



Federal Update for October 19 – 23, 2015



American Legion on Hickey resignation: ‘No joy, only optimism’

by Donnie La Curan in Veteran News

American Legion National Commander Dale Barnett issued the following statement regarding today’s resignation of Department of Veterans Affairs Under Secretary for Benefits Allison Hickey:

“Under Secretary Hickey is to be commended for her dedicated career as a member of the Air Force and her commitment to veterans. Although we called for her resignation, we take no joy in it. The widespread problems at the VA are not the fault of one person. She is one of three leaders that we asked to step down when the problems were first exposed last year. Now that the three senior officials that were in place at VA have left office, The American Legion is optimistic that Secretary McDonald can finally make the cultural changes that he needs so VA can be worthy of the veterans that it serves.”

SOURCE The American Legion

Agent Orange Law Changes as New Cost Fears Surface

By: Tom Philpott

<http://www.dailypress.com/news/military/dp-nws-military-update-1019-20151018-story.html>

The House and Senate veterans affairs committees quietly allowed a provision of the Agent Orange Act of 1991 to expire this month. How significant that will be for Vietnam veterans and their benefits is disputed.

Committee staff and the Department of Veterans Affairs agree the change has not impacted the VA secretary's authority to decide to expand the list of diseases presumed connected to wartime herbicide exposure.

But veteran advocates and at least one lawmaker suggest the change is intended to dampen VA cost risks and perhaps ease political pressure on the secretary and Congress facing a potential tsunami of disability claims.

That scenario assumes that a final review of medical science will establish a stronger link between Agent Orange and hypertension (high blood pressure), a condition that the Center for Disease Control says is so common it afflicts a third of the U.S. adult population VA asked Congress to keep the Agent Orange law intact five more years. Rep. Timothy J. Walz (D-Minn.), a VA committee member, offered a compromise, a bill to leave the law unchanged for two years, long enough so its secretarial review requirements held during VA consideration of a final report of the Institute of Medicine (IOM) of the National Academy of Sciences on health conditions associated with Agent Orange.

The VA committees declined to back these delays because, said a House committee staff member, under separate law "the secretary already has authority to make such [presumption] decisions, and we felt he did not need to be compelled by [the Agent Orange] law to do so." The provision that "sunset" Oct. 1 required the secretary to adhere to certain standards and procedures in determining if additional diseases associated with herbicide exposure should be presumed service connected. Vietnam War veterans diagnosed with ailments on the presumptive list qualify for VA disability pay and medical care.

The expired provision also set a timetable for the secretary to accept or reject IOM findings and required him to explain in writing if he declined to add IOM-identified conditions to the presumptive list.

Walz told colleagues at a hearing last week they effectively "allowed the Agent Orange Act to expire" and "it's altogether possible" the next IOM report, due in March, will support adding hypertension and stroke to the presumptive list. Consequently, Walz said, "literally hundreds of thousands of people" will be able to point to scientific data showing they experienced health consequences from exposure to Agent Orange.

"And the pressure is going to be on," he warned.

Turning to VA Secretary Bob McDonald, Walz advised that if Congress doesn't "have the courage" to respond to the IOM findings, presumably with bigger VA budgets to cover the influx of claims, "they're going to ask you. And much like the Nehmer claims, it's going to add to your work."

Walz was referring to a federal court ruling, *Nehmer v. Department of Veterans Affairs*, which forced VA the last time it added conditions to its presumptive list, including heart disease and Parkinson's, to review all previously filed claims for these conditions and make payments retroactive to original claim dates, or the date of the 1985 Nehmer decision, whichever is later. The scope and cost of this requirement surprised then-VA Secretary Eric Shinseki, as he later conceded. It also exploded the VA claims backlog.

So McDonald told Walz he had made "a very good point." Earlier in the hearing McDonald noted that the disability claims backlog still stood at 611,000 in May of 2013, but that VA finally had reduced it below 75,000.

"If we add another pre-condition and we don't get the people to do it, the 80-plus-percent progress we've made on the backlog will go away," McDonald testified.

Walz sympathized, saying he might face a tough decision resulting in many new claims. McDonald said how Congress responds would be key.

"We prefer to do what's right for the veteran, and then have you help us get the people we need for the job," McDonald said.

No one interviewed was certain what the next IOM report will recommend. Regardless of those findings, or the Agent Orange law change, the secretary still will have authority to expand the list of presumptive conditions, said David R. McLenachen, VA deputy under secretary for disability assistance, in a phone interview last week.

"It's always good to have it straight in the law, set up clearly, what our authority is regarding the Agent Orange Act," McLenachen said. That's why VA didn't want the provision to expire Oct. 1.

But the secretary still has general rule-making authority that "allows us, even while these provisions are expired, to add presumptions," he said.

Barton Stichman, joint executive director of the National Veterans Services Legal Program, a nonprofit group that fights for veterans' benefits, said there is reason to be concerned that the secretary no longer is required by law to consider IOM findings on presumptive diseases, that whatever he decides doesn't have to be explained, and he will have no deadline to decide. From a practical standpoint, Stichman added, any secretary will feel pressured from veterans and support groups to act on IOM findings. But IOM did find "limited or suggested evidence of association" between hypertension and Agent Orange in 2006, and while other conditions with the same degree of association became presumptive, hypertension did not.

About 2.6 million veterans served in Vietnam. Most are still alive. Current law presumes that all of them have been exposed to Agent Orange. VA grants disability ratings of 10 percent to 60 percent for hypertension, depending on severity, and the Centers for Disease Control and Prevention says high blood pressure grows more common as any population ages.

So will this secretary, or future VA secretaries, feel at least as much pressure from Congress to hold down disability costs as VA budgets tighten as he does from advocates for Vietnam veterans?

The Congressional Budget Office apparently heard the same rumors as Walz about the next IOM report and hypertension. Walz wasn't available to be interviewed but a member of his staff said costs were a committee consideration for not embracing his bill. In informal discussions, she said, CBO analysts had raised the specter of added costs "in the billions" if the secretarial review provision of the Agent Orange law didn't expire.

Asked to comment, a House committee staff member said, "CBO has not released an official cost estimate, and we can't speculate regarding potential costs associated with a report [IOM] has not produced."

Representative Tim Walz Minnesota's First Congressional District

FOR IMMEDIATE RELEASE

October 21, 2015

Washington, D.C. [10/21/15] –Today, Congressman Tim Walz introduced a motion to subpoena VA officials to testify before the House Veterans' Affairs Committee. The motion passed by a voice vote.

"To ensure veterans are getting the benefits they have earned in a timely manner, our committee needs to hear directly from those involved in the activities the Office of Inspector General has substantiated," Said Rep. Tim Walz. "The activities documented in the report are troubling and unacceptable. Testifying before Congress is critical to ensuring accountability in this matter."

Early this month, the Office of Inspector General substantiated allegations that high ranking VA officials "used their positions of authority for personal and financial benefit." VA officials named in the report were invited to testify before the House Veterans' Affairs Committee this morning, but did not appear. The Committee met prior to the hearing and passed Rep. Walz's motion to subpoena those individuals. A text of the motion is included below.

Former Undersecretary of Benefits Allison Hickey had also been invited to testify, but resigned prior to the hearing last week.

Walz noted in the hearing he appreciated Deputy Secretary Sloan Gibson's offer to the committee to testify, but also believed it was important for those directly involved to testify.

Text of the motion:

MOTION REGARDING SUBPOENAS OFFERED BY REPRESENTATIVE TIM WALZ

Mr. Chairman, I move that the Committee authorize the issuance of five subpoenas compelling Mr. Danny Pummill, Principal Deputy Under Secretary for Benefits, Veterans Benefits Administration; Ms. Diana Rubens, Director, Philadelphia and Wilmington Regional Offices, Veterans Benefits Administration; Ms. Kimberly Graves, Director, St. Paul Regional Office, Veterans Benefits Administration; Mr. Antione Waller, Director, Baltimore Regional Office, Veterans Benefits Administration; and Mr. Robert McKenrick, Director, Los Angeles Regional Office, Veterans Benefits Administration, to appear and testify at a public hearing on November 2, 2015, regarding the VA Office of Inspector General's final report, entitled, "Inappropriate Use of Position and the Misuse of the Relocation Program and Incentives."

Post-9/11 GI Bill: Additional Actions Needed to Help Reduce Overpayments and Increase Collections

What GAO Found

The Department of Veterans Affairs (VA) identified \$416 million in Post-9/11 GI Bill overpayments in fiscal year 2014, affecting approximately one in four veteran beneficiaries and about 6,000 schools. Overpayments most often occur when VA pays benefits based on a student's enrollment at the beginning of the school term and the student later drops one or more classes (or withdraws from school altogether). Students therefore receive benefits for classes they did not complete, and the "overpayment" must be paid back to VA. A small percentage of overpayments occurred because of school reporting or VA processing errors. GAO found that most overpayments were collected quickly, but as of November 2014 (when VA provided these data to GAO), VA was still collecting \$152 million in overpayments from fiscal year 2014, and an additional \$110 million from prior years, primarily owed by veterans with the remainder owed by schools.

Inadequate guidance, processes, and training have limited VA's efforts to reduce overpayments caused by enrollment changes and school errors.

Guidance for veterans. Many veterans may not realize they can incur overpayments as a result of enrollment changes because VA provides limited guidance to veterans on its policies. As a result, veterans may be unaware of the consequences of enrollment changes until after they have already incurred their first overpayment debt, according to school officials. Because VA is not effectively communicating its program policies to veterans, some veterans may be incurring debts that they could have otherwise avoided.

Enrollment verification process. While veterans using other VA education programs have to verify their enrollment each month, VA generally does not require those using the Post-9/11 GI Bill to do so. By not requiring veterans to verify their enrollment every month, which can cause significant time to lapse between when veterans drop courses and when this is reported, VA's process allows veterans to incur thousands of dollars in overpayments and also increases the program's costs associated with collecting these debts.

Training for school officials. Overpayments also occur when schools make errors, such as reporting enrollment information incorrectly, which VA officials said is sometimes attributable to a lack of training. For example, some school officials routinely made systematic errors reporting enrollment information, creating thousands of dollars in overpayments. Not all school officials attend the different training opportunities VA offers and VA officials said the agency lacks the authority to require school officials to participate in any of them. VA officials said they would like school officials to take a minimum level of training, which could help reduce errors and related overpayments.

The effectiveness of VA's collection efforts is hindered by its notification methods. VA relies solely on paper mail to notify schools and veterans of overpayments. VA generally sends veterans' notices to the addresses from veterans' initial benefit applications. However, these addresses can often be out-of-date, so some veterans do not receive the letters, leaving them unaware of their debts. This can cause veterans to unknowingly miss deadlines for disputing their debts and leave them unprepared to cover living expenses if VA begins withholding future benefit payments or offsetting tax returns for collection. This can also lead to delays in the collection of overpayments from veterans.

Why GAO Did This Study

VA provided \$10.8 billion in Post-9/11 GI Bill education benefits to almost 800,000 veterans in fiscal year 2014. GAO was asked to review overpayments for the program, which can create financial hardships for veterans who are generally required to pay them back and which can result in a significant loss of taxpayer dollars if they are not collected.

This report examines (1) the extent of overpayments, (2) how effectively VA has addressed their causes, and (3) the effectiveness of VA's collection efforts. GAO analyzed overpayment data for fiscal years 2013 and 2014, examined the causes from a generalizable sample of high-dollar overpayments (greater than \$1,667), conducted a case file review of 20 overpayments (selected for a variety of causes), and reviewed VA's monitoring of overpayments. GAO also interviewed senior and frontline staff at two VA offices that process claims and collect debts, officials at nine schools (selected for variation in program length and their status as public, nonprofit, and for-profit), higher education associations, and veteran service organizations.

What GAO Recommends

Congress should consider granting VA explicit authority to require training for school officials. In addition, GAO is making a number of recommendations to improve VA's guidance and processes, including providing program guidance to veterans, verifying veterans' monthly enrollment, and developing additional debt notification methods. VA agreed with GAO's recommendations to the agency and plans to address these issues.

VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care

What GAO Found

GAO found that the Department of Veterans Affairs' (VA) data on primary care panel sizes—that is, the number of patients VA providers and support staff are assigned as part of their patient portfolio—are unreliable across VA's 150 medical facilities and cannot be used to monitor facilities' management of primary care. Specifically, as part of its review, GAO found missing values and other inaccuracies in VA's data. Officials from VA's Primary Care Operations Office confirmed that facilities sometimes record and self-report these data inaccurately or in a manner that does not follow VA's policy and noted that this could result in the data reliability concerns GAO identified. GAO obtained updated data from six of seven selected facilities, corrected these data for inaccuracies, and then calculated the actual panel sizes for the six facilities. GAO found that for these six facilities the actual panel size varied from 23 percent below to 11 percent above the modeled panel size, which is the number of patients for whom a provider and support staff can reasonably deliver primary care as projected by VA. Such wide variation raises questions about whether veterans are receiving access to timely care and the appropriateness of the size of provider workload at these facilities.

Moreover, GAO found that while VA's primary care panel management policy requires facilities to ensure the reliability of their panel size data, it does not assign responsibility to VA Central Office or networks for verifying the reliability of facilities' data or require them to use the data for monitoring purposes. Federal internal control standards call for agencies to clearly define key areas of authority and responsibility, ensure that reliable information is available, and use this information to assess the quality of performance over time. Because VA's panel management policy is inconsistent with federal internal control standards, VA lacks assurance that its facilities' data are reliable and that the facilities are managing primary care panels in a manner that meets VA's goals of providing efficient, timely, and quality care to veterans. In contrast to VA's panel data, GAO found that primary care encounter and expenditure data reported by all VA medical facilities are reliable, although the data show wide variations across facilities. For example, in fiscal year 2014, expenditures per primary care encounter—that is, a professional contact between a patient and a primary care provider—ranged from a low of \$150 to a high of \$396 after adjusting to account for geographic differences in labor costs across facilities. Such wide variations may indicate that services are being delivered inefficiently at some facilities with relatively higher per encounter costs compared to other facilities.

However, while VA verifies and uses these data for financial purposes, VA's policies governing primary care do not require the use of the data to monitor facilities' management of primary care. Federal internal control standards state that agencies need both operational and financial data to determine whether they are meeting strategic goals and should use such data to assess the quality of performance over time. Using panel size data in conjunction with encounter and expenditure data would allow VA to assess facilities' capacity to provide primary care services and the efficiency of their care delivery. By not using available encounter and expenditure data in this manner, VA is missing an opportunity to potentially improve the efficiency of primary care service delivery.

Why GAO Did This Study

VA's 150 medical facilities manage primary care services provided to veterans. VA requires facilities to record and report data on primary care panel sizes to help facilities manage their workload and ensure that veterans receive timely and efficient care. VA also requires facilities to record and report data on primary care encounters and expenditures.

GAO was asked to examine these data and VA's oversight of primary care. This report examines (1) VA's panel size data across facilities and how VA uses these data to oversee primary care, and (2) VA's encounter and expenditure data across facilities and how VA uses these data to oversee primary care. GAO analyzed fiscal year 2014 data on primary care panel size, encounters, and expenditures for all VA facilities. GAO also conducted a more in-depth, non-generalizable analysis of data and interviewed officials from seven facilities, selected based on geographic diversity and differences in facility complexity. GAO also interviewed VA Central Office and network officials to examine their oversight of primary care, including the extent to which they verify the data and use it to monitor the management of primary care.

What GAO Recommends

GAO recommends that VA verify facilities' panel size data, monitor and address panel sizes that are too high or too low, and review and document how to use encounter and expenditure data to help monitor facilities' management of primary care. VA agreed with GAO's recommendations and described its plans to implement them.