138 of the 150 reductions reviewed.

This occurred because VBA neglected to consult VA's Office of General Counsel or relevant departments before implementation, to fully test or communicate the process to staff, and to monitor the results of the automated pension reductions. As a result, VBA jeopardized due process rights, created unnecessary debts, lowered pension payments, and otherwise increased the burden of one of the most vulnerable groups VA serves.

As of November 21, 2022, one of three recommendations remained open.

Records Management Center Disclosed Third-Party Personally Identified Information to Privacy Act Requesters
(Published November 14, 2019)

In May 2016, VBA changed its Privacy Act release policy to allow for the disclosure of third-party information. According to VA officials, this decision to release personal information was made deliberately to reduce a growing Privacy Act request backlog and to improve veterans' access to their records. The OIG's review of 18 of 30 Privacy Act responses found 1,027 third-party names and social security numbers, which included veterans, in records that VBA purposely included in requesters' claims files. VBA also did not inform third parties that their information was being released.

This occurred because the policy change for redaction of third-party information did not require third parties to be notified when their information was released. VBA also did not communicate the policy change to veterans and service members. Therefore, individuals who may have been harmed under this policy would have been unaware that VBA released their personal information.

The OIG made five recommendations, which were closed as of January 4, 2021, after receiving documentation of corrective and planned actions.

Unwarranted Medical Reexaminations for Disability Benefits
(Published July 17, 2018)

The OIG's review of reexaminations found that VBA required an estimated 19,800 veterans to report for unwarranted medical reexaminations during the six-month review period, costing $10.1 million.

This occurred because VBA managers bypassed procedural requirements of a pre-examination review by rating personnel who are best qualified to determine the need for reexaminations. VBA managers explained they were following guidance from VBA's executive in charge that tasks not directly related to making disability rating decisions should not be assigned to rating personnel. The executive in charge explained that rating personnel capacity is limited, and time should not be spent on activities that do not directly relate to making rating determinations. Unwarranted medical reexaminations also occurred due to lack of system automation and inadequate quality assurance reviews.

As a result, VBA caused undue hardship for veterans, did not ensure taxpayer dollars were appropriately spent, and generated excessive work, resulting in significant costs and the diversion of VA personnel from veteran care and services.

The OIG made four recommendations. VBA concurred with three of the recommendations and concurred in principle with one. All four of the recommendations have been closed. However, two of four recommendations were closed as unimplemented. The unimplemented recommendations relate to establishing internal controls to ensure reexaminations are necessary and conducting a review of claims with unnecessary examinations for data-gathering purposes. These two recommendations will be discussed in an upcoming OIG follow-up report to this initial review.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: September 12, 2022

From: Under Secretary for Benefits (20)

Subj: OIG Management Advisory Memorandum — VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs

To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached is VBA's response to the OIG Management Advisory Memorandum — VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs.

The OIG removed point of contact information prior to publication.

(Original signed by)

Joshua Jacobs

Senior Advisor for Policy, Performing the

Delegable Duties of the Under Secretary for Benefits

Attachment

Attachment

Veterans Benefits Administration (VBA)

Comments on OIG Management Advisory Memorandum

VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs

The VBA provides the following comments:

VBA does not concur with the findings within the OIG Management Advisory Memorandum (MAM), "VBA Has Opportunities to Further Incorporate I CARE Values When Planning, Implementing, or Overseeing Programs." VBA Leadership and staff ensure Veterans and beneficiaries are at the center of everything we do, and all decisions made. We hold ourselves accountable both internally and to those we serve, remaining accountable for all decisions and outcomes, and steadfast in correcting errors when identified. Many VBA employees have family and friends who served, are still serving, or are among the 57% of VBA employees who are Veterans themselves. Our workforce is honored and dedicated to serve all Veterans, including those closest to them through the I CARE principles. Although VBA concurred, or concurred in principle, with the OIG reports and recommendations referenced within the MAM, we strongly oppose the implication that VBA did not always fully consider the effect organizational decisions would have on Veterans, beneficiaries, and their families, and offer additional explanation below.

Exempt Veterans Charged VA Home Loan Funding Fees

VBA does not concur with OIG's delineation connecting its previous engagement, "Exempt Veterans Charged VA Home Loan Funding Fees", as an indication of VBA's non-compliance in demonstrating adherence to I CARE values. In previous responses to OIG, VBA provided extensive commentary detailing a complex environment with many competing priorities and limited resources. Furthermore, there were many unanswered legal questions about retroactive funding fee exemptions. VBA demonstrated commitment to I CARE values by prioritizing and implementing many processes, resulting in expanded program access to qualifying Veterans. For example, at the time of the OIG audit, the majority of cases involved a retroactive rating. In most cases, at the time of loan closing, Veterans were not in receipt of disability compensation and were correctly charged a funding fee. It was not until later, when there was a retroactive rating that a refund was determined. While VBA ultimately concurred in principle and agreed to implement OIG's recommendations, VBA did not concur with some of the OIG's findings and conclusions regarding operational practices, historical context, and leadership decisions. As a result, VBA cannot concur with OIG's assertions in this memorandum regarding I CARE values when planning, implementing, or overseeing programs.

Operational Practices: Until the engagement with OIG, VBA had treated funding fee exemptions as a benefit requiring the Veteran, who retroactively became exempt due to a determination made after the date of their loan closing, to apply for a funding fee refund. VA notified Veterans and lenders that if Veterans are rated for VA disability compensation before closing on a VA loan, they may be eligible for a waiver of the funding fee. VA guidance noted that if a Veteran's disability compensation award date is made retroactive prior to a previous VA home loan closing, the Veteran may be entitled to a funding fee refund. VA had communicated this in its Lenders Handbook and Internal Operations Manual (M26-1). Veterans were notified to contact Loan Guaranty Service (LGY) once they were awarded compensation for a service-connected disability to apply for a funding fee refund so that LGY could review their case considering the date of loan origination and the compensation award date to determine if a funding fee refund was warranted. This operational precedent was supported by the design of many of LGY's

oversight controls, which were operationalized to ensure a proper determination was made regarding the funding fee refund decision once a Veteran applied for a refund.

Historical Context: In the draft report, OIG acknowledged the legal complexities of this operational precedent by observing, "VA's Chief Counsel, Loan Guaranty National Practice Group, Office of General Counsel, stated that whether an application is required depends on how VA classifies funding fee refunds. If VA classifies these refunds as a benefit, then an application form is required. Conversely, if VA classifies these refunds as overpayments received by VA, then VA should return the amounts overpaid" (p.10). While LGY opted not to pursue this line of inquiry with the Office of General Counsel (OGC), and instead decided to re-evaluate the historical precedent guiding its operational practices by contacting the Veterans affected and initiating funding fee refunds, OIG's statements on this issue illuminated the fact that there were many unanswered questions regarding the legalities of LGY's historical practices and assumptions regarding VA's classification of funding fee refunds.

Leadership Decisions: Additionally, OIG reviewed LGY's funding fee activity from 2012 through 2017. This is a time when the program experienced an unprecedented growth. LGY was contending with workload considerations due to record loan volume from 2012 through 2018. For example, VA guaranteed almost 540,000 loans in fiscal year (FY) 2012 (a record at the time) only to be followed by subsequent years of record loan volume of approximately 629,000, 631,000, 705,000, and 740,000 in 2013, 2015, 2016, and 2017, respectively. It is also important to note that the program experienced a 300% increase in loan volume from 2008 (i.e., around the time of the housing crisis) to 2017. During this same timeframe, Certificates of Eligibility (COEs) for the VA home loan benefit were being processed at only one Regional Loan Center (RLC) in Atlanta. By having only 35 dedicated LGY staff members at one RLC responsible for issuing all COEs nationally during a time of unprecedented growth in VA loan volume, timeliness was beginning to suffer, inhibiting Veterans' access to their home loan benefit and delaying loan closings which could result in lost contracts. At one point, COEs were being processed in 26 days on average, and many cases were taking even longer. For this reason, LGY leadership decided to prioritize nationalization by distributing COE requests across staff at all RLCs. Because of the efficiencies from nationalization, COEs are now processed in 1.9 days on average, allowing more Veterans to take advantage of their home loan benefit in a timely manner.

Along with the record increases in loan volume, LGY also experienced a parallel increase in phone call volume. In 2015, annual call volume was near 1,000,000 calls annually with a 40-50% blocked call rate and 20-30-minute wait times during peak periods. Because the biggest grouping of phone calls received were inquiries on COEs, the statistics in Atlanta (which was the sole processor of LGY COEs at the time) were far worse. LGY moved to redistribute the call queue (based on callers' area codes) so that the staff in Atlanta could work to process COE requests while LGY worked to nationalize COE processing to all RLCs. However, these initiatives did not provide the full degree of improvement sought. Swift action was needed to serve Veterans who were closing on loans and needed to have their telephone calls answered promptly. LGY leadership was forced to respond to the changing market conditions by diverting additional staff and resources to keep pace with demand and ensure Veterans had access to their home loan benefit. This effort resulted in the implementation of a nationwide telephone system with average wait times under 30 seconds and no blocked calls.

At the same time, LGY was focused on addressing the burgeoning number of unassigned and untimely appraisals. In the first quarter of FY 2017, LGY posted an astounding Appraisal Assignments Pending figure of over 4,000 cases. The appraisal timeliness figure was 17.8 days at the end of FY 2016, and 18.8 days at end of FY 2017. Worse yet, in several troublesome counties in the US, appraisal timeliness was significantly higher; in some areas we saw appraisal delays of up to 32 days in FY 2016; and 54 days in FY 2017. Numerous Veteran and Congressional complaints were being received, and in April 2017, the

House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity summoned LGY's Director to testify on this issue in an oversight hearing. Fortunately, actions taken to address the situation were largely successful in decreasing the number of pending appraisals and increasing appraisal timeliness. Following the hearing, staff were directed to continue their tight focus on ensuring an appropriate appraiser roster numbers that were in-line with demand, and on monitoring and triaging the weekly unassigned cases list to ensure Veterans were getting their appraisals in timely fashion. In addition to the noted challenges, LGY was also working to resolve competing priorities such as the redesign/re-platforming of the VALERI system to assist Veterans in default on their loans and preventing foreclosures and addressing serial refinancing and predatory refinancing. This was an increasingly complex issue that also led to an oversight hearing. This was done in the backdrop of a record level volume in home loans, SAH grants, and foreclosure assistance.

As OIG previously documented, around October 2014, the St. Paul RLC elevated a concern to LGY leadership indicating their belief that approximately 48,000 Veterans may be eligible for funding fee refunds totaling approximately $151 million based on funding fees collected between October 2006 and May 2014. According to the analysis presented to LGY leadership, most of these cases were the result of a retroactive award of compensation for a service-connected disability, meaning that at the time of loan origination, the Veterans were correctly charged the funding fee. At the time, the St. Paul RLC estimated that it would take eight VA staff members (approximately 50 percent of their loan production staff) one year to refund the funding fees identified. LGY noted several discrepancies with St. Paul's data, including the fact that their estimate did not consider the fact that many of the loans on which funding fees were collected had since been paid in full, refinanced, transferred, and/or terminated, adding additional complexities to locating the loan holder and documenting the principal balance reduction. At the time, LGY leadership estimated that it would take, at a minimum, 12 VA staff members devoted to this process for an entire year to complete this undertaking.

Between 2012 and 2017, LGY issued over 19,700 funding fee refunds totaling approximately $97 million. OIG's report did not consider the historical context within which these decisions were being made. When viewed through this context, it is clear that the unprecedented market conditions, demand on LGY resources required to deliver benefits to Veterans, and the historical operational precedent requiring Veterans to contact LGY once they were awarded compensation for a service-connected disability, weighed heavily on the decisions made to focus resources on system and process enhancements to improve the accuracy of COE determinations and benefits delivery.

Despite the historical context and operational precedent delineated above, LGY leadership determined when the resources were available to serve the volume of appraisals, COEs, calls and other work that enables Veterans to access their benefits, to re-evaluate operational practices and to develop processes for actively identifying Veterans who are (a) funding fee exempt at the time of loan origination, and (b) become funding fee exempt after loan origination as the result of a retroactive award and proactively issue refunds. LGY responded intentionally, with staff members across the service volunteering to work overtime to address this issue and was able to implement all of OIG's recommendations and get closure within six months of the report and continues to proactively identify Veterans who become retroactively exempted from the funding fee and issue refunds. There are many factors that affect a program at any given point in time. The actions taken by LGY to better serve Veterans and ensure continued access to the home loan benefit, as well as our overwhelming response to OIG's process improvement recommendations regarding funding fees demonstrates our commitment to I CARE values. LGY not only addressed an issue but has created a process that has continued since the original finding was resolved to ensure funding fee refunds continue to be processed appropriately. Therefore, VBA non-concurs with

OIG's assertion that VBA did not always fully consider the effect organizational decisions would have on Veterans, beneficiaries, and their families.

Improper Processing of Automated Pension Reductions

VBA considered the I CARE value of commitment, which requires VA employees to work diligently to serve Veterans and other beneficiaries, be driven by an earnest belief in VA's mission, and fulfill their individual and organizational responsibilities in its decision to automate pension reductions based on Social Security Administration (SSA) Cost of Living Adjustments (COLAs). VBA's decisions related to this process were focused on the Veterans and beneficiaries to reduce the burden of overpayments. Additional benefits of claims processing timeliness improvement and freeing up resources were also considered to further improve customer service throughout the pension program.

On page 3 in paragraph 2, OIG alleged that VBA negatively impacted Veterans and beneficiaries by proposing the most adverse action possible in the automated processing of COLA cases. VBA's approach took what it determined to be the most appropriate action to minimize the burden on the Veteran/beneficiary. Requiring a second due process period would have unnecessarily extended the time between when the discrepancy was identified, and award adjustment action was taken. This additional delay would have subsequently increased the overpayment amount on the veteran/beneficiary. As a result of these actions, VBA was able to take the appropriate action after the initial due process period expired and minimize the overpayment burden on the veteran/beneficiary.

Additionally, on page 3 in paragraph 2, OIG alleged that the automated system failed to account for the Supplementary Medical Insurance Benefit (SMIB). During the automated processing of COLA cases, the SMIB is not available. This is because the COLA process is completed without direct input from SSA. Exact new SSA rates and new SMIB rates are not made available by SSA until well into the applicable calendar year. By processing COLA cases with the calculated SSA rate, VBA is able to reduce the overpayment burden on the Veteran/beneficiary. Further, if VBA had delayed actions in order to include SMIB, it would create an additional burden on the Veteran/beneficiary and increase the overpayment. It is important to VBA, to minimize wherever possible the overpayments created for Veterans and beneficiaries, not only to provide better customer service, but also to meet VBA's requirements to reduce improper payments under the Payment Integrity Information Act of 2019.

VBA has internal controls in place across all its areas of responsibility to ensure oversight and accountability and evaluate its decision-making effectiveness. In the instance of the automated processing of COLA cases, annual testing is conducted to ensure that the annual COLA rates and adjustment for pension benefits are executed successfully. VBA and its partners in VA's Office of Information Technology (OIT) work year-round on this critical project to ensure monetary benefits keep up with the pace of inflation. Additionally, Special Focused Reviews (SFR), on a random sample of cases from a particular population (e.g., initiative, claim type, etc.) are conducted to ensure the accuracy of each case. VBA conducted an SFR on this very process in March 2020 and identified issues. VBA began to take corrective action ahead of OIG's audit.

VBA's goal is to minimize the overpayment burden on its Veterans and beneficiaries and to reduce the time it takes to finalize these decisions. Overall, VBA has demonstrated its I CARE values not just in its reasoning behind the initial decision to automate this process, but also in its willingness to adjust based on self-identified challenges and OIG's feedback. VBA remains committed to providing the best customer service it can to Veterans and beneficiaries.

Records Management Center Disclosed Third-Party Personally Identifiable Information to Privacy Act Requestors

VBA goes to great length to ensure Veterans' records and their personally identifiable information (PII) are protected. In response to the OIG MAM, VBA did not intentionally put Veteran's information at risk when implementing changes to the Privacy Act release policy. In May 2016, VBA changed its Privacy Act release policy only after VA's Office of General Counsel determined there was legal support for releasing unredacted records. Though the policy allowed releasing unredacted records if VBA purposely included the information in the requester's record, VBA put in place exceptions where VBA will continue to redact third party PII from any federal or military criminal investigation record in conjunction with a request for records. Furthermore, VBA implemented multiple safeguards to further protect Veterans' PII. VBA required employees to review, classify, and place proper controls on all incoming mail prior to associating the mail with a claim folder. This process ensured the mail is associated with the correct claim's folder and the correct documents are uploaded into the correct claim folder. Hence, ensuring VBA only release records where VBA purposely included the information in the requester's record.

Though VBA acknowledged and agreed to implement OIG's recommendations, VBA did not concur with OIG's finding that VBA knowingly put Veterans at risk in an effort to reduce the Privacy Act request backlog. Each VBA employee is committed to VA's five "I CARE" core values and behaves with ***I***ntegrity and ***R***espect of Veterans' information.

In response to OIG's finding, VBA has put in place effective internal controls and ensured Veterans' personal information are protected and properly disclosed. These include:

- VBA continues to assess and fine tune its Privacy Act (PA) release policy to ensure its compliance with the redaction of PII. As of August 2022, VBA has begun revising the Privacy Act release policy, VBA letter 20-19-09, to further safeguard Veterans' information. To ensure proper handling of Veterans' records while holding employees accountable, the revision includes designating Government employees in the final quality check prior to releasing Veterans' information, defining commingled third-party information to be redacted, adding clarification language for Freedom of Information Act (FOIA)/Privacy requests and 38 USC § 7332, and the confidentiality of certain medical records.
- Ensuring Veterans and Service members are fully aware of their fundamental rights; VBA's website is updated with the current VBA Privacy Act release policy regarding release of third-party PII.
- VBA implemented FOIA Modernization procedures to ensure its Centralized Support Division (CSD), formally known as Records Management Center (RMC), complies with requirements for mailing Privacy Act requests in accordance with VA Directive 6609, which requires employees to encrypt, and password protect discs mailed to requestors. The process would integrate FOIA processing with Centralized Intake, automating requests for records electronically and securely while adhering to FOIA/PA laws and VA Directives.
- VBA upholds protecting Veterans' records. When breaches were identified during site visits at the CSD, VBA acted immediately to ensure corrective actions were put in place. A Site Visit Standard Operating Procedure/Checklist was developed and is used as a tool to ensure compliance with requirements for mailing Privacy Act responses. Furthermore, the CSD implemented an internal plan to improve quality reviews and ensure employees were held accountable for the accuracy of Privacy Act releases.

- VBA is collaborating with VA Enterprise to remove Social Security Numbers (SSN) in accordance with the SSN Fraud Prevention Act of 2017 and Consolidated Appropriations Act of 2018.

Unwarranted Medical Reexaminations for Disability Benefits

OIG has historically assessed VA's improvements to audit recommendations considering facts and findings from the review, but also based on their opinion of how activities should be implemented. Recommendation 1 in the Unwarranted Medical Reexaminations for Disability Benefits Report recommended VBA establish internal controls sufficient to ensure reexamination is necessary prior to employees ordering the exams. VBA concurred with the recommendation and took action to develop a recurring Tableau report that provides monthly data on future reexamination diaries as a measure on internal controls. In OIG's January 8, 2019, January 17, 2019, and April 17, 2019, responses, they affirmed that VBA provided evidence of the internal control as documented in the recommendation, but they also opined that "VBA needs to provide evidence that RVSRs are making the determination on whether a reexamination is necessary. RVSRs are the employees who have the expertise to review medical records to determine whether available medical evidence is sufficient to continue the current evaluation and/or cancel future reexaminations."

On May 13, 2019, VBA disagreed with OIG's comment that RVSR employees be required to make the determination on whether a reexamination is necessary to implement the recommendation. OIG's position to require an RVSR make this determination dictates an assignment of VBA's workload and job responsibilities for VBA employees. Not only does OIG's opinion of which personnel should take specific actions go against OIG's position that they do not prescribe actions for VBA, this comment of mandating RVSR workload is not supported by evidence. There was no data presented during the OIG's review that showed a significant distinction in error rates or quality between RVSR and non-RVSR employees to support OIG's position. Therefore, VBA updated OIG that we maintain our original position, that this work will be completed by VBA employees within the rating activity or other locally designated claims processors with demonstrated expertise. This was also clarified in the Procedures Adjudication manual in February 2019, where Compensation Service updated text to reflect that all matured review examination controls be referred for review by the rating activity or other locally designated claims processors with demonstrated expertise in review-examination ordering. VBA employees entrusted to make these reexamination determinations at any level have been fully trained to review Veteran records appropriately.

Finally, VBA provided OIG with a status update following the completed Routine Future Examination (RFE) Review Project (October - November 2020) which showed a higher accuracy rate for VSRs (84.65%) compared to the RVSR accuracy rate (62.96%) when ordering exams for EP 310s. This further negates OIG's longstanding opinion that RVSRs, as decision makers, are the only personnel with knowledge and experience to determine whether examinations are necessary. OIG's reference to this specific report as evidence that VBA's actions imply non-committal to VA's I CARE values is incorrect.

VBA implemented several internal controls and procedural changes to ensure reexaminations are warranted including:

- Creating recurring Tableau reports,
- Updating applicable manual references,
- Revising quality checklists to capture unnecessary RFEs,
- Conducting consistency studies on RFEs to assess performance,
- Conducting a targeted RFE review by RO and

- Communicating deficiencies and best practices to the field on multiple occasions.

Additionally, VBA evaluated data on reexaminations and their disability rating outcomes and revised its procedures by issuing Policy Letter (PL) 21-01, *Updated Guidance on Routine Future Examinations*, on October 7, 2021, to address the OIG report findings. This PL revised procedures to further reduce the need for reexaminations.

VBA remains committed to the I CARE values, as we are passionate about serving Veterans and their beneficiaries through integrity, commitment, advocacy, respect, and excellence in every part of our day-to-day work.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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