



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

The Systematic Technical
Accuracy Review Program
Has Not Adequately
Identified and Corrected
Claims-Processing
Deficiencies

REVIEW

REPORT #19-07059-169

JULY 22, 2020



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Executive Summary

Veterans rely on VA to make timely, accurate, and consistent decisions on disability compensation claims to ensure they receive the benefits to which they are entitled. The Veterans Benefits Administration (VBA) has a Compensation Service that provides oversight of the delivery of disability compensation benefits to veterans. The Systematic Technical Accuracy Review (STAR) program is one part of the Compensation Service's multifaceted quality assurance program to ensure disability compensation benefits are provided in a timely and accurate manner. The STAR program is intended to provide quality review and analyses of all elements of processing a specific claim. STAR quality reviews are performed on individual, randomly selected claims from across the country. According to VBA's Compensation Service, the mission of the STAR program is

To identify deficiencies in the claims process and provide meaningful feedback to all regional office employees, Congress, [the] VA Office of Inspector General (OIG), and other constituents, with the goal of improving the decision-making process and enhancing the quality of the decisions provided to all veterans and their beneficiaries.

STAR analysts perform quality reviews on randomly selected individual disability compensation claims to identify claims-processing deficiencies and provide feedback to improve decision-making. VBA uses the results of these reviews, which are reported to the public, to estimate claims-processing accuracy for each of its regional offices and the entire nation. If STAR team members fail to identify all deficiencies during a claim review or fail to provide appropriate feedback, VBA may not be able to effectively monitor services to veterans or improve the decision-making process and the quality of decisions.

The VA OIG sought to determine whether the STAR program

- Ensured accurate quality reviews,
- Included adequate procedures to ensure accuracy and timeliness on initiated and finalized corrective actions on STAR errors, and
- Provided feedback to management and staff to facilitate improvements in the decision-making process and enhance the quality of claims decisions to all veterans and their beneficiaries based on STAR's mission.

This review is one in a series of five VA OIG reports regarding VBA's quality assurance program.

What the Review Found

VBA did not take sufficient actions to make certain the STAR program fully achieved its stated mission of identifying deficiencies in the claims process and providing meaningful feedback to regional office employees. Consequently, VBA did not have the quality data needed to drive operational decisions and improve decisions provided to veterans and their beneficiaries.

The OIG team examined a statistical sample of 100 claims from which it estimated that about 55 percent of claims had deficiencies, including

- Benefit-entitlement errors that could affect veterans' disability compensation payments,¹ and
- Procedural deficiencies such as having to report for an unnecessary examination.

Other STAR issues included

- Problems with the process for correcting errors that resulted in untimely and inaccurate actions, and
- Feedback from reviews that did not enhance the quality of disability compensation claims decisions.

The OIG team found that the quality review process needs improvement. Under the STAR program, if a STAR analyst identifies errors, then that claim is examined by a senior reviewer. The OIG team estimated that benefit-entitlement and procedural deficiencies existed in 34 percent of claims reviewed by both a STAR analyst and a senior reviewer. The OIG team also found that STAR analysts were generally identifying benefit-entitlement errors and not placing as much emphasis on finding procedural deficiencies. The OIG team determined there was no formal process for reviewing procedural deficiencies. In addition, only claims with identified benefit-entitlement errors were subjected to a second review for validation by a senior reviewer. Moreover, senior reviewers who conducted second reviews also missed deficiencies as no comprehensive file review was done and they only focused on the deficiencies identified by the STAR analysts.

The OIG team found that the expertise and accuracy of the work of STAR staff could not be ensured, which also influenced the quality of the review process. STAR staff did not have nationally mandated claims-related training. In fiscal year 2018, VBA employees who processed claims were required to complete a minimum of 40 hours of claims-related training. STAR analysts and senior reviewers did not have this requirement.

¹ A benefit-entitlement error occurs when a claims processor takes an action that violates current regulations or other directives and affects the outcome or has the potential to affect the outcome of a veteran's claim, such as an overpayment or underpayment.

The OIG team also estimated VBA did not ensure that about 82 percent of claims requiring corrective actions based on STAR reviews were corrected accurately or in a timely manner. VBA's Office of Field Operations has control over the corrections process. However, the OIG team determined that VBA did not establish adequate policies, procedures, or monitoring to ensure corrections were completed in a timely and accurate manner. Thus, there was minimal bridging between the Office of Field Operations staff, STAR staff, and the regional offices to monitor, enforce, or otherwise ensure that accurate corrections were made in a timely manner.

Finally, the OIG team determined that the STAR program was not fulfilling its mission to provide meaningful feedback to all regional office staff to improve decisions provided to veterans and their beneficiaries. From the perspective of regional offices, STAR feedback was outdated and not readily accessible, and therefore not used to make operational changes. STAR reviews reached claims processors long after they had missed—and likely continued to miss—deficiencies, and the program's feedback was not helpful to regional office staff because it required extensive time to analyze and was housed in an electronic system that staff were still learning to navigate.

The deficiencies in the STAR program, combined with inadequate internal controls, make it more likely that VBA lacks the quality data needed to drive operational decisions. These shortcomings also undermine VBA's ability to ensure timely and accurate disability claim decisions for veterans.

What the OIG Recommended

The OIG recommended that the under secretary for benefits implement a plan to ensure STAR analysts focus on and assess all procedural deficiency elements included on the quality review checklist. The OIG recommended a formal second-review process when STAR analysts do not identify claims-processing deficiencies. In addition, the OIG recommended improving the current second-review process when STAR analysts identify claims-processing deficiencies and consider requiring senior reviewers to conduct a comprehensive examination of all issues assessed by the analyst. The OIG also recommended that the under secretary assess the current training requirements for STAR staff to increase the accuracy of reviews, and establish adequate policies, procedures, and monitoring to ensure corrections are completed timely and accurately. The OIG further recommended the under secretary develop a plan to provide quality review data and meaningful feedback to assist regional offices in improving the quality of decision-making.

Management Comments

The under secretary for benefits concurred with recommendations 1, 2, 3, and 5, and provided acceptable action plans. The under secretary concurred in part with recommendations 4 and 6. For recommendation 4, VBA agreed that some, but not all procedural errors have the potential to affect benefits. The under secretary provided an acceptable action plan whereby VBA's quality

assurance staff will work to categorize procedural deficiencies through a modification to the STAR quality review checklist, placing emphasis on critical errors. For recommendation 6, VBA noted that STAR enables regional offices to see error trend analyses so they may address them at the local level, and STAR facilitates stakeholder awareness of claims processing quality at the national level. The under secretary provided an acceptable action plan to convert STAR data into a format that is more usable and aligned with other types of reports currently used by regional offices. The OIG will monitor VBA's progress and follow up on the implementation of all recommendations until all proposed actions are completed.



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Abbreviations

OIG	Office of Inspector General
QMS	Quality Management System
QRT	Quality Review Team
STAR	Systematic Technical Accuracy Review
VBA	Veterans Benefits Administration



Introduction

Making timely, accurate, and consistent decisions on disability compensation claims is vital to ensuring that veterans receive the benefits they deserve. The Veterans Benefits Administration (VBA) Systematic Technical Accuracy Review (STAR) program is intended to provide quality review and analysis of all elements of processing a specific claim. STAR quality reviews are performed on individual, randomly selected claims from across the country. According to VBA's Compensation Service, the mission of the STAR program is

To identify deficiencies in the claims process and provide meaningful feedback to all regional office employees, Congress, [the] VA Office of Inspector General (OIG), and other constituents, with the goal of improving the decision-making process and enhancing the quality of the decisions provided to all veterans and their beneficiaries.

The VA OIG conducted this review to determine whether the STAR program

- Ensured accurate quality reviews,
- Included adequate procedures to ensure accuracy and timeliness on initiated and final corrective actions on STAR errors, and
- Provided feedback to management and staff to facilitate improvements in the decision-making process and enhance the quality of claims decisions to all veterans and their beneficiaries based on the STAR program's mission.

Entities Related to the STAR Program

As shown in figure 1, the VBA entities associated with the STAR program are the Compensation Service and the Office of Field Operations. STAR staff include consultants, referred to in this report as STAR analysts, and senior quality review specialists, referred to as senior reviewers.

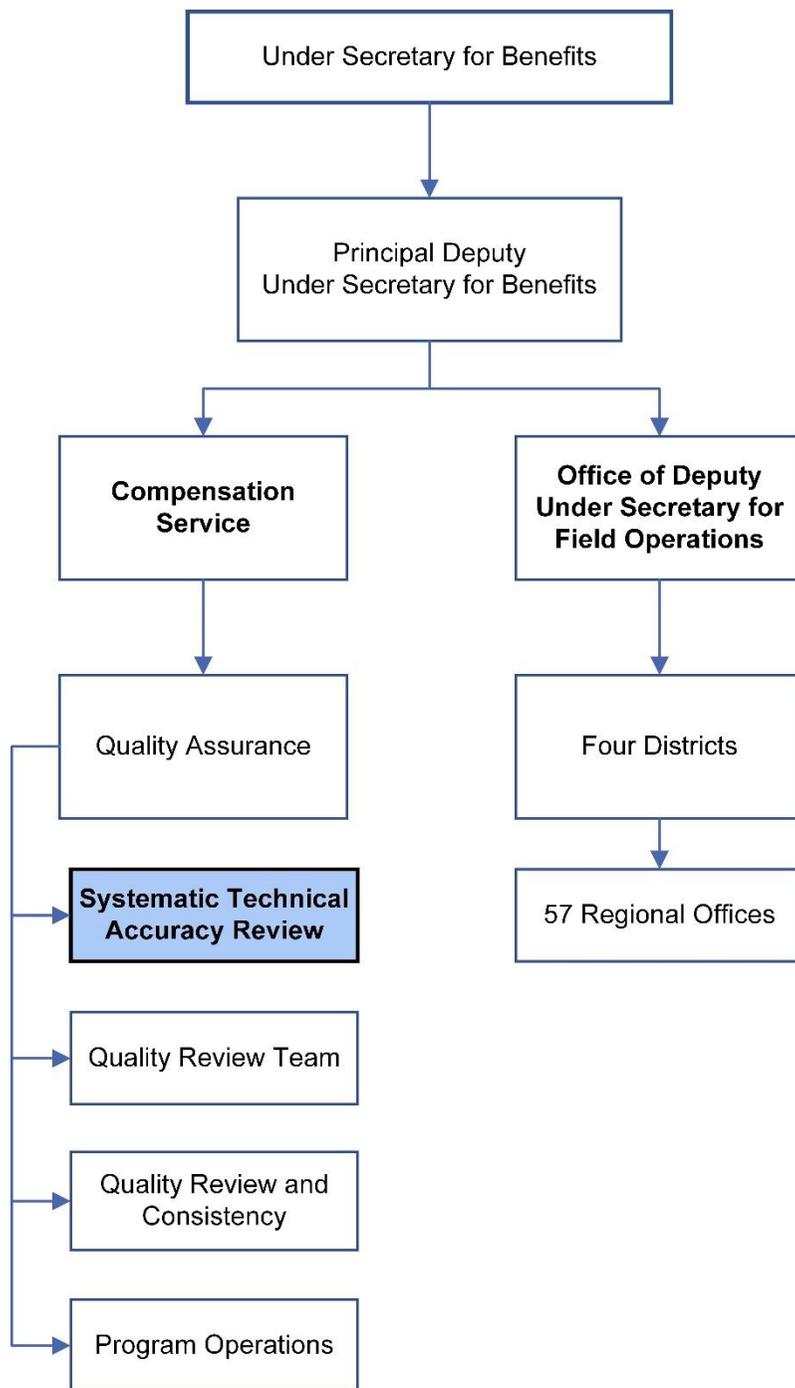


Figure 1. Organization of entities associated with STAR

Source: VA OIG analysis

Compensation Service

The Compensation Service provides oversight of the delivery of disability compensation benefits for veterans. The STAR program is one part of the Compensation Service’s multifaceted quality

assurance program to ensure disability compensation benefits are provided in a timely manner. During the OIG review period, the quality assurance program consisted of four components.

1. **STAR:** VBA uses this program to measure the accuracy with which compensation claims are processed nationwide. Results from these evaluations determine the quality statistics VBA reports to the public and are used in trend analyses to identify training needs. The reviews affect regional office quality metrics but do not affect employees' individual performance assessments.
2. **Quality Review Team program:** Staff conduct quality reviews of regional office employees and perform error trend analyses to identify areas for training and mentoring. The purpose of the program is to enhance quality in every VBA facility that processes compensation claims. Per the Compensation Service executive director, quality results are not made available to the public.
3. **Quality Review and Consistency program:** This program assesses regional office variance in disability ratings for the most frequently rated disabilities, conducts studies to evaluate the consistency of raters across regional offices, and provides guidance to quality review teams.
4. **Program Operations** (the site visit program): Staff conduct site visits to review veterans service center operations, maintain the quality assurance manual, review and approve changes to controls for pending workload, and provide special assistance to regional offices and other stakeholders regarding compensation.²

The STAR and Quality Review Team (QRT) programs both focus on claims-processing accuracy. QRT reviews are completed on the work of a single employee, while STAR reviews are completed on the entire claim, which includes the work of multiple employees. Errors cited by STAR are broken into two categories: (1) benefit-entitlement errors that may affect the outcome of a veteran's claim, such as an overpayment or underpayment; and (2) procedural deficiencies that do not affect the outcome.

STAR Analysts and Senior Reviewers

STAR analysts assess the processing accuracy of disability compensation claims nationwide. The quality assurance program includes STAR analysts who identify deficiencies using the STAR quality review checklist and senior reviewers who perform peer reviews of claims in which STAR analysts identified errors. STAR analysts are required to have one year of specialized experience related to the quality assurance position; senior reviewers are higher-level employees who review analysts' work. The STAR staff consists of 12 analysts and the peer review team

² VBA restructured the quality assurance program in June 2019 with no significant impact to this report.

consists of six senior reviewers. Both teams report to the Compensation Service quality assurance director.

Office of Field Operations

The Office of Field Operations oversees operations at VBA's district, regional, and other field offices to ensure that VBA delivers benefits and services effectively and efficiently. In terms of the STAR program, this office is responsible for ensuring corrective action is taken on deficiencies identified in reviews.

The office is also responsible for the following as related to the STAR program:

- Developing achievable performance measures that ensure timeliness, quality, and consistency of benefits
- Evaluating the performance of regional and other field offices
- Overseeing operations at VBA's regional offices, including managing staff to ensure adherence to established policies and procedures regarding STAR error corrections

History of the STAR Program

In October 1998, the STAR program was established to comply with the Government Performance and Results Act. The purpose of the program was to ensure consistency in assessing accuracy at the national and regional office levels. Results from STAR evaluations determine VBA's quality statistics that are reported to the public. STAR quality review checklists were designed to facilitate consistent structured reviews of claims. The 1998 checklist had eight review elements and 21 categories to assess the accuracy of claims-processing actions; the most current version of the rating quality checklist has 16 claim review elements and 166 categories.

In fiscal year 2013, VBA began calculating issue-based accuracy in addition to claim-based accuracy. Claim-based accuracy is an all-or-nothing measure. A claim with 10 issues is considered 0 percent accurate if even one issue was incorrectly processed. Issue-based accuracy is more granular. That same claim is considered 90 percent accurate if nine out of 10 issues were properly processed. VBA's claim-based accuracy rate is determined by dividing the total number of cases that have a benefit-entitlement error by the total number of cases reviewed, whereas issue-based accuracy is determined by dividing the total number of issues with benefit-entitlement errors by the total number of issues reviewed. VBA has continued to report both claim-based and issue-based quality measures. According to VBA's sampling methodology,

“as a result of the two different accuracy criteria and calculations, the issue-based accuracy will result in higher accuracy rates compared to the claim-level accuracy rate.”³

STAR Program Review Process

VBA guidelines state that the quality review process is intended to assist managers in monitoring services to veterans.⁴ Each month, the Office of Performance Analysis and Integrity generates a list of claims for national quality review by STAR staff. These claims are a random sample from those completed during the previous month. Completed means that the claims have been decided and the decisions have been communicated to the veterans or their beneficiaries. The STAR program uses an electronic system called the Quality Management System (QMS) to assign, track, and complete quality reviews.

A STAR review assesses the accuracy of all claims-processing actions, including the final decision on a claim. Actions include

- Gathering information,
- Developing the claim,
- Rating the claim (for example, by assigning a percentage that indicates the severity of the disability), and
- Authorizing the claim.

The review process is shown in figure 2.

³ VBA, Quality Assurance Sampling Methodology, July 24, 2019.

⁴ Historical VBA Manual 21-4, chap. 3, sec. 3.01.c, “Quality Review and the VSC,” updated November 28, 2016.

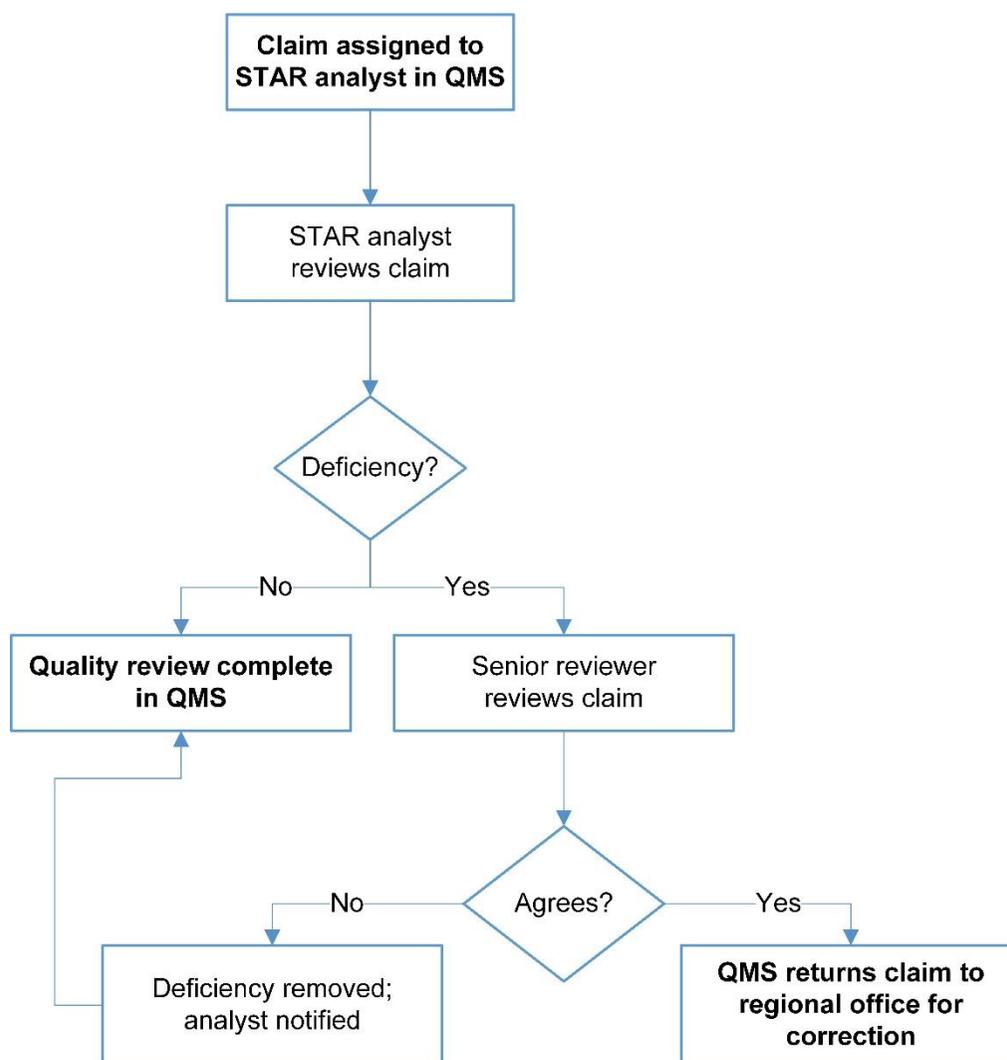


Figure 2. STAR review process

Source: VA OIG analysis of STAR quality review process

STAR analysts identify benefit-entitlement errors and procedural deficiencies. A benefit-entitlement error occurs when a claims processor takes an action that violates current regulations or other directives and affects the outcome, or has the potential to affect the outcome, of a veteran’s claim.⁵ For example, an error might result in an overpayment or underpayment to a veteran. When STAR analysts identify this kind of error, they are required to record it in QMS, which automatically forwards the claim to a senior reviewer for validation.

⁵ Historical VBA Manual 21-4, chap. 3, sec. 3.03.b, “General Guidelines for BE Quality Reviews,” updated January 26, 2018.

A procedural deficiency generally does not rise to the level of a benefit-entitlement error.⁶ Procedural deficiencies are recorded in QMS, but do not get forwarded to a senior reviewer for validation. An example of a procedural deficiency would be establishing an unnecessary routine future examination. STAR program staff assess these deficiencies in regional offices each month for quality improvement purposes.

⁶ Historical VBA Manual 21-4, chap. 3, sec. 3.03.d, “Procedural Deficiencies,” updated January 26, 2018.

Results and Recommendations

Finding: VBA Has Not Effectively Managed the STAR Program to Fully Achieve Its Mission

VBA did not take sufficient actions to ensure the STAR program fully achieved its stated mission of identifying deficiencies in the claims process and providing meaningful feedback to regional office employees. Consequently, VBA did not have sufficient data to drive operational decisions and improve claims decisions for veterans and their beneficiaries.

The OIG team estimated from a sample of 100 claims that the STAR staff inaccurately performed about 55 percent of the 2,783 quality reviews they completed from July 1 through September 30, 2018. The inaccuracies included both benefit-entitlement errors and procedural deficiencies. The OIG team also identified problems with the process for correcting errors identified during STAR quality reviews. The OIG team estimated that for 291 of 355 cases requiring corrections (82 percent), actions were not initiated within the required 30 days, were not accurate, or mandatory notes explaining the specific corrective actions taken were not entered in the Veterans Benefits Management System.

Further, the OIG team determined that feedback from STAR quality reviews was not enhancing the quality of disability compensation claims decisions. STAR feedback was delayed in reaching the claims processors in regional offices who made the errors, and aggregate data posted on the STAR website were difficult for individual offices to use in making operational decisions. The deficiencies identified by the OIG team existed because VBA's systems and processes designed to ensure the STAR program met its mission were ineffective.

What the OIG Did

This review is one in a series of five VA OIG reports regarding VBA's quality assurance program and covered a population of 2,783 STAR quality reviews that were completed during the review period of July 1 through September 30, 2018. The OIG team chose this time period to ensure VBA staff had sufficient time to correct errors that STAR analysts identified. From the population, the OIG team analyzed a statistical sample of 100 quality reviews to assess compliance with VBA's claims-processing manual and the quality review checklist. The sample included quality reviews for which STAR analysts did not identify any benefit-entitlement errors and quality reviews for which STAR analysts identified one or more benefit-entitlement errors. The team used VBA's electronic systems, including QMS and the Veterans Benefits Management System, to review the sampled cases and relevant documentation. The team discussed the case reviews with VBA officials and included their comments in the report as appropriate.

The OIG team also did the following to accomplish the objectives of this review:

- Interviewed management and staff at VBA’s central office in Washington, DC, and at the STAR program office in Nashville, Tennessee
- Examined regulatory requirements, documentation, and actions applicable to the national quality assurance program
- Conducted site visits to regional offices in Boston, Massachusetts; Los Angeles, California; Providence, Rhode Island; and San Diego, California

The following sections illustrate how

- STAR quality reviews did not adequately identify claims-processing deficiencies,
- Claims-processing deficiencies identified by STAR analysts were not corrected timely or accurately by regional office staff, and
- STAR feedback and data were not beneficial to enhance the quality of claims decisions.

STAR Quality Reviews Did Not Adequately Identify Claims-Processing Deficiencies

As mentioned above, the OIG team estimated that STAR analysts did not identify all claims-processing deficiencies in about 1,529 of 2,783 STAR quality reviews completed during the review period (55 percent). This included approximately 869 missed benefit-entitlement errors (31 percent) and 1,064 missed procedural deficiencies (38 percent). Some quality reviews missed both benefit-entitlement errors and procedural deficiencies.

Missed claims-processing deficiencies were identified in two categories: (1) quality reviews in which the STAR analysts identified a benefit-entitlement error, and (2) quality reviews in which the STAR analysts did not identify a benefit-entitlement error.

STAR Reviews in Which a Benefit-Entitlement Error Was Identified

The OIG team determined that STAR analysts identified a benefit-entitlement error in 355 of the 2,783 quality reviews examined (13 percent). When a STAR analyst identifies a benefit-entitlement error during a quality review, the claim goes to a senior reviewer for a second review and validation. The senior reviewer examines documentation material relevant only to the error identified. If the senior reviewer agrees with the error, the claim goes back to the regional office for correction or further action based on the error identified. If the senior reviewer disagrees with the error identified by the STAR analyst, the senior reviewer removes it and no further action is taken. Despite this process, the OIG team estimated that additional claims-processing deficiencies were missed in about 121 of the 355 quality reviews (34 percent) when a STAR analyst had identified a benefit-entitlement error and a procedural deficiency that was validated by a senior reviewer. Of the 355 claims, the OIG team estimated that 92 claims

contained missed benefit-entitlement errors (26 percent) and an additional 92 claims contained missed procedural deficiencies (26 percent).

Example 1 provides details on a quality review in which the STAR analyst identified one deficiency but missed another.

Example 1

A STAR analyst identified deficiencies in the processing of a veteran's claim. However, the OIG team found an additional deficiency that neither the STAR analyst nor the senior reviewer identified. The claims processor failed to grant service connection for a left knee disability, despite the medical evidence and military treatment records indicating the disability occurred in service. The left knee disability warranted a 10 percent evaluation.⁷ At the time of the OIG team's review, the veteran had yet to be granted entitlement to the benefit. While this will not change the veteran's current monetary benefit, the veteran could be entitled to an ancillary benefit such as special monthly compensation.⁸

STAR Reviews in Which No Benefit-Entitlement Error Was Identified

The OIG team estimated that STAR analysts did not identify a benefit-entitlement error in 2,428 of the 2,783 quality reviews examined (87 percent). The STAR quality assurance officer noted that if a STAR analyst does not identify a benefit-entitlement error during a quality review, no second review is conducted and no further action is taken. The OIG team estimated that claims-processing deficiencies were missed in about 1,408 of those 2,428 quality reviews (58 percent). This estimate included both benefit-entitlement errors and procedural deficiencies. Of the 1,408 claims in which STAR staff missed claims-processing deficiencies, 777 contained missed benefit-entitlement errors (32 percent) and 971 contained missed procedural deficiencies (40 percent). Since some reviews contained both benefit-entitlement errors and procedural deficiencies, the percentages do not sum.

Example 2 provides details on a quality review in which the STAR analyst did not identify a deficiency and no second review was performed.

⁷ 38 CFR § 4.1 states that "The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability."

⁸ VBA Manual 21-1, part 4, subpart 2, chap. 2 sec. H.1.a., "Definition SMC: Special monthly compensation is an additional level of compensation to veterans (above the basic levels of compensation payable based on disability ratings of 0 to 100 percent) for various types of anatomical losses or levels of impairment due solely to service-connected disabilities," September 9, 2019.

Example 2

A STAR analyst found no deficiencies in the processing of a veteran's claim. However, the OIG team found that the veteran was entitled to a higher evaluation from 2002 through 2017 for service-connected asthma based on the requirement for daily use of an inhaler, which the claims processor failed to grant. Because this deficiency has yet to be corrected, the veteran is owed more than \$52,000 in retroactive benefits.

Factors Contributing to STAR Analysts' Failure to Identify All Claims-Processing Deficiencies

The OIG team determined that multiple factors contributed to deficient quality reviews by STAR analysts. These factors included (1) an inadequate second-review process for quality reviews, (2) lack of a formal training plan for STAR analysts, and (3) less emphasis placed on procedural deficiencies.

Improvements Needed in Second-Review Process

The OIG team determined that the STAR second-review process needs improvements. The STAR process requires a comprehensive review associated with a specific claim. All the evidence associated with a claim must be reviewed to ensure all issues were correctly decided.⁹ STAR senior reviewers stated they validate the deficiencies that the analysts identified. They do not review all claims-processing actions leading up to and including the final decision for a claim. In addition, they noted their primary focus is to validate any deficiencies cited by the STAR analyst, although they will follow up on any additional deficiencies noticed. By not completing the required comprehensive review of the claims folder, the OIG team concluded that senior reviewers missed claims-processing errors that were also missed by the STAR analysts more than a third of the time.

Further, the STAR program's second-review process does not extend to those quality reviews for which STAR analysts did not identify a claims-processing deficiency. The STAR quality assurance officer stated that some spot-checking was done, but there is no formal schedule or selection of these claims for verification. The quality assurance officer agreed with the OIG team's assessment that STAR analysts failed to identify claims-processing deficiencies in claims reviewed and stated that STAR was planning to expand its second-review process to incorporate claims where STAR analysts did not cite any claims-processing deficiencies.

⁹ VBA Manual 21-4, chap. 3, sec. 3.03.a., "Quality Review Checklists," and sec. 3.03.f., "Reviewing All Evidence Associated with a Claim," updated January 26, 2018.

Recommendation 1 addresses the need for VBA to improve the current second-review process when STAR analysts identify claims-processing deficiencies and consider requiring senior reviewers to conduct a comprehensive look at all issues examined by the analysts.

Recommendation 2 calls for a formal second quality review process when STAR analysts do not identify claims-processing deficiencies.

No Formal Training Plan for STAR Analysts

Although VBA mandates annual claims-related training for all regional office employees who process claims, Compensation Service employees, including STAR staff, do not have a national training plan. For fiscal year 2018, approximately 11,400 claims-processing employees, managed by the Office of Field Operations, had formal training plans requiring a minimum of 40 hours of claims-related training to ensure their professional development and expertise. However, the OIG team's analysis of completed training during fiscal year 2018 showed that STAR analysts completed an average of only 19 hours, while six senior reviewers averaged 17 hours of claims-related training. The OIG team concluded that the lack of a formal training plan for STAR analysts and senior reviewers likely contributed to missed claims-processing deficiencies during quality reviews. The team further concluded that establishing a formal training plan, similar to that of claims-processing employees at the regional offices, would lead to improvements in this area.

A prior STAR supervisor, stated that, in her opinion STAR analysts were not adequately trained due to the pace of policy changes, and a formal training plan should be required. The STAR quality assurance officer said that since STAR has been pushed to review more cases, training has declined. He further stated that STAR needed a formal training plan.

Recommendation 3 relates to the need to assess the current training requirements for STAR staff and establish a formal training plan that promotes claims-processing expertise and accuracy.

STAR Placed Less Emphasis on Identifying Procedural Deficiencies

The OIG team estimated STAR analysts identified 175 of 2,783 procedural deficiencies (6 percent); however, the OIG team estimated 1,064 of 2,783 (38 percent) cases may have had procedural deficiencies. Based on the findings and statements from VBA staff, the OIG team determined that STAR placed less emphasis on identifying procedural deficiencies.

VBA's claims-processing manual requires analysts to perform a review and analysis of all elements of processing a specific claim or issue, including those relating to procedural deficiencies. Additionally, the quality assurance checklist, which STAR analysts are required to complete, includes questions related to both benefit-entitlement errors and procedural deficiencies.

The OIG team interviewed both the Compensation Service quality assurance director and the STAR quality assurance officer regarding STAR analysts' failure to identify all procedural deficiencies during claims reviews.

- The Compensation Service quality assurance director agreed that if an issue is listed on the checklist, it should be reviewed by the analyst for compliance. He stated he was unsure whether STAR staff de-emphasized procedural deficiencies.
- The STAR quality assurance officer stated he was not convinced that procedural deficiencies should be part of the checklist and opined that it may be more appropriate for the QRT program to assess procedural deficiencies. The quality assurance officer further stated that STAR has been focusing on outcome-based deficiencies and has not been tracking and assessing procedural deficiencies monthly or monitoring regional office adherence, as was previously required.

The OIG team also interviewed regional office staff who reported they generally did not receive feedback on procedural deficiencies that were identified in their reviewed claims. Some regional office staff did not remember receiving information or training on procedural deficiencies based on STAR reviews. Further, regional office management stated they did not notice many comments related to procedural deficiencies and did not receive regular feedback on procedural deficiencies from STAR.

The deputy under secretary for field operations stated that STAR analysts should have been identifying and assessing procedural deficiencies and monitoring regional office adherence to VBA's claims-processing guidance. The deputy under secretary further stated that identifying these deficiencies is important to help drive operational decisions, such as determining whether additional training is needed for VBA's claims processors. The OIG team concluded that the focus by STAR staff on identifying benefit-entitlement errors contributed to missed procedural deficiencies during quality reviews. The OIG team found only a small percentage of quality reviews in which STAR analysts identified procedural deficiencies.

Recommendation 4 relates to the need for VBA to implement a plan to ensure STAR analysts place more emphasis on and assess all procedural deficiency elements included on the quality review checklist.

Regional Office Staff Failed to Correct Identified Claims-Processing Deficiencies in a Timely or Accurate Manner

VBA guidance requires timely and proper correction of claims deficiencies. However, the OIG team estimated that about 291 of 355 of STAR quality reviews that required corrective actions (82 percent) were not corrected timely or accurately by regional office staff. Regional office staff did not initiate corrective actions within the required 30 days, take accurate actions, or enter mandatory notes in the Veterans Benefits Management System. Table 1 summarizes the

projected percentage of claims not properly corrected based on the results of the OIG team’s review.

Table 1. Percentage of Claims Not Properly Corrected

Deficiency	Percentage of Claims Affected
Correction was not initiated within 30 days, as required ¹⁰	54
Final correction was not completed accurately	46
Mandatory notes explaining corrective action were not entered in VBA’s electronic system, as required	51

Source: VA OIG analysis of statistically sampled STAR quality reviews completed during the review period

Note: Some reviews contained multiple deficiencies, resulting in percentages that do not sum

Example 3 provides details of a claim that was not corrected timely and Example 4 provides details of a claim that was not corrected accurately.

Example 3

STAR-cited benefit-entitlement error: The VBA claims processor assigned a 0 percent evaluation for service-connected psoriasis when the veteran was entitled to a 10 percent evaluation. The correction of this error would have increased the veteran’s combined evaluation from 10 percent to 20 percent and therefore would have increased his monthly payment. Corrective action was not initiated for 133 days after STAR staff notified the regional office of the error. The delay resulted in a retroactive award to the veteran of about \$1,200.

Example 4

STAR-cited benefit-entitlement error: The VBA claims processor assigned a 0 percent evaluation for service-connected right-hand disability when a 10 percent evaluation was warranted based on painful motion of the right index finger. After being notified of the error, the regional office made an inaccurate correction and failed to grant the proper 10 percent evaluation to which the veteran was entitled. The 10 percent did not affect the veteran’s overall rating or

¹⁰ VBA Manual 21-4, chap. 3, sec.5.g., “Time Limit for Corrective Action,” updated August 15, 2018. The correcting regional office is required to initiate and report the corrective action taken for each error within 30 days of notification of the error.

the benefit amount but could in the future, as combined evaluations may entitle the veteran to additional benefits.

Factors Contributing to the Untimely and Inaccurate Correction of Identified Claims-Processing Deficiencies

The OIG team determined that VBA did not establish adequate policies, procedures, or monitoring to ensure corrections were completed in a timely and accurate manner. For example, once a regional office receives notification of an error and initiates corrective action, STAR staff consider the correction process “complete” and perform no additional follow-up.

The Office of Field Operations has authority over the regional office staff making corrections. The deputy under secretary for field operations stated that regional offices are responsible for ensuring that corrections are made. He also stated he had not seen the errors the OIG team identified, but that the corrections should be completed accurately and in a timely manner.

STAR, as part of the Compensation Service, can follow up on the status of corrective actions identified during STAR reviews; however, they do not have authority over the VBA employees who need to make the corrections. The STAR quality assurance officer said STAR currently “has no teeth to get regional offices to make these corrections a priority” even though it should be involved in overseeing the corrections.

The OIG team determined that within the current organizational structure, there was minimal bridging between the Office of Field Operations, STAR, and the regional offices to monitor, enforce, or otherwise ensure that corrections are made timely and accurately. The Compensation Service executive director stated that she is aware of issues with corrections and that STAR personnel have been working with the Office of Field Operations and the regional offices for three years on resolving outstanding corrections, some of which date back to 2010. VBA has authority over all these parties and is in a position to establish a more effective structure.

Recommendation 5 involves establishing adequate policies, procedures, and monitoring to ensure corrections are completed timely and accurately.

STAR Feedback and Data Were Not Beneficial to Enhance the Quality of Claims Decisions

The OIG team determined that the STAR program was not fulfilling its mission to provide meaningful feedback to all regional office staff to enhance the quality of the decisions they make on veterans’ claims.

During fiscal year 2016, VBA implemented a national work queue, which is a workload distribution tool to enhance VBA’s productive capacity. The national work queue centrally manages the national claims workload by prioritizing and distributing claims across regional offices to maximize resources, improve processing timeliness, and better serve veterans.

However, the national work queue also impacted the ability of the STAR program to report regional office accuracy figures. The national work queue allows multiple claims processors throughout the country to work portions of a single claim. Some STAR analysts indicated it is difficult to identify the claims processors who should receive feedback.

Feedback Was Often Outdated

The OIG team obtained information indicating that the results of STAR reviews did not always promptly reach claims processors. According to the STAR quality assurance officer, STAR had a backlog of quality reviews because it did not have enough staff to complete them. He noted that another cause of the lag in feedback was STAR's process for communicating deficiencies to regional offices. The notification of a deficiency is sent by QMS to the regional office that finalized the claim, which is not necessarily the same office where the deficiency occurred. If the claims processor responsible for the identified deficiency is not an employee at the regional office where the notification is sent, the notification is forwarded via QMS to that employee's regional office for corrective action. A regional office management analyst stated that the responsible employee may not receive notification of missed deficiencies for months, at which point the employee no longer remembers the case and has likely continued to miss the same checklist item. Regional office management and staff interviewed by the OIG team expressed a preference for local quality data from the QRT program, which were up-to-date and helpful for training.

Feedback Was Not Readily Accessible

VBA management reported they have continued to expand the types of quality data and feedback channels to regional offices. This includes a quality assurance dashboard, reports, calls, and mentoring. They further stated the STAR reports webpage contains numerous reports designed to assist the field and enhance the quality of claims for veterans. However, through interviews with VBA staff, the OIG team obtained information indicating that regional offices did not find STAR feedback helpful because it required extensive time to analyze and was housed in an electronic system that staff were still learning to navigate.¹¹ Further, feedback took time to analyze because it lacked context and deficiencies were attributed to offices other than those responsible. A service center manager stated regional offices had to determine on a case-by-case basis whether reported deficiencies applied to them. Deficiencies were attributed to the last regional office to work the claim, which was not necessarily the office where errors or deficient processes occurred. STAR managers acknowledged that STAR feedback was not as useful as it could have been.

Regional offices also found that QMS, which VBA uses to manage the STAR quality review process and house the data, was not user-friendly. A management analyst noted regional office

¹¹ QMS was implemented in July 2017.

staff struggled to find the reports with feedback specific to a particular office. A quality assurance data analyst who is an expert system user agreed that navigation was not easy and said the system's many report options were overwhelming, so she could see that as causing a problem for regional office users.

The QRT chief stated he does not feel STAR data is as useful as it once was for providing information that helps regional offices take action. The Compensation Service executive director acknowledged that data provided by the QRT program are more meaningful than STAR data at the regional office level. The deputy under secretary for field operations stated, "I think the intent of the STAR program is sound, but not sure if it is measuring the right things or if the program can do more to align with local quality."

Recommendation 6 is meant to help VBA ensure the STAR program develops a plan to provide usable data and meaningful feedback that will assist regional offices in improving the quality of decision-making.

Conclusion

The OIG team found that multiple factors prevented VBA's STAR program from meeting its defined mission. Data quality was diminished because STAR staff did not identify all deficiencies on the quality review checklist on either the initial or second review. Additionally, the expertise and accuracy of STAR staff could not be ensured as there was no formal training plan. Corrections were not prioritized or monitored because there was minimal bridging between the Office of Field Operations, the STAR program, and the regional offices to enforce corrections. From the perspective of regional offices, STAR feedback was outdated, not in an accessible form, and not used to make operational changes. The OIG team concluded that the STAR program has not met its overarching mission. The deficiencies in the STAR program, combined with inadequate internal controls, contribute to VBA lacking the quality data needed to drive operational decisions. These shortcomings also undermine VBA's ability to ensure timely and accurate disability claim decisions for veterans. Unless VBA makes adjustments, resources will continue to be used without improving the quality of decisions for veterans and their beneficiaries.

Recommendations 1–6

The OIG made the following recommendations to the under secretary for benefits:

1. Improve the current second-review process for quality reviews when STAR analysts identify claims-processing deficiencies and consider requiring senior reviewers to conduct a comprehensive review of all issues assessed by the analyst.
2. Establish a formal second-review process for quality reviews when STAR analysts do not identify claims-processing deficiencies.

3. Assess the current training requirements for STAR staff and establish a formal training plan that promotes claims-processing expertise and accuracy.
4. Implement a plan to ensure STAR analysts place more emphasis on and assess all procedural deficiency elements included on the quality review checklist.
5. Establish adequate policies, procedures, and monitoring to ensure corrections are completed timely and accurately.
6. Ensure STAR develops a plan to provide usable data and meaningful feedback to assist regional offices in improving the quality of decision-making.

Management Comments

The under secretary for benefits concurred with recommendations 1, 2, 3, and 5, and provided acceptable action plans. To address recommendation 1, VBA will conduct a comprehensive assessment of the current primary and secondary review processes and implement best practices gleaned from other quality review constructs. To address recommendation 2, VBA noted that they implemented a formal review process in October 2019 for claims where no critical error was cited. VBA requested closure of the recommendation. Upon receipt, the OIG will review documentation on VBA's new process and assess closing the recommendation. To address recommendation 3, VBA will use the same mandated national training curriculum for veterans service representatives and rating veterans service representatives for the STAR team training requirements. To address recommendation 5, VBA will review existing policies, procedures, and processes related to error corrections and identify any areas for clarification or improvement.

The under secretary concurred in part with recommendations 4 and 6. For recommendation 4, VBA agreed that some procedural errors have the potential to affect benefits. The under secretary provided an acceptable action plan whereby VBA's quality assurance staff will modify the STAR quality review checklist to emphasize critical errors and categorize procedural deficiencies. For recommendation 6, VBA noted that STAR enables regional offices to see error trend analyses so they may address them at the local level. Moreover, the analyses increase stakeholder awareness of claims-processing quality at the national level. The under secretary provided an acceptable action plan to present STAR data in a format that is more usable and aligned with other types of reports currently used by regional offices.

The OIG will monitor VBA's progress and follow up on the implementation of all recommendations until all proposed actions are completed.

Appendix A: Scope and Methodology

Scope

The OIG team conducted its work from March 2019 through April 2020. The review covered all quality reviews pulled and reviewed by the STAR staff for the period July through September 2018. The OIG team chose this time period to ensure VBA had sufficient time to complete the correction process. The data are located on VBA's Compensation Service Intranet STAR report page and were provided to the OIG team by VBA's Performance Analysis and Integrity staff. The total universe for this period was 2,783 distinct quality reviews.

Methodology

To accomplish the review objective, the OIG team identified and reviewed applicable laws, regulations, policies, procedures, and guidelines related to work items and internal controls. The team interviewed and obtained statements from VBA staff related to work processes associated with work items and internal controls, including management and staff at

- The STAR office (Nashville, Tennessee),
- Four regional offices (Boston, Massachusetts; Los Angeles, California; Providence, Rhode Island; and San Diego, California), and
- VBA's central office (Washington, DC).

In coordination with VA OIG statisticians, the OIG team reviewed a stratified random sample of 100 cases in two strata. The team discussed the findings with VBA officials and included their comments where appropriate.

Appendix B provides more details on the statistical sampling methodology.

Fraud Assessment

The OIG assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. The OIG exercised due diligence in staying alert to any fraud indicators and completed the following actions:

- Identified laws and regulations related to the review subject matter
- Assessed previous reviews, audits, and inspections as reported by the OIG and other auditing organizations regarding VBA
- Completed the Fraud Indicators and Assessment Checklist
- Reviewed the OIG's hotline records for reports of fraud in the review area

- Collaborated with staff from the OIG Office of Investigations

The OIG did not identify any instances of fraud during this review.

Data Reliability

The OIG team used computer-processed data from VBA STAR reports generated by the Office of Performance Analysis and Integrity. To test for reliability, the team determined whether any data were missing from key fields or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared elements of VBA STAR data, such as veterans' file numbers, end product codes, claim labels, completion dates, and individuals who processed the claims, against information contained in the 100 Veterans Benefits Management System electronic claims folders reviewed.¹²

Testing of the data disclosed that they were sufficiently reliable for the review objective. Comparison of the data with information contained in the veterans' claims folders reviewed did not disclose any problems with data reliability.

Government Standards

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*.

¹² VBA Manual 21, Part 4, Appendix B.1.a, "End Product Codes and Work-Rate Standards for Quantitative Measurements," updated August 22, 2019. The end product system is the primary workload monitoring and management tool for the veterans service centers.

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the objective, the OIG team reviewed a statistical sample of claims pulled and reviewed by the STAR staff for the period July through September 2018 (the review period). The OIG team used statistical sampling to quantify the extent of cases in which STAR reviews were inaccurate, and in which STAR errors were not corrected properly.

Population

The review population included 2,783 quality reviews pulled and reviewed by STAR staff during the review period.

Sampling Design

The OIG team selected a statistical sample of 100 records from the population. This included a stratified random sample of 50 cases from each of the following two strata:

- Stratum 1 consisted of all rating STAR quality reviews that resulted in errors or comments
- Stratum 2 consisted of all rating STAR quality reviews where no error was found

The OIG team sampled each stratum to determine whether reviews were accurate (no deficiency) or had a deficiency in regard to claims-processing guidance.

Weights

The OIG team calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn. The OIG team uses the weights to compute estimates. For example, the OIG team calculated the error rate point estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The point estimate (i.e., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. If the OIG team repeated this review with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error:

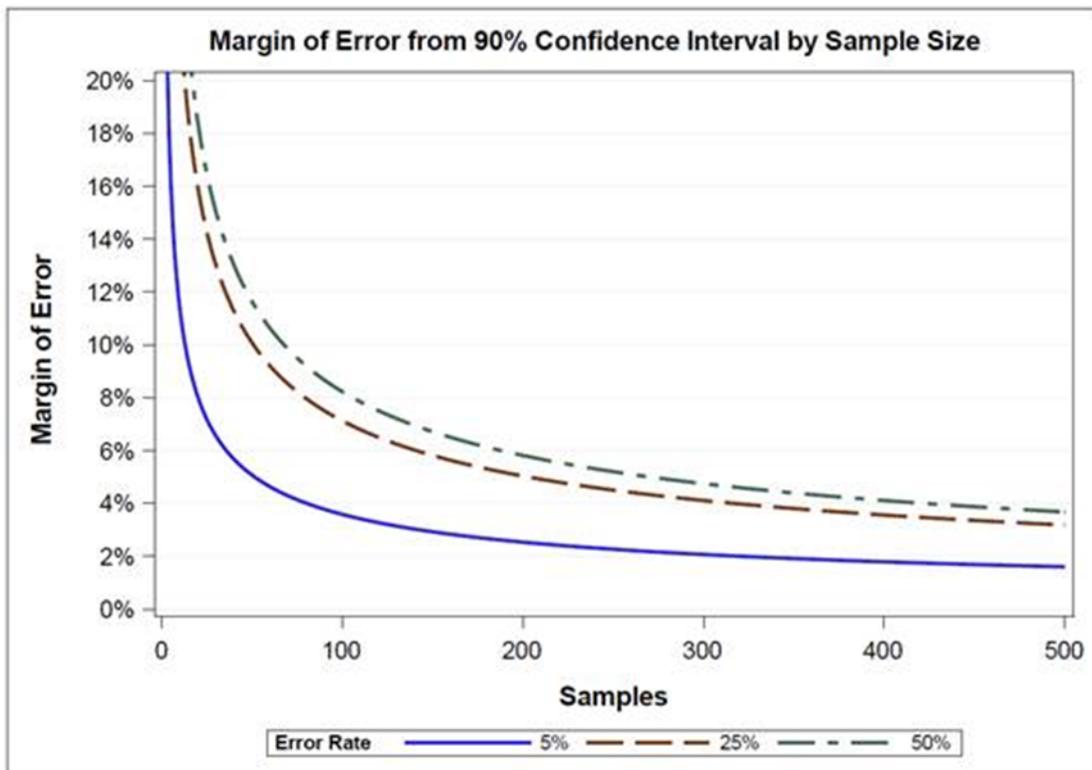


Figure B.1. Effect of sample size on margin of error

Source: VA OIG statistician's analysis

Projections

The following tables detail the analysis and projected results.

Table B.1. STAR Identification of Additional Errors and/or Deficiencies in Reviews Where a Benefit-Entitlement Error Was Identified (Stratum 1)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify benefit-entitlement errors and/or procedural deficiencies*	17	121 (34%)	40 (11%)	81 (23%)	161 (45%)
STAR identified benefit-entitlement errors and/or procedural deficiencies	33	234 (66%)	40 (11%)	194 (55%)	274 (77%)
Total	50	355 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

*Includes reviews with no additional benefit-entitlement errors and/or procedural deficiencies

Table B.2. Senior Reviewer Identification of Additional Benefit-Entitlement Errors on Second Review (Stratum 1)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR senior review did not identify additional benefit-entitlement errors	13	92 (26%)	37 (10%)	55 (16%)	129 (36%)
STAR senior reviewer identified additional benefit-entitlement errors	37	263 (74%)	37 (10%)	226 (64%)	300 (84%)
Total	50	355 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.3. Senior Reviewer Identification of Procedural Deficiencies on Second Review (Stratum 1)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR senior reviewer did not identify procedural deficiencies	13	92 (26%)	37 (10%)	55 (16%)	129 (36%)
STAR senior reviewer identified procedural deficiencies	37	263 (74%)	37 (10%)	226 (64%)	300 (84%)
Total	50	355 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.4. Overall Accuracy When No Benefit-Entitlement Error Was Identified (Stratum 2)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify benefit-entitlement errors and/or procedural deficiencies	29	1,408 (58%)	248 (12%)	1,124 (46%)	1,693 (70%)
STAR identified benefit-entitlement errors and/or procedural deficiencies	21	1,020 (42%)	284 (12%)	735 (30%)	1,304 (54%)
Total	50	2,428 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.5. Identification of Benefit-Entitlement Errors When No Error Was Identified by Analyst (Stratum 2)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify benefit-entitlement errors	16	777 (32%)	269 (11%)	508 (21%)	1,046 (43%)
STAR identified benefit-entitlement errors	34	1,651 (68%)	269 (11%)	1,382 (57%)	1,920 (79%)
Total	50	2,428 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.6. Identification of Procedural Deficiencies When No Error Was Identified by Analyst (Stratum 2)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify procedural deficiencies	20	971 (40%)	282 (12%)	689 (28%)	1,253 (52%)
STAR identified procedural deficiencies	30	1,457 (60%)	282 (12%)	1,175 (48%)	1,739 (72%)
Total	50	2,428 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.7. Identification of Benefit-Entitlement Errors (Stratum 1 and Stratum 2)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify benefit-entitlement errors	29	869 (31%)	271 (10%)	598 (21%)	1,140 (41%)
STAR identified benefit-entitlement errors	71	1,914 (69%)	271 (10%)	1,643 (59%)	2,185 (79%)
Total	100	2,783 (100%)			

Source: *OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician*

Table B.8. Identification of Procedural Deficiencies (Stratum 1 and Stratum 2)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify procedural deficiencies	33	1,064 (38%)	285 (10%)	779 (28%)	1,348 (48%)
STAR identified procedural deficiencies	67	1,720 (62%)	285 (10%)	1,435 (52%)	2,004 (72%)
Total	100	2,783 (100%)			

Source: *OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician*

**Table B.9. Identification of Claims-Processing Deficiencies
(Stratum 1 and Stratum 2)**

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify benefit-entitlement errors and/or procedural deficiencies	46	1,529 (55%)	287 (10%)	1,242 (45%)	1,816 (65%)
STAR identified benefit-entitlement errors and/or procedural deficiencies	54	1,254 (45%)	287 (10%)	967 (35%)	1,541 (55%)
Total	100	2,783 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.10. Overall Accuracy of STAR (Stratum 1, Stratum 2, and Corrections)

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify benefit-entitlement errors, procedural deficiencies, and/or had correction deficiencies	69	1,485 (53%)	289 (10%)	1,196 (43%)	1,774 (64%)
STAR identified benefit-entitlement errors and procedural deficiencies, and had no issues with corrections	31	1,298 (47%)	289 (10%)	1,009 (36%)	1,587 (57%)
Total	100	2,783 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

**Table B.11. Identification of Procedural Deficiencies by STAR
(Stratum 1 and Stratum 2)**

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
STAR did not identify procedural deficiencies	87	2,608 (94%)	118 (4%)	2,490 (89%)	2,726 (98%)
STAR identified procedural deficiencies	13	175 (6%)	118 (4%)	57 (2%)	293 (11%)
Total	100	2,783 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.12. Timeliness of Corrections by Regional Office Employees

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
Corrections were not initiated within 30 days	27	192 (54%)	42 (12%)	150 (42%)	234 (66%)
Corrections were initiated within 30 days	23	163 (46%)	42 (12%)	121 (34%)	205 (58%)
Total	50	355 (100%)			

Source: OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician

Table B.13. Accuracy of Final Corrections by Regional Office Employees

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
Corrections were not completed accurately	17	121 (46%)	40 (14%)	81 (32%)	161 (60%)
Corrections were completed accurately	20	142 (54%)	41 (14%)	101 (40%)	183 (68%)
Total	37	263 (100%)			

Source: *OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician*

Table B.14. Entry of Mandatory Notes by Regional Office Employees

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
Corrections missing mandatory notes	19	135 (51%)	41 (14%)	94 (37%)	176 (65%)
Corrections with mandatory notes	18	128 (49%)	40 (14%)	87 (35%)	168 (63%)
Total	37	263 (100%)			

Source: *OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician*

Table B.15. Overall Timeliness, Accuracy, and Entry of Notes for Corrections by Regional Office Employees

Result	Count from sample	Projection	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit
Corrections not initiated within 30 days, not completed accurately, and/or missing mandatory notes	41	291 (82%)	32 (9%)	259 (73%)	323 (91%)
Corrections initiated within 30 days, completed accurately, and had mandatory notes	9	64 (18%)	32 (9%)	32 (9%)	96 (27%)
Total	50	355 (100%)			

Source: *OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician*

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: May 27, 2020

From: Under Secretary for Benefits (20)

Subj: OIG Draft Report – The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims Processing Deficiencies [Project No. 2019-07059-DN-0254] - VIEWS 02783270

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

1. Attached is VBA's response to the OIG Draft Report: The Systematic Technical Accuracy Review Program Has Not Adequately Identified and Corrected Claims Processing Deficiencies.

The OIG removed point of contact information prior to publication.

(Original signed by)

Paul R. Lawrence, Ph.D.

Attachment

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

**Veterans Benefits Administration (VBA)
Comments on the OIG Draft Report:
The Systematic Technical Accuracy Review Program Has Not Adequately
Identified and Corrected Claims Processing Deficiencies**

VBA concurs with the findings in OIG's draft report and provides the following comments.

The Systematic Technical Accuracy Review (STAR) program was designed to focus specifically on national quality across all regional offices (ROs). The STAR program is designed to give VBA stakeholders a view over time of the service Veterans are receiving at a national claims processing level. STAR conducts its reviews on a statistically valid random sample of completed claims as tracked by a VBA end product and assesses the quality of the entire end-to-end processing of the claims reviewed. Thus, the STAR program, by nature of its holistic review of a completed claim, is not constructed to give claims processors fast feedback on the work they do as they do it. Rather, the companion quality assurance mechanism of local quality reviews, conducted at ROs through a network of hundreds of quality review team professionals, provides feedback on a transaction-by-transaction basis close in time to when the employee took an action during the claims process.

Also, STAR focuses on critical benefit errors that impact Veterans claims, such as whether the correct payment was made as of the right effective date. STAR notes procedural deficiencies and provides feedback to ROs through various channels; however, such procedural, non-benefit entitlement related deficiencies are more conducive for feedback by the local quality review teams because they are actively reviewing and providing immediate feedback to individual employees on actions taken. Thus, STAR should not be measured as a standalone quality assurance mechanism for compensation and pension claims quality but rather as one component of a broader quality assurance portfolio.

VBA also notes that STAR issue-based rating quality has been holding steady between 95% and 96% against a goal of 96% for more than two and a half fiscal years, and authorization quality is at a record high of over 93% against a goal of 91%.

VBA provides the following comments in response to the recommendations in OIG's draft report.

Recommendation 1: Improve the current second review process for quality reviews when STAR analysts identify claims processing deficiencies and consider requiring senior reviewers to conduct a comprehensive review of all issues assessed by the analyst.

VBA Response: Concur. STAR analysts are recruited from among VBA's most experienced and talented claims processors. Under the current process, errors found by the primary STAR analyst through a thorough checklist-driven review, undergo a validation by a senior reviewer. STAR is committed to continuous process improvement and ensuring accuracy of claims processing. VBA will conduct a comprehensive assessment of the current primary and second review process and implement best practices gleaned from other quality review constructs. This assessment will include consideration of requiring senior reviewers to conduct a comprehensive review of all issues assessed by the analyst, taking into account available resources. VBA expects to complete this review by October 31, 2020.

Target Completion Date: October 31, 2020.

Recommendation 2: Establish a formal second review process for quality reviews when STAR analysts do not identify claims processing deficiencies.

VBA Response: Concur. VBA had been utilizing an informal review process but subsequently implemented a formal review process in October 2019. Claims where no critical error was cited by the

initial STAR analyst are now eligible for review. VBA has an established process whereby Senior Quality Review Specialists review a monthly random sample of these cases completed by the STAR analysts as an audit check and provide feedback.

VBA requests closure of this recommendation.

Recommendation 3: Assess the current training requirements for STAR team and establish a formal training plan that promotes claims processing expertise and accuracy.

VBA Response: Concur. VBA will utilize the same mandated National Training Curriculum (NTC) for Veterans Service Representatives and Rating Veterans Service Representatives for the STAR team training requirements. This provides the STAR analysts with the same claims processing training that field stations receive. The STAR staff was notified of this NTC requirement in May 2020. A formal training plan is already in place for newly hired STAR analysts. The Quality Assurance staff is also developing a formalized training plan focused on the most current hot topics related to the STAR process. VBA expects to complete this training plan by October 31, 2020.

Target Completion Date: October 31, 2020.

Recommendation 4: Implement a plan to ensure STAR analysts place more emphasis on and assess all procedural deficiency elements included on the quality review checklist.

VBA Response: Concur in part. As part of VBA's overall Quality Assurance program for compensation claims, the STAR program is designed to focus on national quality across all VBA ROs on completed claims. STAR focuses on critical benefit errors that impact Veterans claims, such as whether the correct payment was made as of the right effective date. STAR notes procedural deficiencies and provides feedback to ROs through various channels, and VBA believes this is appropriate for STAR reviews. Procedural, non-benefit entitlement related deficiencies are more conducive for feedback by the local quality review teams because they are actively reviewing and providing immediate feedback to individual employees on a larger volume of actions taken. Individual quality reviews conducted by the local quality review team are the basis for assessing the critical element of quality in employee performance standards.

Therefore, the Quality Assurance staff will work to categorize procedural STAR deficiencies through a checklist modification, placing emphasis on critical errors. VBA agrees that some, but not all, procedural errors have the potential to affect benefits. STAR will focus on which error types affect benefits and complete VBA's review of quality checklists with expected completion date of October 31, 2020.

Target Completion Date: October 31, 2020.

Recommendation 5: Establish adequate policies, procedures, and monitoring to ensure corrections are completed timely and accurately.

VBA Response: Concur. VBA has modernized the tracking of quality reviews through the Quality Management System (QMS). QMS enables VBA to easily track error corrections for reviews conducted by STAR and local RO quality review teams.

Procedures for error corrections are currently outlined in VBA's procedural manual, which outlines the actions required by ROs to correct and report error corrections identified by STAR. Additionally, as part of VBA's requirement in M21-4, 5.4.f., ROs are required to conduct a Systematic Analysis of Operations (SAO) of their local Quality Review Teams. This SAO includes an analysis of the RO timeliness of national and local quality review error corrections.

Compensation Service will partner with the Office of Field Operations (OFO) and the District Offices to review existing policies, procedures, and processes related to error corrections to identify any areas for clarification or improvement. VBA will develop and implement a plan to address the monitoring of error corrections. As part of this plan, OFO will continue to monitor compliance by utilizing QMS data on errors and ensure ROs take appropriate action in a timely manner. OFO will require all ROs to submit their Quality SAOs for fiscal year (FY) 2020 for review through the Districts to OFO.

VBA expects to conduct the review, implement the error correction plan, and complete the SAO review by October 31, 2020.

Target Completion Date: October 31, 2020.

Recommendation 6: Ensure STAR develops a plan to provide usable data and meaningful feedback that best assists regional offices in improving the quality of decision-making.

VBA Response: Concur in part. VBA's STAR program is one part of a larger portfolio of quality assurance programs. STAR enables the ROs to see error trends analyses so they may address them at the local level and provides stakeholder awareness of claims processing quality at a national level.

The STAR sample is pulled from completed claims up to a month after the claim is completed. STAR reviews are a lagging indicator that can provide meaningful national error trends analysis, but they are not meant to provide immediate employee feedback at the transactional level. Local quality review teams are best suited to provide immediate employee feedback and improve quality of decision-making at each RO.

Nevertheless, the STAR staff provides meaningful feedback to ROs in many ways to assist them in addressing quality of claims processing issues. The STAR staff makes available error trend analyses on its STAR reports intranet page that provide ROs with overall trends in quality. The analyses are available by RO, district, and national levels. In addition, feedback on accuracy of claims processing trends are also available through a myriad of channels, including the RO quality dashboard, STAR monthly quality calls and notes, special focused review reports, and current national accuracy results by RO. Furthermore, STAR staff provides error mentoring with claims processing employees at an RO's request. In collaboration with the Quality Assurance site visits staff, STAR conducts larger group mentoring sessions focused on station needs. A designated STAR Senior Quality Review Specialist is assigned as a liaison for each District Office and its ROs to collaborate on quality issues.

Compensation Service will develop a plan to partner with OFO and the Office of Performance Analysis and Integrity to convert STAR data from an excel format to a tableau report format, which is more usable and aligned with other types of reports currently in use at ROs. VBA expects to complete this plan by October 31, 2020.

Target Completion Date: October 31, 2020.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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