Department of Veterans Affairs

Office of Inspector General

Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs

CHAMPVA was generally well-managed and program controls were effective. Reviewing certain claims paid in prior years and aggressively pursuing third party liability claims could increase cost recoveries.

Report No. 8R8-A08-054
Date: December 31, 1997

Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:
Director, Health Administration Center (741/00)

Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs

1. The purpose of the audit was to evaluate the effectiveness of the Veterans Health Administration's (VHA's) management of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). In addition, we performed the audit to respond to a Congressional request that the Office of Inspector General (OIG) review the CHAMPVA program, analyze program costs, and provide information on where and how CHAMPVA beneficiaries receive care.

2. CHAMPVA provides healthcare benefits for the dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service. Under the program, beneficiaries typically obtain medical services from private providers, and CHAMPVA reimburses the beneficiaries and/or providers for the cost of the services. The VHA Health Administration Center (HAC) in Denver, Colorado is responsible for determining beneficiary eligibility, processing claims for reimbursement, and otherwise administering the program. As of September 30, 1997, there were 81,239 beneficiaries enrolled in CHAMPVA. During Fiscal Year (FY) 1997, the HAC processed 912,671 claims pertaining to medical services for 48,999 of the enrolled beneficiaries. FY 1997 program costs totaled $98.0 million, of which $90.8 million was direct costs for medical care claims and $7.2 million was indirect costs for program administration.

3. We concluded that the CHAMPVA program was generally well-managed and program controls were effective. Prior OIG audits had found that the most significant weakness in the program was the absence of good controls to ensure that CHAMPVA benefits were not provided to ineligible persons. Our audit found that the HAC had corrected this problem and that eligibility determinations were accurate. The HAC had also established good procedures to ensure that claim payments were accurate, that rates paid were reasonable, and that high cost claims were monitored to ensure that care was necessary and appropriate. The major risks in the program were effectively controlled, program resources and interests were protected, and the program was generally in compliance with applicable laws, regulations, and VA policies.

4. The HAC's efforts to improve operations was reflected in cost trends for the program. From FY 1994, when the HAC assumed full responsibility for processing claims, through FY 1997 direct costs for beneficiary care increased from $84.1 million to $90.8 million, an average increase of only 2.0 percent a year. Since the number of beneficiaries also increased, direct costs measured in terms of cost per beneficiary were essentially stable over the 4-year period. Over the same period, total indirect costs decreased from $7.9 million to $7.2 million, and indirect costs per claim processed decreased from $10.31 to $7.89.

5. Our review of data pertaining to where and how CHAMPVA beneficiaries received care found that a large variety of healthcare professionals and institutions provided a wide range of medical services to beneficiaries. To illustrate, in FY 1996 beneficiaries received services from more than 69,500 different providers. The largest category of services was outpatient care (which accounted for 48.8 percent of FY 1996 CHAMPVA costs), followed by inpatient care (35.2 percent), pharmacy services (13.9 percent), and miscellaneous other services (2.1 percent).

6. The audit identified two opportunities to further improve program operations by increasing the recovery of medical care costs. First, the HAC could use commercial medical procedure and diagnostic code auditing software to review prior year outpatient claims for inappropriate payments. In January 1996, the HAC began using this software to review current claims. Based on the HAC's success with the software, we estimated that a review of about $111.1 million in outpatient claims paid during the 4 and one-quarter fiscal years before January 1996 could identify about $4.2 million in inappropriate payments that may be recoverable. Second, the HAC identified but did not always aggressively pursue potentially liable third parties. Our review of 37 potential third party cases that the HAC had not fully developed found that 3 cases were the result of incidents where a third party could possibly be held liable for the cost of care. CHAMPVA paid a total of $293,229 for these three cases.

7. We recommended that the HAC ensure that: (a) prior year claims are reviewed for erroneous payments and recovery pursued when appropriate; and (b) the possible third party claims identified by the audit are pursued and that procedures are developed to ensure that future third party cases are promptly identified and aggressively pursued. The HAC Director concurred with the recommendations and provided an acceptable implementation plan. We consider all audit issues resolved and we will follow up on the completion of planned corrective actions.

For the Assistant Inspector General for Auditing

(Original signed by:)
DAVID SUMRALL
Director, Seattle Audit Operations Division

Table of Contents

Results and Recommendation

Reviewing Claims Paid in Prior Years and Pursuing Third Party Liability Claims Could Increase Cost Recoveries

The Health Administration Center (HAC) had established effective controls for the CHAMPVA program, and as a result eligibility determinations were correct, claim payments were accurate, rates paid were reasonable, and high cost claims were monitored to ensure that care was necessary and appropriate. However, the audit identified two opportunities to further improve program operations by increasing the recovery of medical care costs. First, the HAC could utilize its medical procedure and diagnostic code auditing software to review claims paid during the 4 years before Fiscal Year (FY) 1997, the first full year the software was used. Based on the savings the HAC achieved by using the software to audit FY 1997 claims, we estimate that about $4.2 million in inappropriate prior year payments may be recoverable. Second, the HAC could further increase recoveries by more aggressively pursuing third party liability cases. Our review of 37 high cost injury claims paid during FY 1996 identified 3 claims that required further pursuit because third parties could possibly be held liable for $293,229 in CHAMPVA-paid care.

CHAMPVA Was Generally Well-Managed and Controls Were Effective

The HAC had established effective controls to ensure that eligibility determinations were accurate, rates paid were reasonable, beneficiaries actually received the care VA paid for, and high-cost claims were monitored. In addition, the HAC had also implemented reasonable procedures to prevent, detect, and pursue fraud.

Beneficiaries Eligible. Historically, the most significant weakness in the CHAMPVA program was the absence of good procedures and controls to ensure that only eligible beneficiaries were enrolled in the program and that beneficiaries were removed from the CHAMPVA rolls if they became ineligible. (Dependent children usually become ineligible when they reach age 18 or age 23 if enrolled in school, and spouses usually become ineligible at age 65 if they are eligible for Medicare.) Three OIG audits performed in the 1980s found significant numbers of ineligibles enrolled in CHAMPVA, with millions of dollars improperly paid for medical services for these ineligibles. Our audit found that the HAC had corrected this problem:

- The HAC worked aggressively to remove ineligibles from program rolls. This effort reduced the number of enrolled beneficiaries from 230,000 in FY 1986 to 81,239 as of September 30, 1997.

- Our review of eligibility records for a judgment test sample of 80 beneficiaries who had claims paid in FY 1996 found that all 80 were eligible for the benefits received.

Payments Accurate and Rates Reasonable. To pay claims, the HAC used a claims processing computer program that had edits to ensure that payments did not exceed applicable Federal or community rates for outpatient and inpatient services. In addition, for outpatient claims the HAC

used commercial outpatient medical procedure and diagnostic code auditing software that identified inappropriate or questionable procedures. Our review found that:

- The HAC's computer is programmed to compare rates billed by providers to the rates established for the Department of Defense's (DoD's) Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) and to the prevailing rates for the communities where the services were provided. These rates are generally comparable with Medicare rates.

- Our review of a judgment test sample of 50 claims paid during FY 1996 found that none of the payments exceeded established rates, and the rates paid were in line with Medicare rates for the same procedures. Where applicable, the HAC had checked claims with its code auditing software. For the 50 claims we found no evidence of inaccurate payments.

Beneficiaries Received Services. To ensure that beneficiaries actually received services, when claims were paid computer-generated letters were sent to the beneficiaries or veteran-sponsors detailing the services:

- These letters described the CHAMPVA-paid services and directed the recipients to call the HAC's toll-free number if they have not received the services.

- Our telephone interviews and mail surveys of a judgment test sample of 30 beneficiaries found that all 30 had received the CHAMPVA-paid services and that they were generally aware of the procedures to follow if they ever received a payment notification for services they had not received.

High Cost Claims Monitored. Management had established computer and manual controls to monitor high-cost claims. The claims processing program automatically referred inpatient claims over $10,000 and most other claims over $500 to HAC staff for review. We reviewed the records pertaining to the 10 beneficiaries who had the highest total value claims paid during FY 1996 and found that each record contained evidence that staff had monitored the costs, the need for care, and the quality of care provided.

Fraud Prevention Procedures Implemented. The management controls described above were part of the procedures used to identify possible fraudulent claims. In addition to those controls, HAC management had implemented other actions to detect fraud and to report possible incidents of fraud. These actions included:

- Installing the code auditing software to detect erroneous and/or possibly fraudulent bills.

- Placing providers and beneficiaries who have submitted questionable claims on a "watch list."

- Establishing a "fraud log" to track the status of possible fraudulent claims.

Reviewing Claims Paid in Prior Years Could Increase Cost Recoveries

As mentioned above, the HAC used code auditing software to identify and correct billing and coding errors on outpatient claims. This software was effective in preventing payments for inappropriate or questionable claims. During FY 1997, the first full year of operation, the software prevented about $1.47 million in inappropriate payments. In our opinion, this success indicates that the software could be effectively used to evaluate outpatient claims paid in prior years. Based on our discussions with Office of Inspector General (OIG) counsel, we believe that the HAC could pursue recovery of inappropriate payments made during the last 4 years before the code auditing software was installed. We estimated that using the software to reevaluate these prior year claims could result in identifying potential recoveries of up to $4.18 million. We recognize that there are many variables that would affect actual recoveries, such as the cost of additional software that may be needed and the cost of staff time for reviewing claims and pursuing recoveries.

HAC management generally agreed that there was potential for increasing recoveries of inappropriate prior year claims if there was legal authority for such recovery based on receiving a legal opinion from the VA Office of General Counsel. However, management expressed concerns about the possible financial burden on veterans and their dependents as a result of providers rebilling as a result of HAC recovery actions. They also expressed concern about the level of staffing and other resources that would have to be committed to identify, develop, and pursue recovery of incorrect prior year payments. To address these concerns we suggested that they test the feasibility of a recovery effort by reprocessing a sample of prior year paid claims using the software program and pursuing recovery as staff time/overtime was available. Such a test would allow management to determine the ratio of recoveries to resource costs before committing to a full-scale reevaluation and recovery effort. To further assist HAC management in addressing this issue we identified three other options:

- For about $10,000 the HAC could contract with the software manufacturer to perform a test of 100,000 prior year claims.

- The HAC could purchase add-on software that could be used in conjunction with the current software to review prior year claims. This software would cost about $41,000 and would require a $11,000 annual license fee.

- The HAC could contract with a commercial firm to review claims and pursue recovery. This would cost about $35,000, and the firm would keep 45 percent of the recoveries.

Regardless of the method HAC management chooses, we think that they should review prior year claims and where feasible pursue recovery of the estimated $4.18 million in questionable claims paid before the code auditing software was installed.

Aggressively Pursuing Third Party Claims Could Increase Cost Recoveries

The HAC identified but did not always aggressively pursue liable third parties. Federal law requires that whenever possible, action should be taken to recover the cost of care from liable

third parties (Public Law 87-693). The HAC's automated claims processing system used procedure and diagnostic codes associated with traumatic injuries to identify potential third party claims and generated a letter to the beneficiary asking for information pertaining to the circumstances of the injury. However, if there was no response to this letter, HAC staff did not take follow-up action.

In FY 1996, the HAC processed 46 cases that involved procedure codes suggesting traumatic injuries and that had claims of $10,000 or more. We reviewed records pertaining to all 46 cases and found that the HAC had identified 9 potential third party liability cases and was pursuing recovery of claim payments totaling $438,996. In the remaining 37 cases, the HAC neither received responses to the initial inquiry letters nor took any follow-up action. Our review of the 37 cases found that 3 were the result of incidents where a third party could possibly be held liable for the cost of care. The HAC paid a total of $293,229 on these three cases.

We recognize that the actual amount of recovery would depend on many variables, such as a judicial determination of liability and limits of accident insurance policies. However, based on the amount of the claims paid for the beneficiaries in these three cases, we believe that action should be taken to establish third party liability and pursue recovery. During the audit we discussed this issue with management. Management acknowledged a need to improve pursuit of third party cases and began implementing actions to strengthen follow-up procedures.

Conclusion

The CHAMPVA program was generally well-managed. The HAC had corrected the major problem identified by previous audits -- the absence of procedures to identify and remove from the rolls ineligible beneficiaries. Management had implemented good controls to ensure that beneficiaries were eligible, that claim payments were accurate, and that claim charges were reasonable. The major risks in the program were effectively controlled, program resources and interests were protected, and the program was generally in compliance with applicable laws, regulations, and VA policies. To further improve program operations, the HAC should use code auditing software to review prior year claims for recoverable inappropriate payments and should more aggressively develop and pursue potential third party liability claims.

For More Information

- The history of CHAMPVA, prior OIG reviews, and other background information are presented in Appendix 1, pages 7-10.

- The audit objectives, scope, and methodology are discussed in Appendix 2, pages 11-12.

- More detail on the audit results, analysis of CHAMPVA costs, and information on where and how beneficiaries received care is presented in Appendix 3, pages 13-20.

Recommendation 1

We recommend that the Director of the Health Administration Center ensure that:

a. Prior year claims are reviewed for erroneous payments and recovery is pursued when appropriate.

b. The possible third party claims identified by this audit are pursued and that procedures are established to ensure that future third party liability cases are promptly identified and aggressively pursued.

The associated monetary benefits for Recommendation 1 are shown in Appendix 4, page 21.

Health Administration Center Director Comments

The Director concurred with both audit recommendations. While he agreed that there was potential for increasing recoveries of prior year payments, he reiterated his concerns about the legal authority to pursue such recoveries and about the resource commitment required. To address these concerns, the HAC requested a General Counsel opinion on legal issues pertaining to the recommended review. If this opinion supports the review, the HAC will explore the various options, including those suggested by the OIG. If a cost-effective approach can be developed, the review will proceed.

Implementation Plan

In November 1997, the HAC requested a General Counsel opinion on the authority to review prior year claim payments. If the opinion states that there is legal authority to pursue the review, the HAC will develop a review approach and will keep the OIG informed of the progress of the review.

To improve third party recoveries the HAC established a log to track letters sent to beneficiaries requesting information on possible third party liability claims. In addition, the HAC established a task force to review recovery procedures and recommend further improvements. (See Appendix 5, pages 23-24, for the full text of the Director's comments and implementation plan.)

Office of Inspector General Comments

The Director concurred with the audit recommendations and provided an acceptable implementation plan. We agree that any legal questions should be resolved before proceeding with the review of prior year claims. We consider all audit issues resolved and we will follow up on the completion of planned corrective actions.

Background

The Veterans Healthcare Expansion Act of 1973 (Public Law 93-82, September 1, 1973) authorized VA to establish the CHAMPVA program. The mission of CHAMPVA is to provide healthcare benefits for the dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service. (Within the CHAMPVA program these veterans are called "sponsors.")

CHAMPVA is essentially a health insurance program. Under the program beneficiaries usually obtain medical services from private providers, such as physicians or hospitals. For these services, beneficiaries usually pay 25 percent of the cost of any inpatient or outpatient care plus an annual outpatient deductible of $50 per individual or $100 per family. To request CHAMPVA reimbursement for the remaining 75 percent of the cost of care, beneficiaries or providers submit claims to the HAC. HAC staff review the claims to ensure that beneficiaries are eligible for the care received and that claimed reimbursements are reasonable. For approved claims, the HAC transmits payment authorizations to VA's Austin, Texas Data Processing Center, which forwards the information to the Department of Treasury, which then issues checks to beneficiaries and providers.

Although beneficiaries generally obtain care from private providers, since 1992 they have also been allowed to receive care in VA facilities under the CHAMPVA In-House Treatment Initiative (CITI). This initiative was developed to offer available VA services to CHAMPVA beneficiaries and to provide an opportunity for VA to retain funds that otherwise would have been paid to private providers. Since FY 1992, the Veterans Health Administration (VHA) has encouraged its facilities to participate in the CITI program.

Prior OIG Audits

From 1982 through 1995 the OIG completed five audits pertaining to the CHAMPVA program. Four of these audits found that CHAMPVA was paying for care provided to ineligible beneficiaries:

- In 1982, the OIG performed two audits of CHAMPVA. The first audit identified several deficiencies, with the main problem being that at least 10 percent of the veteran-sponsors had at least one ineligible beneficiary enrolled in the program (Report No. 2AB-A08-066; March 30, 1982). The main purpose of the second audit was to determine the cost of care provided to ineligibles. This audit concluded that in FY 1981 this cost was $4.2 million (Report No. 2AB-A08-129; September 24, 1982).

- In 1987, the OIG performed a follow-up audit to determine if VHA had implemented the recommendations of the two 1982 audits. This audit's main finding was that CHAMPVA was still providing benefits to ineligible persons. During the 4-year period from FY 1983 through FY 1986 about 28.3 percent of the individuals who received CHAMPVA benefits were ineligible. VA paid about $40.7 million for their care and about $2.2 million in

administrative costs to process the associated claims (Report No. 7R8-A08-115; September 23, 1987).

- In 1995, the OIG briefly reviewed the calendar year 1994 claim processing procedures at the HAC. This review concluded that while many operational improvements had been implemented, claims for some ineligible beneficiaries were still being paid (Report No. 6WA-A08-048; April 30, 1996).

The fifth audit evaluated the potential for treating CHAMPVA beneficiaries at VA facilities. This audit concluded that many facilities had enough excess capacity to provide some care to CHAMPVA beneficiaries. Partly as a result of this audit, VHA established the CITI initiative (Report No. 0R8-A08-041; March 30, 1990).

Program Changes

During the first 13 years of the program, from its inception in FY 1973 through FY 1986, VAMCs were responsible for processing CHAMPVA applications and determining if applicants were eligible for the program. In FY 1987, responding to the OIG audits, VHA centralized the eligibility determination responsibility to VAMC Denver. In June 1989, VHA established the CHAMPVA Center in Denver and transferred responsibility for beneficiary eligibility determinations to the new Center.

Claims Processing. CHAMPVA claim processing procedures have also changed over the years. During the 17-year period from FY 1973 through FY 1990, VA contracted with DoD's Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) to process CHAMPVA claims. OCHAMPUS, in turn, established contracts with health insurance companies, such as Aetna and Blue Cross, to process and pay both CHAMPVA and CHAMPUS claims. The insurance companies served as fiscal intermediaries (FIs) and were reimbursed by OCHAMPUS for the cost of beneficiary care plus a fee for processing claims. Each year OCHAMPUS billed VA for the cost of the CHAMPVA claims paid to FIs and for the administrative costs of supporting the CHAMPVA program. In December 1990, VA and DoD began transferring claim processing responsibilities from OCHAMPUS to the CHAMPVA Center. By December 1993, the transition was complete, and the Center was fully responsible for performing all program administrative functions, including claims processing.

Expanded Role for CHAMPVA Center. Since FY 1994, the scope of CHAMPVA Center operations has expanded to include responsibility for four other activities: (1) VA's Foreign Medical Program, which provides care for certain veterans and/or their dependents who are residing or traveling abroad; (2) the VA Funded Examination Program for the Spouses and Children of Persian Gulf Veterans, which provides for medical examinations for the dependents of veterans who are suffering from illnesses that may be associated with their service in the Persian Gulf War; (3) VA's Mail Management Program, which allocates VHA's budget for postal services, maintains data on VHA mail costs, and communicates regulatory and procedural information pertaining to mail management; and (4) the Medications-by-Mail program, which uses the resources of VA's Consolidated Mailout Pharmacies to provide medications to certain beneficiaries.

In 1996, to reflect the expansion of the CHAMPVA Center's responsibilities, the name was changed to the Health Administration Center. As of September 1997, the HAC had 163.5 full-time equivalent employees (FTEE). Of these, 147.5 FTEE were assigned to CHAMPVA and 16.0 FTEE were assigned to the other HAC programs.

Program Data

As discussed above, during the first 21 years (FY 1973-FY 1994) of the CHAMPVA program, there were several changes in program administration. As a result, program data was not consistently defined or reported, particularly workload data such as the number of beneficiaries enrolled or the number of claims processed. Because of this, it is not possible to reliably determine historical workload trends or to compare current workload data with historical data. In FY 1991, the HAC began correcting this problem by clearly defining and consistently tracking CHAMPVA workload and productivity data.

Claims Paid. The only workload data that was regularly reported since the establishment of the program was the number of claims paid. However, this data was not a reliable measure of workload trends because the definition of a claim had changed over time. From FY 1973 to FY 1991, when the FIs processed claims, a claim was defined as all invoices received in a single envelope. This definition changed during the 4-year transition period, FY 1991 through FY 1994, when claims processing responsibilities were being transferred from the FIs to the HAC, and claims were processed both by the FIs and the HAC. During this period the HAC redefined a claim as a single invoice for one episode of care, provided to one beneficiary, by one provider. Because FIs continued to use the old definition and the HAC used the new definition, data on the total number of claims was not consistent. For example, if an FI processed a submission consisting of three invoices it would be counted as a single claim, while the same submission processed by the HAC would typically be counted as three separate claims. Since FY 1994, each invoice has generally been considered a separate claim. In FY 1997, the HAC processed 912,671 claims.

Enrolled Beneficiaries. Before the FY 1987 centralization of eligibility determinations, VHA did not accurately monitor the number of enrolled beneficiaries. During FY 1986, VHA estimated that the program had about 230,000 enrolled beneficiaries. As mentioned above, the 1987 OIG audit found that an estimated 28.3 percent of the beneficiaries were ineligible. In response to this audit, VHA began purging the rolls of the ineligible beneficiaries. By the end of FY 1988, the number of enrolled beneficiaries had been reduced to about 84,866. From FY 1988 through FY 1994, the number of beneficiaries trended downwards, reaching a low of 70,729 in FY 1994. Since FY 1994, the trend has been upward, and as of the end of FY 1997 there were 81,239 enrolled beneficiaries.

Enrolled Veteran-Sponsors. In FY 1995, the HAC began maintaining data on the number of veteran-sponsors who had dependents enrolled as CHAMPVA beneficiaries. As of the end of FY 1996, there were 59,233 enrolled sponsors. (FY 1997 sponsor data was not available at the time we completed the audit.)

Program Costs. Program costs have ranged from a low of $13.2 million in FY 1974, CHAMPVA's first year of operation, to a high of $102.6 million in FY 1992. Since the transition of all administrative and claims processing responsibilities to the HAC was completed in FY 1995, total gross program costs have increased about $3.8 million, from $94.2 million in FY 1995 to $98.0 million in FY 1997. All of the increased costs were attributable to claim payments, and none were attributable to administrative costs. In fact, these costs (indirect operating costs such as staff salary and benefits, equipment, and supplies) actually decreased about $1.4 million, from $8.6 million to $7.2 million. (See Appendix 3, pages 15-17, for a more detailed discussion of program costs.)

Objectives, Scope, and Methodology

Objectives

The purpose of the audit was to evaluate the effectiveness of VHA's management of the CHAMPVA program. The audit objectives were to:

- Evaluate management procedures and controls for determining beneficiary eligibility and for processing claims.

- Respond to a request from the U.S. House of Representatives Committee on Veterans' Affairs that the OIG review the CHAMPVA program, analyze program costs, and provide information on where and how care is delivered to beneficiaries (July 24, 1996, letter from the Chairman of the House Committee on Veterans' Affairs to the OIG).

Scope and Methodology

To meet the audit objectives we analyzed program cost and workload data and we reviewed laws, regulations, and VA policies pertaining to the CHAMPVA program. We discussed the program with VHA Central Office officials, HAC management and staff, healthcare providers and vendors, sponsors, and beneficiaries. We also interviewed representatives of commercial health insurance companies, health insurance claims processing software manufacturers, and others involved in private sector health insurance. The audit of CHAMPVA operations covered FY 1996, the most recent year for which complete records were available when we began the audit. Our analysis of CHAMPVA cost and workload information included FY 1997 data that was available when we completed the audit.

Management Controls. Our evaluation of CHAMPVA management controls consisted of the following steps:

- To evaluate eligibility determination procedures we reviewed records pertaining to a judgment test sample of 80 beneficiaries who filed claims during FY 1996.

- To determine if the rates paid on claims were accurate and reasonable, we reviewed a judgment test sample of 50 claims paid during FY 1996. We compared the amounts billed to the amounts paid and we compared the rates paid to the applicable CHAMPUS, Medicare, or community rates.

- We tested whether the CHAMPVA-paid services were needed and were actually received by the beneficiaries. To do this we reviewed quality assurance reports and invoices and obtained information from a judgment test sample of 30 beneficiaries, their sponsors, and/or their designated representatives.

- We evaluated management efforts to reduce and control claim costs. To do this we reviewed correspondence files and reports of telephone discussions between HAC staff, beneficiaries, sponsors, and providers and related records pertaining to the 10 beneficiaries who had the highest value claims paid during FY 1996.

- To evaluate HAC procedures for identifying incidents of possible fraud and forwarding information about these incidents to proper authorities, we reviewed the HAC's watch list and pending claims referrals and we discussed HAC procedures with OIG staff who investigate allegations of healthcare fraud.

- To evaluate HAC medical care cost recovery procedures, we reviewed records pertaining to all beneficiaries who had FY 1996 claims for care exceeding $10,000 and having diagnostic and procedure codes associated with traumatic injury (which indicated that a third party, such as an insurance company, might be liable for the cost of care).

It should be noted that we had originally planned to test a larger number of claims and to interview more beneficiaries, sponsors, and providers. However, because our test samples identified no deficiencies, we concluded that additional testing was not necessary.

How and Where CHAMPVA Beneficiaries Received Care. To determine how and where beneficiaries received care, we reviewed computer records pertaining to all claims paid during FY 1996. For each claim paid, the records included information showing the type of provider, kind of service provided, costs billed by and paid to providers and/or beneficiaries, and the geographical location of beneficiaries and providers.

Standards Followed. The audit was conducted in accordance with generally accepted government auditing standards. To meet the audit objectives, we used computer-processed data contained in the HAC's automated records systems. We conducted tests to assess the reliability of this data. Based on the results of our tests, we concluded that the data was sufficiently reliable to meet the audit objectives.

Details Of Audit

CHAMPVA Management Controls

Eligibility Determinations Were Accurate. The historic problem of inaccurate eligibility determinations had been corrected. The HAC had established effective procedures to obtain from VA Regional Offices necessary information to determine CHAMPVA applicants' eligibility for benefits. There were also good procedures to check with OCHAMPUS to make sure that applicants were not eligible for CHAMPUS benefits (in which case they would not be eligible for CHAMPVA). In addition, the HAC had established automated controls to identify beneficiaries whose continued eligibility for CHAMPVA needed to be reviewed because they had reached ages at which they would normally no longer be eligible for CHAMPVA. Our review of eligibility records for a judgment test sample of 80 CHAMPVA beneficiaries who had claims paid in FY 1996 found that all 80 were eligible for the benefits received.

Payments Matched Amounts Billed and Rates Paid Were Reasonable. The HAC used a computerized claims processing system to process all claims. The system had safeguards to ensure that payments were accurate. These safeguards included programming to compare rates billed by providers to the rates established for OCHAMPUS or the prevailing rates for the geographic area where the services were provided. Claim payment authorizations were limited to 75 percent (the CHAMPVA portion) of the OCHAMPUS rates and/or prevailing rates. Our review of a judgment test sample of 50 claims found that none of the payments exceeded the established rates or the amounts billed.

VA-Paid Services Were Received. Management had established procedures to help ensure that providers did not bill for services that beneficiaries had not received. To ensure that beneficiaries actually received CHAMPVA-paid services, computer-generated letters were sent to beneficiaries (or their representative) each time a claim was paid. The letters showed the name of the provider, descriptions of the procedure(s) billed, and the date the services were provided. The letters directed the beneficiaries to call the HAC's toll-free number if they had not received the services listed.

When a beneficiary informed HAC staff that the listed services had not been provided, the staff directed the provider to send additional documentation to support the questioned claim. If the documentation was not provided or was not adequate to support the claim, the case was sent to the HAC's Debt Collection Unit (DCU). The DCU then initiated action to recover the amount paid for services that the beneficiary did not receive.

We contacted a test sample of 30 beneficiaries (and/or the beneficiaries' representatives) and found that all 30 had received the CHAMPVA-paid services. During FY 1996, CHAMPVA paid 2,749 claims with costs totaling about $1.5 million for care provided to these 30 beneficiaries. In addition, we found that the 30 respondents were generally aware of the procedures for informing the HAC if they received a payment notification for services that had not been provided.

High Cost Claims Were Monitored. The claims processing program automatically referred inpatient claims over $10,000, outpatient claims over $2,500 submitted by providers, and other claims over $500 (outpatient claims submitted by beneficiaries and pharmacy, dental, and travel claims) to HAC staff for further review. These reviews were generally performed by registered nurses who were knowledgeable about health insurance issues.

To determine if this monitoring was effective, we reviewed records pertaining to the 10 beneficiaries who had the highest value claims paid during FY 1996. For these 10 beneficiaries CHAMPVA paid 2,788 claims with costs totaling $2.43 million. We found evidence that costs and quality of care were monitored. This evidence included copies of medical records, invoices, and consultant reports. In addition, these records contained reports and notes of discussions with beneficiaries (and/or beneficiaries' representatives), healthcare providers, physician consultants, and/or others. These discussions addressed issues such as length of stay in critical care units, need for continued hospitalization, need for specialized treatment, and lower cost treatment alternatives. In our opinion, these records demonstrated that HAC staff had made reasonable efforts to effectively monitor and control high cost claims.

Procedures To Identify Fraudulent Claims Were Implemented. In addition to the controls discussed above, HAC management had established controls to prevent, detect, and report possible incidents of fraud. These controls included:

- Installing commercial code auditing software to detect erroneous and/or possibly fraudulent bills. The software identified apparent irregular billing practices such as: (1) "upcoding," which is the practice of using a procedure code that results in higher payments than the procedure actually performed; (2) "bundling," which is grouping unnecessary procedures or tests with those that are necessary; and (3) "unbundling," which is separating one procedure into several separate component procedures to maximize payments.

- Developing written policy that assigned responsibility for the fraud prevention effort to CHAMPVA's Quality Management Division.

- Preparing written guidelines and providing staff training that specifically addressed healthcare fraud issues.

- Establishing written procedures for performing internal review of erroneous and/or possible fraudulent claims.

- Maintaining a "watch list" of providers and beneficiaries who had submitted questionable claims. Providers or beneficiaries who were identified in the media, government, or health insurance industry reports as subjects of medical care fraud investigations were also placed on this list. All claims from providers or beneficiaries on the watch list were subjected to a more detailed prepayment review than other claims.

- Establishing a "fraud log" to track the status of possible fraudulent claims.

- Promptly notifying law enforcement authorities of possible fraudulent claims.

Although there are no procedures that will completely prevent fraud or that will detect every incident of fraud, we concluded that the HAC's procedures represented a reasonable approach to fraud prevention and significantly contributed to the protection of CHAMPVA resources.

Program Costs

Direct Costs Per Beneficiary Were Stable. It is not possible to meaningfully compare or analyze CHAMPVA costs over the entire history of the program. The main reason for this, as disclosed by previous OIG audits, was that before 1987 CHAMPVA costs included significant amounts paid for care provided to ineligibles. VHA began correcting this problem in FY 1987, and by FY 1989 the purging of ineligibles from the CHAMPVA rolls was substantially complete.

As Table 1 shows, since 1989 CHAMPVA direct costs (the cost of care provided to beneficiaries) have fluctuated from year to year, but the trend for the entire 9-year period FY 1989 - FY 1997 was one of slow, moderate growth in total direct costs:

Table 1. CHAMPVA Direct Costs (FY 1989 - FY 1997)

Fiscal Year	Direct Cost ($ Millions)	Beneficiaries Enrolled	Direct Cost Per Beneficiary
1989	$72.2	84,095	$858.55
1990	80.3	85,080	943.82
1991	89.2	81,932	1,088.70
1992	90.8	81,163	1,118.74
1993	84.3	77,088	1,093.56
1994	84.1	70,729	1,189.05
1995	85.6	76,738	1,115.48
1996	88.6	78,008	1,135.78
1997	90.8	81,239	1,117.69

Source: CHAMPVA Workload and Cost Reports

Over the 9-year period direct costs increased an average of about 2.9 percent a year, and since FY 1994, when the HAC assumed responsibility for processing substantially all claims, annual increases in direct costs averaged only about 2.0 percent. In our opinion, the growth in direct costs since FY 1994 was largely caused by increases in the beneficiary population. During the 4-year period FY 1994 - FY 1997, direct costs per beneficiary were essentially stable. In our opinion, the fact that direct costs per beneficiary were so stable in recent years demonstrates that the HAC has established effective procedures to control CHAMPVA costs. While this stability was probably partially attributable to a slowdown in medical care cost inflation, we believe that the HAC's efforts also played a major role. The HAC had established effective procedures to prevent the inappropriate payment of CHAMPVA funds for care provided to ineligibles, for care billed at incorrect rates, for unnecessary or inappropriate care, and for fraudulent claims.

Indirect Costs Decreased. Indirect costs are all costs other than payments for beneficiary care and include such costs as employee salaries and benefits, equipment, and supplies. The most meaningful period for analyzing indirect costs is the 4-year period FY 1994 - FY 1997, the

period during which the HAC has had responsibility for substantially all CHAMPVA claims processing. There are two reasons for this. First, the 4 years preceding this period were transition years, with claims processing done by both the HAC and OCHAMPUS. During these years indirect costs were unusually high because VA was paying the OCHAMPUS administrative fee and also incurring start-up costs for the HAC. Second, the most significant measure of indirect cost is indirect costs per claim paid, and prior to FY 1994 there was no consistent definition of the term "claim."

As Table 2 shows, during the 4 years that the HAC has been responsible for claims processing both total indirect costs and indirect costs per claim have decreased:

Table 2. CHAMPVA Indirect Costs (FY 1994 - FY 1997)

Fiscal Year	Indirect Costs ($ Millions)	Claims Processed	Indirect Cost Per Claim
1994	$7.9	766,416	$10.31
1995	8.6	832,862	10.33
1996	7.7	821,355	9.37
1997	7.2	912,671	7.89

Source: CHAMPVA Workload and Cost Reports

Another way of evaluating the reasonableness of CHAMPVA indirect costs is to compare the indirect costs in FY 1989, the last full year that OCHAMPUS processed CHAMPVA claims, to indirect costs in FY 1997, the most recent full year of HAC operations:

- In FY 1989, when total CHAMPVA costs were $78.0 million, indirect costs were $5.8 million, or 7.4 percent of total costs.

- Eight years later in FY 1997, total costs were $98.0 million, and indirect costs were $7.2 million, still 7.4 percent of the total.

In our opinion, the decreases in total indirect costs and in indirect costs per claim during the FY 1994 - FY 1997 period and the stability of indirect costs as a proportion of total costs since 1989 persuasively indicated that the HAC had effectively controlled indirect costs.

Comparison of CHAMPVA Costs to Health Insurance Costs. To further evaluate the reasonableness of costs, we compared the cost of CHAMPVA, which is essentially a health insurance program, to the cost the Government would theoretically incur to provide comparable private health insurance coverage for CHAMPVA beneficiaries. For this comparison, we used data pertaining to the Federal Employees Health Benefit (FEHB) plan. FEHB offers participants a wide range of national fee-for-service insurance plans that would theoretically be available for CHAMPVA beneficiaries no matter where they lived and that would cover the same types of medical services covered by CHAMPVA. In making the comparison we assumed that the entire cost of the insurance premium would be paid by the Government and that beneficiaries would pay the same deductibles they pay under CHAMPVA.

Our analysis found that in FY 1996 it would have cost about $115.7 million to provide CHAMPVA beneficiaries with the least costly (standard option) FEHB coverage, or about $19.4 million more than the $96.3 million cost of CHAMPVA. (High option FEHB coverage would have cost about $299.1 million, or $202.8 million more than CHAMPVA).

Where and How CHAMPVA Beneficiaries Received Care

Types of Services Provided

During FY 1996, CHAMPVA paid a total of about $88.6 million for medical care services that 46,667 beneficiaries received from 69,511 different providers. While CHAMPVA's databases did not track each type of healthcare provider by title (such as physician or nurse) it did allow these categories to be identified. Our review found that a wide range of healthcare entities and professionals provided care to CHAMPVA beneficiaries. Healthcare entities included medical centers, physician practice groups, residential treatment facilities, outpatient clinics, domiciliaries, pharmacies, hospices, home health agencies, public health agencies, and VA facilities. Healthcare professionals included physicians, physician assistants, psychologists, nurses, dentists, social workers, and marriage and family counselors. HAC staff monitored providers and types of claims. To do this they established six claim/provider categories -- outpatient, inpatient, pharmacy, durable medical equipment, travel, and dental.

Outpatient Care. The highest cost category of care was outpatient services. These services were typically provided by physicians in individual and group practices, by outpatient clinics, and by allied health practitioners, such as physical therapists, social workers, and family therapists. During FY 1996, CHAMPVA paid 65,659 providers about $43.2 million for 486,824 outpatient claims filed by 44,593 beneficiaries. Of the $43.2 million, about $41.7 million (96.5 percent) was paid to private providers for treatments provided to 43,269 beneficiaries. In addition, for treating 2,738 beneficiaries, $1.5 million (3.5 percent) was paid to VA facilities under the CITI initiative.

Inpatient Care. The second highest costs were for inpatient treatment. Typically this treatment was provided in community hospitals, hospices, and other residential care facilities. During FY 1996, CHAMPVA paid 3,069 providers about $31.2 million for inpatient care provided to 5,485 beneficiaries. Of this $31.2 million, about $29.3 million (93.9 percent) was paid to private providers for treating 5,234 beneficiaries. An additional $1.9 million (6.1 percent) was paid under CITI to VA facilities for providing inpatient care to 299 beneficiaries.

Pharmacy Services. The third highest cost category was pharmacy claims. These claims were for medication typically provided by community drug stores and pharmacies and by hospital and clinic pharmacies. During FY 1996, CHAMPVA paid about $12.3 million to 1,836 pharmacy providers[1] for 316,566 claims filed for 23,549 beneficiaries. Of this amount, CHAMPVA paid about $10.9 million (88.6 percent) for medication provided by private pharmacies for 21,866

[1] The number of pharmacy providers does not represent the number of individual pharmacies used by CHAMPVA beneficiaries. CHAMPVA payments to large chain store pharmacies were usually charged to a single tax identification number on a periodic basis. For example, one chain store was considered a single provider, but beneficiaries actually had prescriptions filled at 861 branches of this store.

beneficiaries. An additional $1.4 million (about 11.4 percent) was paid to VAMCs under the CITI program for 2,248 beneficiaries. In addition, about $63,000 was paid to VA's Centralized Pharmacy Mail-Out Program (CMOP). About 189 of the 23,549 beneficiaries who filed pharmacy claims participated in CMOP.

Other Services. The remaining $1.9 million in FY 1996 payments went to 1,291 durable medical equipment providers ($1.4 million for 1,453 beneficiaries), 925 ambulance companies and other travel providers (about $500,000 for 1,208 beneficiaries), and 301 dental services providers (about $33,000 for 306 beneficiaries).

Geographic Distribution of CHAMPVA Care

CHAMPVA beneficiaries received care in all 50 States, the District of Columbia, Puerto Rico, Guam, American Samoa, and the Virgin Islands. However, as Table 3 shows, 10 states accounted for about one-half of CHAMPVA care:

Table 3. The 10 States with the Highest Numbers of CHAMPVA Beneficiaries Receiving Care in FY 1996

	Number of Beneficiaries		Cost of Claims	
State	**Number**	**Percent**	**Amount**	**Percent**
Florida	4,708	10.1	$10,214,227	11.5
Texas	3,496	7.5	7,643,470	8.6
California	2,114	4.5	5,006,775	5.7
North Carolina	1,980	4.3	3,443,822	3.9
Oklahoma	1,907	4.1	3,490,067	3.9
Georgia	1,856	4.0	3,875,514	4.4
New York	1,830	3.9	3,321,697	3.8
Ohio	1,540	3.3	2,955,906	3.3
Arkansas	1,512	3.2	2,929,341	3.3
Virginia	1,502	3.2	2,982,042	3.4
10 States Total	**22,445**	**48.1**	**$45,862,861**	**51.8**
Remaining States/Locations	24,222	51.9	42,732,990	48.2
Total	**46,667**	**100.0**	**$88,595,851**	**100.0**

Source: CHAMPVA Workload and Cost Reports

Of the 46,667 beneficiaries who had claims paid, 22,445, or about 48 percent, resided in the 10 States listed in the table. Claims from these 10 States accounted for about $45.9 million (51.8 percent) of the $88.6 million in FY 1996 CHAMPVA payments. The remaining 24,222 beneficiaries who accounted for the remaining $42.7 million in claim costs resided in the other 40 States, Puerto Rico, and various American Territories.

Reviewing Claims Paid in Prior Years Could Result in Significant Recoveries

In January 1996, the HAC installed code auditing software to evaluate outpatient claims and help prevent inappropriate payments. The program was effective in preventing payments for:

- Multiple medical procedures that normally would not be performed on the same date of service.

- Individual procedures that are normally performed as part of more complex procedures and generally not billed separately.

- Services of clinical assistants whose presence was not required to perform a given procedure.

Because the code auditing program was effective for checking current claims, we think that the HAC should use it to reevaluate claims paid before January 1996. Based on our discussions with OIG legal staff, we believe that the HAC could pursue recovery of erroneous payments made during the 4 and one-quarter fiscal years prior to the January 1996 activation of the code auditing process.

To estimate the amount of potential recovery that could result from reviewing and reevaluating paid claims, we reviewed HAC reports on the savings achieved through the use of the code auditing software during FY 1997. These reports showed that savings were $1.47 million, or 3.76 percent of the total $39.07 million paid on outpatient claims. During the period from FY 1992 through the First Quarter of FY 1996, before the HAC began using the software, payments on claims processed by the HAC totaled about $111.1 million. (During this period OCHAMPUS was still processing some outpatient claims.) Based on the 3.76 percent inappropriate payment prevention rate achieved in FY 1997, we estimated that reviewing the $111.1 million in prior year payments could result in identifying about $4.2 million in inappropriate payments that have recovery potential. We recognize that there are many variables that would effect the actual amount of recoveries, such as the amount of staff time needed to review and reprocess paid claims and the costs of purchasing additional software and hiring staff to pursue collections.

HAC management had concerns about reviewing prior year claims. To address these concerns we recommended that they test recovery potential by reprocessing a sample of recent prior year paid claims using the code auditing program and pursuing recovery as staff time is available. Keeping a record of the costs of this test would allow management to determine if it would be cost effective to undertake a larger scale recovery effort. To further assist management in addressing this issue we identified three additional options:

1. Representatives of the code auditing software manufacturer told us that they could arrange a test of 100,000 prior year claims for a cost of about $10,000. The test would identify the value of potentially inappropriate claims. HAC management could evaluate these claims and determine if the values of the recoverable amounts would warrant the resource expenditure necessary to pursue recovery.

2. The software manufacturer's representatives told us that using their current software in conjunction with an additional software program would allow HAC staff to narrow the focus of any manual review to the most problematic claim codes and providers. The representatives estimated that this new program would cost about $41,000 installed, plus an $11,000 annual license fee. This fee would be payable only for the time the program was actually used. This means that if all prior year claims were identified during a 1-year period

the total cost of the program would be $52,000 ($41,000 + $11,000).

3. We found that there are private companies that will review and analyze these claims and pursue recovery of inappropriate payments for a fee. A representative of the company we contacted estimated that the fee for reviewing prior year claims and pursue recovery would be about $35,000 plus 45 percent of the amount of the recoveries.

Aggressively Pursuing Third Party Claims Could Increase Cost Recoveries

The HAC did not always aggressively pursue possible third party claims. The HAC's automated claims processing system used procedure and diagnostic codes associated with traumatic injuries to identify potential third party claims. When the system identified a potential third party claim, the computer generated a letter to the beneficiary and/or sponsor asking for specific information pertaining to the circumstances of the injury and the availability of other insurance to reimburse the costs incurred by CHAMPVA. The use of this initial inquiry letter resulted in some recoveries from third parties. (In FY 1996 these recoveries totaled $277,480.) However, if the beneficiary and/or sponsor did not respond to this letter, no follow-up action was taken. If the beneficiary (or the beneficiary's representative, usually an attorney) provided information showing that a third party was responsible for the incident, a third party claim was established and pursued.

To determine the impact of not aggressively pursuing all potentially liable third parties, we reviewed records pertaining to all claims totaling $10,000 or more that had associated diagnostic and procedure codes suggesting traumatic injuries. There were 46 cases that met these criteria. We found that the HAC computer had identified all 46 as potential third party cases and had sent letters requesting third party information. However, only nine beneficiaries, or their representatives, had responded to these letters or had provided the requested third party information. In these nine cases, the HAC had established third party claims and was pursuing recovery of payments totaling $438,996.

In the remaining 37 cases, the HAC neither received responses to initial inquiry letters nor took any follow-up action. Our detailed review of the 37 cases showed that 3 were the result of incidents where a third party could possibly be held liable for the cost of care. During FY 1996, CHAMPVA paid a total of $293,229 in claims for care of these 3 beneficiaries. We recognize that the actual amount of recovery would depend on variables such as a judicial determination of liability and limits of accident insurance policies. However, based on the amount of the claims paid in these three cases, we believe that the HAC should take aggressive action to determine third party liability and pursue recovery of claims costs.

During the audit we discussed this issue with HAC management. Management acknowledged a need to improve pursuit of third party cases and began improving follow-up procedures. Specific procedures implemented during the audit included designating a staff member as the third party case coordinator, exploring the option of denying payments to beneficiaries who do not respond to inquiry letters, and establishing a follow-up log to help ensure prompt follow-up by HAC staff.

Monetary Benefits
In Accordance With IG Act Amendments

Report Title: Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs

Project Number: 7R8-014

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds[2]	Questioned Costs
1a	Potential recovery of funds by reviewing prior year paid claims	$4.2 million	
1b	Potential recovery of funds by aggressively pursuing recovery of claims costs from potentially liable third parties	$293,229	

[2] The monetary benefit shown represents the total estimated possible recovery. The cost of any recoveries will be offset by the cost of HAC and Office of General Counsel staff time to develop and pursue these cases. The actual dollar amount of these recoveries will be controlled by numerous variables. For example, inappropriate prior year payments may not be recoverable from providers who have gone out of business, and third party recovery amounts will depend on factors such as legal determinations of liability and liability limits of insurance coverage.

Health Administration Center Director Comments

Department of Veterans Affairs

Memorandum

Date: November 26, 1997

From: Director, Health Administration Center

Subj: Response: Draft Report, Audit of the Civilian Health Administration Program of the Department of Veterans Affairs (Project No. 7R8-014)

To: Director, Seattle Audit Operations Division (52SE)

1. The following is in response to the Draft Report, Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs.

2. Recommendation #1: That the Director of the Health Administration Center ensure that prior year claims are reviewed for duplicate, erroneous, and/or fraudulent payments and recovery is pursued when appropriate.

Comment: We concur that there is potential for increasing recoveries of prior year claim payments. However, as the audit report notes, we are concerned about our legal authority to review prior year payments and about the resource commitment required. To address these concerns, we have requested a General Counsel opinion on legal issues pertaining to the recommended review. If this opinion supports the review, we will explore the various options, including those suggested by the OIG. If we can develop a cost-effective approach we will proceed with this review.

Implementation Plan: We requested a General Counsel opinion in November 1997. If the opinion states that the HAC has the legal authority to pursue the review, we will develop a review approach and will keep the OIG informed of the progress of the review.

3. Recommendation #2: CHAMPVA staff develop and aggressively pursue possible third party liability claims identified during this audit and establish procedures to ensure that future third party liability cases are promptly identified and actively pursued

Comment: We concur with this recommendation and have implemented the following actions.

a. A log has been established to track letters that have been sent to beneficiaries requesting TPL information. Using that log, if the information is not returned within 45 days, a follow-up letter is sent.

b. A task force within HAC has been established to review current procedure and recommend improvements. One of the initiatives they are working on is rewriting the language of our TPL follow-up letter to improve clarity for the recipient and increase the response rate. Another initiative is to analyze the types of claims that are referred to MCCR in an automated fashion and provide specifications to IRM to eliminate referral of claims that are not true TPLs.

VA Form 2105
Mar 1989

Health Administration Center Director Comments, Continued

c. The Center is pursuing inclusion in a national RFP (Request for Proposal) to contract MCCR to a private vendor.

4. As the only federal health benefits program directly involved in claims processing activities, I understand how difficult and complex it is to audit this operation. I must express my appreciation for the hard work and perseverance of your audit team. It is our mission to be a Center of Excellence, and audits are not only welcome, but also beneficial in assisting our organization to become more efficient.

(Original signed by:)
Michael W. Hartford

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