Department of Veterans Affairs

Office of Inspector General

AUDIT OF VETERANS BENEFITS ADMINISTRATION BENEFIT PAYMENTS INVOLVING UNREIMBURSED MEDICAL EXPENSE CLAIMS

Beneficiary claims for unreimbursed medical expenses are at risk for processing errors and potential program fraud.

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VA Office of Inspector General
Washington, DC 20420

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Memorandum to the Under Secretary for Benefits (20)

Audit of Veterans Benefits Administration Benefit Payments Involving Unreimbursed Medical Expense Claims

1. At the request of the former Under Secretary for Benefits, who was concerned about potential program fraud, the Office of Inspector General (OIG) conducted an audit of the Veterans Benefits Administration's (VBA) benefit payments to beneficiaries receiving increased benefits as a result of Unreimbursed Medical Expense (UME) claims. The objectives of the audit were to:

- Evaluate the effectiveness and efficiency of VBA's procedures for verification of UME claims.
- Identify the extent of unsupported UME claims and processing errors.
- Determine the extent of any potential program fraud.
- Determine causes and identify solutions to any deficiencies identified.

2. VBA administers an Improved Pension (IP) program that pays benefits to veterans because of a Department of Veterans Affairs (VA) determination of the veteran being permanently and totally disabled, or to a surviving spouse or child because of a veteran's death. Basic eligibility for benefits is based on honorable wartime service and recipients must meet specific income and net worth limitations. During Fiscal Year (FY) 2001, $2.9 billion in IP benefits were paid to 507,149 veterans and their survivors. VBA also administers a parents' Dependency and Indemnity Compensation (DIC) program that pays benefits to surviving parents due to a veteran's service connected death. Basic eligibility for benefits in this program is also subject to income limitations, but not net worth limitations. During FY 2001, $22 million in DIC benefits were paid to 9,384 surviving parents of deceased veterans. Benefits paid in these programs are reduced by any income that the beneficiaries receive. Beneficiaries are allowed to offset income received by the amount of UMEs, once these expenses exceed 5 percent of the Maximum Available Pension Rate (MAPR) for IP, and once UMEs exceed 5 percent of reported income for DIC.

3. The audit found that beneficiaries are inappropriately submitting UME claims that may significantly increase the level of their benefit payments. Processing of these claims was not effectively handled by VBA, resulting in processing errors and potential program fraud with a significant number of erroneous benefit payments to claimants (both overpayments and underpayments).

4. Processing errors and potential program fraud results in beneficiary overpayments of as much as $124.7 million and underpayments totaling as much as $19.9 million annually. These processing errors and potential program frauds represent significant potential lifetime overpayments and underpayments to beneficiaries.

5. Processing errors and potential program fraud have occurred because VA Regional Offices (VAROs) are not effectively managing the processing of UME claims. Also, VBA needs to enhance the effectiveness of its verification of UME claims under the Provider Proof

Verification (PPV) program and ensure that higher cost claims (UME claims over $15,000) are verified. Erroneous benefit payments occurred due to the following:

Overpayments

- Medicare (Part B) premiums expenses were claimed, but not actually paid.
- Income and net worth were not properly reported.
- Continuing Medical Expense Deductions (CMEDs)[1] were not properly adjusted to reflect actual lower costs.
- Claimed nursing home costs were not reduced for Medicaid reimbursements.
- Other processing errors occurred because UME claims were not fully developed or mathematical errors were made in computing UME claims.

Underpayments

- Medicare (Part B) premiums paid were not properly claimed or adjusted by VBA to reflect increases in annual expenses.
- UME claims were not fully developed or mathematical errors were made in computing UME claim amounts.

Potential Program Fraud

- Income, net worth, or UME were not properly reported.
- UME claims were for expenses that had already been reimbursed.
- The death of a veteran was not reported to VA timely, and not all of the IP checks were returned.

6. We recognize that VBA's planned establishment of Pension Maintenance Centers (PMCs) will offer the opportunity to better manage and control UME claims processing. However, we believe that in the short term, some improvement actions can be made in processing UME claims as VBA moves to a more centralized processing approach. These actions include:

- Establishing performance criteria for processing UME claims and holding responsible officials accountable for performance deficiencies.
- Preparing a notification letter to all beneficiaries in the IP and parents' DIC programs that informs them of:
  - The potential to claim UMEs for Medicare (Part B) premiums.
  - The importance of only claiming these UMEs if not reimbursed by the State or other third-party.
- Requiring a Share System[2] social security information inquiry on all Eligibility Verification Reports (EVRs)[3] and UME claims to verify claimed Medicare (Part B) premiums expenses and make adjustments as appropriate.

[1] These expenses are allowed prospectively if they are recurring or reasonably predictable (i.e., nursing home fees).
[2] This system allows VBA access to social security benefit information, including Medicare payments.
[3] VA uses these reports to confirm continued eligibility of beneficiaries of its need-based programs. Most IP and parents' DIC beneficiaries must complete an EVR at least once a year.

- Increasing the PPV program sampling selection process back to 1 percent and monitor results to determine how many UME cases are actually being selected and how many cases did not have acceptable support for UMEs.
- Requiring support of UME claims for all beneficiaries, if a need is demonstrated by PPV program monitoring.
- Establishing VBA policy to require support of future UME claims for a 3-year period where acceptable support was not received under the PPV program.
- Modifying the Benefits Delivery Network (BDN) system so that UME claims and costs can be identified for review. Capture of this automated information would help ensure that higher cost claims (UME claims over $15,000) could be identified and verified.
- Recovering UME related beneficiary overpayments identified by the audit and making payments to beneficiaries for benefits that they are entitled to receive.

7. Implementation of the report recommendation will provide the opportunity for improved claims processing and program oversight that could help ensure that VBA provides beneficiaries with the benefit payments that they are entitled to receive. The Under Secretary for Benefits agreed with the report findings, and provided acceptable implementation plans that address the intent of the recommendation. We will follow up on the planned actions until they are completed.

(original signed by:)
MICHAEL SLACHTA, JR.
Assistant Inspector General for Auditing

RESULTS AND RECOMMENDATIONS

Beneficiary Claims For Unreimbursed Medical Expenses Are At Risk To Processing Errors and Potential Program Fraud

VBA needs to more effectively manage beneficiary UME claims to reduce the risks of processing errors and potential program fraud. UME claims processing errors and potential program fraud are resulting in a significant number of erroneous benefit payments to claimants (both overpayments and underpayments). In addition, we found that some UME adjustments that would have increased benefit payments were not processed.

Processing Errors Resulted In Overpayments Of Benefits To Beneficiaries

Based on the results of our random sample, we estimated that processing errors resulted in overpayments to as many as 24,236 beneficiaries by as much as $49.1 million annually. Estimated lifetime[4] overpayments for these cases could be as much as $396.6 million. *(Details are presented in Appendix III on pages 14-21)*. Processing errors were identified in 50 of the 328 (15.2 percent) sample UME cases reviewed, and resulted in overpayments totaling $159,511 for the following reasons:

- In 14 cases, the beneficiaries claimed Medicare (Part B) premiums, but review of the social security benefit information in the Share System showed that they were not paying a premium to Medicare. The overpayments for these 14 cases totaled $5,550, with an average overpayment per case of $396.
- In 10 cases, income or net worth was not properly reported or processed. The overpayments for these 10 cases totaled $66,259, with an average overpayment per case of $6,626.
- In 10 cases, the UME claim was not fully developed (unsupported UMEs were allowed) or mathematical errors were made when processing the claim. The overpayments for these 10 cases totaled $12,307, with an average overpayment per case of $1,231.
- In nine cases, the CMED was not properly adjusted to reflect the actual amount claimed. The overpayments for these nine cases totaled $14,510, with an average overpayment per case of $1,612.
- In seven cases, the award was not properly adjusted for beneficiaries that have nursing home expenses paid by Medicaid. The overpayments for these seven cases totaled $60,885, with an average overpayment per case of $8,698.

[4] Lifetime estimates were calculated using VBA's life expectancy table for net worth determinations contained in VBA Manual M21-1, Part IV, Chapter 16, and Addendum B. The annual dollar impact was multiplied by the number years of life expectancy. We did not calculate or project lifetime benefits on cases where the claimant died, the claim had been terminated for other reasons, or claims that had one-time processing errors such as mathematical errors. Also, the estimates did not include future increases in VA benefits, income, or UME claims.

The following are examples of processing errors that resulted in overpayments:

- A beneficiary had not filed a UME claim. The VARO established a CMED in September 1998 on the beneficiary's behalf for Medicare (Part B) premium expenses based on a Share System printout showing social security benefit information. Based on the annual increase in Medicare (Part B) premiums, VARO staff made adjustments to the CMED without the beneficiary requesting them to or without a UME claim. Program guidelines require that support such as a Target[5] M15 screen inquiry must be obtained prior to allowing this UME without specific request from the beneficiary. There was no evidence in the claims file that a Target inquiry had been made. Our review of the Share System showed that the State the beneficiary resided in began paying his Medicare (Part B) premium expenses in 2001. As a result, the beneficiary was overpaid $132 in IP annually. The lifetime overpayment would be $1,901.
- A beneficiary submitted a UME claim for $1,004 that included Medicare (Part B) premiums, and the VARO set up a CMED for only the Medicare (Part B) premiums. A review of the beneficiary's automated master record found that while there was a verified amount for social security benefits, there was no verified amount for the Medicare (Part B) premiums. A review of social security benefit information through the Share System found that the State the beneficiary resided in had been paying the Medicare (Part B) premiums since 1996. As a result, the beneficiary was overpaid $540 in IP annually. The lifetime overpayment would be $4,806.
- A beneficiary is a resident of a State Nursing Home (NH). The beneficiary is receiving the maximum allowable pension because of a reported $37,072 in NH care costs that offsets $24,004 in other reported income. The NH costs are set up as a CMED. On the last two EVRs the beneficiary stated that Medicaid covers all or part of NH fees. Contact with the Veterans Benefits Specialist at the NH confirmed that the NH is Medicaid approved and receives Medicaid payments for the beneficiary. Under Title 38 United States Code, Section 5503, the beneficiary's IP should have been reduced to $90 per month because he is not married and has no dependents. As a result, the beneficiary was overpaid $14,436 in IP annually. The lifetime overpayment would be $128,480.

Processing Errors Resulted In Underpayments Of Benefits To Beneficiaries

Based on the results of our random sample, we estimate that processing errors resulted in underpayments of as much as $19.9 million annually to as many as 58,436 beneficiaries. Estimated lifetime underpayments could be as much as $172.4 million. *(Details are presented in Appendix III on pages 14-21.)* Processing errors were identified in 75 of the 328 (22.9 percent) sample UME cases reviewed, and resulted in benefit underpayments totaling $26,942 for the following reasons:

- In 60 cases, Medicare (Part B) premiums were not processed correctly (i.e., paid but not claimed, or CMED not properly adjusted to reflect increases in premiums). Medicare (Part B) premiums alone were not enough to offset income until the Calendar Year (CY) 2000

[5] This VBA system provides access to beneficiary claims information.

premium increase. Underpayments for the 60 cases totaled $15,357, with an average underpayment per case of $256.

- In 15 cases, the UME claims were not fully developed (UMEs not allowed that should have been), or mathematical errors were made when processing the claims. Underpayments for the 15 cases totaled $11,585, with an average underpayment per case of $772.

The following are examples of processing errors that resulted in underpayment of benefits:

- VARO staff had flagged a beneficiary's claims file to show that he was paying a non-standard Medicare (Part B) premium rate. The beneficiary's automated master record showed the rate was currently $54.60 per month ($655 annually). The beneficiary submitted a Medical Expense Report claiming $149.28 in UMEs for CY 2001. VARO staff took no action on the claim because it did not exceed 5 percent of the MAPR that is required before the beneficiary's income can be reduced. However, VARO staff should have added the Medicare (Part B) premiums expense to the claim and processed an adjustment to the beneficiary's reported income since the combined expenses would have exceeded the 5 percent threshold for claimable expenses. This would have reduced the beneficiary's reported income and increased his annual benefits payment by $204.
- We found no documented claim adjustment actions in a beneficiary's claims file since 1999. However, a review of the beneficiary's automated master record showed that the veteran had increased social security benefits and Medicare (Part B) premium expenses, yet these changes were not reflected in the beneficiary's Income for VA Purpose (IVAP) or CMED. If the VARO staff had processed these necessary adjustments, the beneficiary's IP would have increased by $568 annually, with a lifetime benefits increase of $5,282.
- We found no documented claim adjustment actions in the beneficiary's claims file after 1997. A review of the beneficiary's automated master record showed that both the veteran and his spouse were paying Medicare (Part B) premiums. VBA Manual M21-1, Part IV, Section 16.31 b. (9) states that a UME deduction for Medicare premiums may be allowed without a specific claim from the beneficiary if there is evidence that the premiums are being paid. Had the beneficiary been notified or been sent an EVR, he could have filed a UME claim for $1,200, resulting in an increase to his IP by $591 annually. The lifetime increase in benefits would be $5,260.

Potential Program Fraud Resulted In Beneficiary Overpayments

Based on the results of our random sample, we estimate that as many as 9,108 claimants fraudulently obtain as much as $75.6 million in benefit payments annually. Fraudulent lifetime benefit payments could be as much as $962.3 million. *(Details are presented in Appendix III on pages 14-21.)* Potential fraud was identified in 9 of the 328 (2.7 percent) sample UME cases reviewed.

We referred the nine potential fraud cases to the OIG Office of Investigations (OI) for determination of fraud. Potential fraudulent claims resulted in benefit overpayments totaling $80,972 for the following reasons:

- In seven cases, beneficiaries did not properly report assets, including income, or UMEs. Overpayments in these seven cases totaled $69,264, with an average overpayment per case of $9,895.
- In one case, our verification of UMEs claimed showed that the beneficiary received insurance reimbursements for or did not pay some of the UMEs claimed. The overpayment totaled $10,445.
- In one case, the beneficiary died prior to receiving his first check and the effective date of his award. This award was based on UMEs submitted with his application. The two checks that were not returned to VA totaled $1,263.

The following are examples of potential fraud that resulted in overpayments of benefits:

- A beneficiary applied for and began receiving IP benefits in 1999. On his application for IP, the beneficiary reported a total net worth of $18,464 for himself, $31,384 for his spouse, and $5,974 in annual medical expenses. The application also listed $16,931 in social security benefits for the beneficiary and his spouse. On his Medical Expense Report dated January 17, 2001, the beneficiary claimed $19,270 in UMEs. However, we found that the claim included NH expenses of $9,485 and Long Term Insurance expenses of $960 that were not paid by the beneficiary. We contacted the beneficiary's insurance company and found that not only did he have a long-term disability claim with them for NH costs; the insurance company had also set him up for a premium waiver on his policy. The impact of this potential fraud to VA would be $10,445 annually with a lifetime overpayment of $87,738.
- A beneficiary had not properly reported his spouse's income, and was not entitled to receive IP. The veteran has inappropriately received $12,480 in IP annually with a lifetime overpayment of $379,392.

We will provide VBA program officials with a listing of the beneficiary overpayment and underpayment cases so appropriate payment adjustments can be made.

The extent of UME processing errors and potential program fraud identified in our review points to a need for more effective program oversight and performance assessment to help ensure that beneficiaries receive the benefits they are entitled to receive. The UME processing errors we identified should be avoidable with more effective processing. To accomplish this, VBA needs to establish specific performance criteria for processing UME claims and hold responsible officials accountable for performance deficiencies that are identified.

Additional Beneficiaries Could Have Claimed UMEs With Increased Benefit Payments

Additional beneficiaries could have claimed UMEs that would increase their benefit payments. Based on the results of our random sample, as many as 42,465 additional beneficiaries could have filed UME claims totaling as much as $22.3 million to offset income totaling as much as

$197.8 million. These potential claims would have increased annual benefit payments by as much as $5.4 million. *(Details are presented in Appendix III on pages 14-21.)*

In 30 of the 328 (9.1 percent) random sample cases reviewed, the beneficiaries paid Medicare (Part B) premiums[6], but had not submitted UME claims for these expenses. These potential UME claims were identified by documentation we found in the claims files or review of automated records systems (Target and Share). Generally, these cases had no EVR controls because the beneficiaries' only income was VA and social security benefits, thus requiring no input from the beneficiary for the VARO staff review. In 10 of the 30 (33 percent) cases, we found no documented activity involving the beneficiary's claim for over 3 years. Examples of potential UME claims are as follows:

- The last EVR in a claims file was submitted in 1994. The beneficiary claimed UME for Medicare (Part B) premium deductions in that year; however, no CMED was established. Review of the beneficiary's automated claims record showed that both the veteran and his spouse continued to pay annual Medicare (Part B) premiums, but did not submit any additional UME claims. Had these UMEs been claimed, the beneficiary would have received an additional $600 in IP annually, with an additional lifetime increase in benefits of $7,200.
- The last EVR in a claims file was submitted in 1999. The beneficiary claimed UME for Medicare (Part B) premium deductions in that year. However, the beneficiary's automated claims record showed that the veteran continued to pay annual Medicare (Part B) premiums, but did not submit any additional UME claims. If this UME had been claimed, the beneficiary would have received an additional $120 in IP annually, with an additional lifetime increase in benefits of $1,116.

After the Medicare (Part B) premium increase in 2000, this expense alone now exceeds 5 percent of the MAPR that is required before a beneficiary's IVAP can be reduced for computing benefit payments. Based on the significance of this potential UME claim and opportunity for beneficiaries to receive increased benefit payments, we believe that VBA should prepare a notification letter to all beneficiaries in the IP and parents' DIC programs that would highlight the need to submit UME claims for these premium expenses. The letter should inform beneficiaries that Medicare (Part B) premiums may now be used to reduce IVAP, with increased benefit payments. The letter should also highlight the importance of only claiming these UMEs if they are not reimbursed by the State or other third-party. Also, based on the number of processing errors we found involving beneficiary claims for Medicare (Part B) premiums, VBA needs to require a Share System inquiry be completed on all EVRs and UME claims to verify the expenses claimed.

[6] VBA Manual M21-1, Part IV, Chapter 16, Section 16.31 b. (9) states – "If there is entry in the 'SMIB VER RATE' field on the (Target) M15 screen, a UME deduction for Medicare (Part B) premiums without a specific claim from the claimant can be allowed." This issue was highlighted in the STAR Reporter (a newsletter for quality improvement issued to address concerns identified by STAR program reviews) in March 2001. The newsletter informed field staff that if Medicare (Part B) premiums are identified by Share inquiries, UME deductions to income could be allowed without being specifically claimed by the beneficiaries.

VBA Needs To Improve Program Oversight And Enhance Verification Of Beneficiary UME Claims

Our review of UME claims found that VBA's automated systems do not have the capability to capture automated information that identifies all UME claims. As a result, sufficient information is not available to effectively select UME cases for review as part of the monthly PPV program that verifies veterans' UME claims. Our review of statistical data compiled from VARO reports for a 2-year period (July 3, 1997 to July 6, 1999), showed that on average only 99 of the 397 (24.9 percent) cases that were selected monthly for the PPV program actually involved UME claims. While the case selection process only resulted in a review of a small number of actual UME claims, the PPV program identified over $1 million in unsupported UME claims. With improved case selection, the effectiveness of the PPV program could be enhanced with the opportunity to identify additional unsupported UME claims and recover overpayments.

Additionally, this lack of the capability of VBA's automated systems to capture automated information prevents VBA from determining the number and dollar impact of all UME claims nationwide. Our random sampling case review found that these claims are significant with as many as 126,107 claimants filing UME claims annually totaling as much as $451.5 million to offset income totaling as much as $835.6 million. These claims increased benefit payments by as much as $261.9 million. *(Details are presented in Appendix III on pages 14-21.)*

VBA's plan to establish PMCs may offer the opportunity to better manage and control UME claims processing with fewer errors that result in payment discrepancies. However, as VBA moves to a more centralized processing approach, it also needs to improve its follow-up process to verify beneficiary UME claims. Because VBA does not have complete automated information on beneficiary UME claims, its ability to monitor and verify the accuracy of these claims is limited.

During the course of the audit, we issued an Interim Advisory[7] that addressed the need to maintain more complete automated information that can be used for improved program oversight. By capturing automated information on all UME claims, VBA would be able to:

- Accurately determine the impact of UME claims on the IP program.
- Enhance the effectiveness of the PPV program by selecting only cases that involve UME claims for review.
- Provide additional opportunities to identify unsupported or fraudulent UME claims.

In response to our Interim Advisory, VBA modified the case selection process for the PPV program, rather than make extensive modifications to automated systems that would be needed to capture all the automated information on UME claims. Beginning in January 2002, the case selection process was changed to select only cases with CMEDs or with retroactive payments effective January 1st of the year being reviewed. In addition, the sample size was also reduced to

[7] Interim Advisory, Audit of Accuracy of Pension Payments Involving Unreimbursed Medical Expense Claims (OIG Project No. 2000-00061-D2-0023) issued May 16, 2001.

½ percent because fewer cases would need to be reviewed because all cases selected would be UME claims.

Based on our review of the PPV program, we believe that the sample size should remain at 1 percent to provide a minimal level of monitoring of support for UME claims and VARO processing effectiveness. We reviewed 62 randomly selected cases out of the 654 cases in which support for UMEs was reported as received by VAROs in CY 2000. This review showed that 21 of the 62 (33.9 percent) cases had the following processing errors:

- In 3 of the 62 (4.8 percent) cases, UMEs were not actually claimed. These cases should have been identified as "Meds Not A Factor" cases and not as "Proof Received" cases.
- In 9 of the 62 (14.5 percent) cases, we found no supporting evidence in the claims file.
- In 9 of the 62 (14.5 percent) cases, the proof received was not sufficient.[8]

In an effort to ensure the integrity of the PPV program, VBA has begun including PPV program cases in VARO onsite program reviews conducted by VACO staff. In addition to this effort, VBA needs to establish policy to require support for UME claims for a 3-year period where acceptable support was not received as part of the PPV program monitoring. If a need is demonstrated by the PPV program results, VBA should consider requiring support of UME claims from all beneficiaries.

We believe that capturing automated information on all UME claims is needed to strengthen program oversight and integrity. Modifications to VBA's automated information systems should be made to capture information on all UME claims. This would ensure that higher cost claims (UME claims over $15,000[9]) could be identified and verified. Until necessary modifications can be completed, VBA should implement procedures at the PMCs to capture automated information, such as tracking the amounts claimed, on all UME claims. These measures would help further strengthen program integrity and ensure UME claims are supported.

Conclusion

Processing errors and potential program fraud have occurred because of ineffective case management for monitoring of the accuracy and support for UME claims. Improved claims processing and program oversight could help ensure that VBA provides beneficiaries with the benefit payments that they are entitled to receive.

[8] VBA Manual M21-1, Part IV, Chapter 16, Section 16.31 m. contains specific criteria to meet for acceptable or sufficient proof under the PPV program.

[9] This review threshold would result in the verification of the more costly UME claims (NH costs) to ensure that they are supported.

Recommendation 1.

That the Under Secretary for Benefits takes the following actions to strengthen oversight and control over the UME claims process:

a. Enhance processing of UME claims to ensure that beneficiaries receive the benefits they are entitled to receive by establishing performance criteria for processing UME claims and holding responsible officials accountable for performance deficiencies that are identified.

b. Prepare a notification letter to all beneficiaries in the IP and parents' DIC programs that informs them of:

- The potential to claim UMEs for Medicare (Part B) premiums.
- The importance of only claiming these UMEs if they are not reimbursed by the State or other third-party.

c. Require a Share System social security information inquiry be completed on all EVRs and UME claims to verify claimed Medicare (Part B) premium expenses and make adjustments as appropriate.

d. Increase the PPV program sampling selection process back to one percent and monitor results to determine the number of UME cases that are actually being selected and how many cases did not have acceptable support for UMEs.

- Consider requiring support of UME claims for all beneficiaries, if a need is demonstrated by PPV program monitoring.

e. Establish VBA policy to require support for future UME claims for a 3-year period where acceptable support was not received under the PPV program.

f. Modify the BDN system so that UME claims and costs can be identified for review. Capture of this automated information would help ensure that higher cost claims (UME claims over $15,000) could be identified and verified.

g. Recover UME related beneficiary overpayments identified by the audit and make payments to beneficiaries for benefits that they are entitled to receive.

Under Secretary for Benefits Comments

The Under Secretary for Benefits agreed with the report findings, and provided acceptable implementation plans that address the intent of the recommendation.

Implementation Plan

The Under Secretary provided the following implementation plans for recommendation 1 (a-g):

(a) VBA's consolidation of pension maintenance activities into three PMCs has as one of its stated objectives enhanced performance of program integrity functions. One of the measures by which the pension centers will be measured in the coming year is the execution of program integrity efforts of which UMEs are a part.

(b) The "Medical Expenses" paragraph of VA form 21-0287 will be amended to read as follows: "You can report medical expenses that you had to pay including Medicare (Part B) premiums. Do not report any amounts paid by insurance, Medicaid, or anyone else. You can only report the amount that you paid. We're enclosing a form for you to use to report these expenses. But remember, we must receive your report of medical expenses before the end of the next calendar year. For example, medical expenses paid in 2002 must be received by December 31, 2003."

(c) A pending change to M21-1, Part IV, Paragraph 16.31m(8) will include the following language: "Place a copy of a Share System Social Security print in the claims file each time an award is processed to allow a UME deduction for Medicare premiums."

(d) A Project Initiation Request to increase the PPV program sample selection process back to 1 percent is in concurrence. The Compensation and Pension (C&P) Service currently monitors results of the PPV program to determine how many cases did not have acceptable support for UMEs. This monitoring will continue. We will consider requiring support of UME claims for all beneficiaries if a need is established by PPV program monitoring.

(e) We are amending M21-1 Part IV, Paragraph 16.31m(6) to provide that documentary proof of medical expenses will be required for a 3-year period from the date it is determined that acceptable documentation of prior medical expenses was not received under the PPV program.

(f) During discussions between OIG and VBA representatives it was agreed that we would not modify BDN. However, we are amending M21-1, Part IV, Paragraph 16.31b(1)(c) to read as follows: "Telephone the nursing home to verify that claimed nursing home fees in excess of $15,000 per year were paid by the claimant without reimbursement. Document the call on a Report of Contact."

(g) We will review every case and make a decision.

(See Appendix V on pages 23-25 for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

The Under Secretary's implementation plans are acceptable. VBA's agreement to verify claimed UMEs for NH costs in excess of $15,000 is an acceptable alternative to our recommendation to modify BDN to identify higher cost claims for review. The audit found that the majority of higher cost claims involved NH costs. We will follow up on the planned actions until they are completed.

Appendix I

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The purpose of the audit was to determine the accuracy and support of UME claims. The objectives of the audit were to:

- Evaluate the effectiveness and efficiency of VBA's procedures for verification of UME claims.
- Identify the extent of unsupported UME claims and processing errors.
- Determine the extent of any potential program fraud.
- Determine causes and identify solutions to any deficiencies identified.

Scope and Methodology

To accomplish the audit, we selected a random sample of 500 cases out of the 342,573 IP and parents' DIC cases with monthly benefit payments greater than $200 as of September 30, 2000. Because VBA's automated systems did not have the capability to capture automated information on all UME claims, we stratified the universe of 342,573 cases in an effort to isolate cases that had UME claims. Additionally, we reviewed a random sample of 62 of the 654 cases selected under the PPV program, in which provider proof was received in CY 2000. We also reviewed a random sample of 99 out of the 1,032 cases where provider proof was pending as of December 31, 2000. *(Details are presented in Appendix III on pages 14-21.)*

We held discussions with program officials in VBA's C&P Service to identify program management controls and procedures. We visited six VAROs (Washington, Philadelphia, Pittsburgh, Boston, Roanoke, and Winston-Salem) to review claims files and evaluate management controls over the UME claims process. While onsite, we met with the VARO Directors, Veterans Service Center Managers (VSC), and VSC staff. We also had beneficiary claims files sent to our office for review to identify UME claims and determine if they were accurately processed and supported. If we found no sufficient support of the UME in the claims file, we requested additional support from the claimant or provider.

We used automated information from VBA's Compensation, Pension, and Education Master Record System for sample selection. An assessment of the reliability of this automated information was made by comparison testing of selected data elements to documentation in the claims files. We concluded, based on our comparison test, that the automated information we used to accomplish the project objectives was sufficiently reliable.

The audit was performed in accordance with generally accepted Government Auditing Standards for performance audits.

Appendix II

BACKGROUND

VA pays pensions, a need-based benefit, under three programs to wartime veterans whom VA considers to be permanently and totally disabled from non-service connected disabilities and who's IVAP is below the limit established by Congress. Survivors of wartime veterans may also qualify for pensions based on financial need. There is no disability requirement for survivors or wartime veterans age 65 or older. Two of the pension programs, Section 306 and Old Law, are closed and eligibility is restricted to beneficiaries with continuous entitlement to these benefits from the date the programs ended until the present. The IP program is the only program open to new beneficiaries. VA also pays parents' DIC (based on a veteran's service connected death) to financially dependent parents whose IVAP is below the limit set by Congress. The intent of these VA need-based benefit programs is to give the claimants minimum levels of financial security. Both programs are impacted by the beneficiaries' incomes. The number of IP and parents' DIC beneficiaries and estimated expenditures at the beginning of FY 2001 are presented in the following table.

Number of IP and Parents' DIC Beneficiaries Beginning FY 2001[10]

	Number of Beneficiaries	Total Annual Benefits Amount	Average Annual Benefit Amount
Improved Pension			
Veterans	340,312	$2,116,153,884	$6,218
Survivors	179,929	$580,305,984	$3,225
Total	**520,241**	**$2,696,459,868**	**$5,183**
Parents' DIC	10,413	$24,295,327	$2,333

Relationship Of Benefit Payments To Income, Net Worth, And UMEs

Because both IP and parents' DIC are need-based benefit programs, entitlement is based on the claimants' incomes. While net worth is also considered for IP, it is not a factor for parents' DIC. Net worth is evaluated at the time of application for the need-based benefit. Unlike income limits that are established by Congress, there is no specific dollar amount established for excessive net worth. However, the general rule is that if a claimant's assets are sufficiently large enough that the claimant could live off these assets for a reasonable period of time, then the claimant would not be eligible for a need-based benefit. If circumstances change so that excessive net worth is no longer a factor, the claim can be reopened or a new claim can be filed. Likewise, net worth should be monitored by VBA while the claimant is receiving benefits and benefits should be terminated if net worth becomes excessive.

Under these need-based benefit programs the maximum annual rate payable, as set by Congress, is reduced by the income a beneficiary receives. Generally, the higher the beneficiary's income the lower the rate of benefits payable will be. A beneficiary's IVAP may be reduced by deducting UMEs paid by the claimant, which increases the rate of IP or parents' DIC benefit payments up to the maximum rate payable. UMEs are not deducted from a claimant's income dollar-for-dollar. For IP, only those UMEs exceeding 5 percent of the applicable MAPR are

[10] The source of this data was the VBA Annual Benefits Report FY 2000 dated February 2001.

deductible. For parents' DIC, only those UMEs exceeding 5 percent of the claimant's reported annual income are deductible.

Beneficiary Reporting Of UMEs To VA

VA uses EVRs to confirm the continued eligibility of beneficiaries of its need-based benefit programs. Most IP and parents' DIC program beneficiaries must complete an EVR at least once a year. However, those beneficiaries who have social security income only or no reported income from any source, are not sent EVRs and are only required to submit changes in income if they occur. VBA verifies social security benefits annually through the Social Security Administration.

A separate form for reporting UMEs is included with EVRs mailed to IP and parents' DIC program beneficiaries. Properly reported UMEs can result in a retroactive increase in benefits for the past EVR period (retroactively), or a reduction of the IVAP used in determining the rate payable for the future EVR period (prospectively). Usually, the medical expense deduction and resulting retroactive increase in benefits are allowed after the fact. However, a continuing deduction may be allowed if a claimant has unreimbursed medical expenses that are expected to continue from year to year. Examples of continuing UME deductions are NH fees, wages of in-home attendants, Medicare (Part B) premiums, or costs of private health insurance.

UMEs may be used to reduce IVAPs if all of the following conditions exist:

- The beneficiary has actually paid the expenses. Medical expenses may be allowed prospectively if they are recurring or reasonably predictable (i.e., NH fees).
- The beneficiary has not received and will not receive reimbursement for the expenses from any source.
- The unreimbursed expenses were incurred on behalf of the beneficiary or a relative of the beneficiary who is a member of the beneficiary's household.
- The expenses were paid on or after the date of entitlement to the needs-based program.
- Total UMEs exceed 5 percent of the applicable MAPR for IP or exceed 5 percent of income for parents' DIC.

A beneficiary is not routinely required to submit support of payment of UMEs claimed. However, the beneficiary must provide all of the following information before the UME claim can be allowed:

- Name of payee, date paid, and amount actually paid for which no reimbursement is expected.
- Specific medical purpose for which payments were made.
- For whom paid (i.e., self, spouse, or other dependent).

Verification Of Reported UME

Support must be submitted if VARO staff processing the reported UME has reason to question the expenses. If a claimant fails to respond to the request for support or is unable to provide

support, VARO staff can require support be submitted for future periods before a UME claim is approved. As a result of a 1991 General Accounting Office (GAO) report[11] recommendation, VBA established the PPV program in 1993 to systematically verify the accuracy of UMEs claimed by beneficiaries.

Under the PPV program, VBA randomly selects ½ percent of all IP cases for verification of UME claims, if any. The cases requiring verification are selected monthly and referred to the VAROs having jurisdiction of the claims file for development and any necessary award adjustments. Case development includes determining if a UME claim was filed for the 12-month period prior to selection under the PPV program. If the case selected had a UME affecting the rate of pension payable and support of payment of the claimed expenses is not of record, VARO staff notifies the beneficiary that this support must be submitted. Copies of the claimant's canceled checks alone are not acceptable support. Acceptable support can be a bill receipt, statement on the provider's letterhead, computer summary, or other document from the provider.

If the beneficiary does not provide support or if support provided is not sufficient, the unverified expenses are removed from the award, which may result in a retroactive reduction in the pension payable and an accounts receivable being established. VAROs must report to VACO the final action taken on all UME verification cases, including the amount of any accounts receivable.

VBA Has Begun Centralizing Pension Maintenance Responsibilities To PMCs

As a result of the Secretary of Veterans Affairs concern over the timeliness and accuracy of claims processing, the VA's Claims Processing Task Force was created in April 2001. One of the task force's recommendations was to develop specialized PMCs to work specific pension maintenance tasks in order to increase efficiency, quality, and free up labor hours to support higher priority claims processing. PMCs were established in December 2001 to centralize pension maintenance work from 57 VAROs to improve performance through specialization and increase expertise. The goal is to complete centralization of this workload into three PMCs by the end of CY 2003. The PMCs are located at the Philadelphia, Milwaukee, and St. Paul VAROs.

When fully staffed and operational, the PMCs will process all non-original IP, death pension, and parents' DIC claims. The appropriate VAROs of jurisdiction will continue to process all original claims for these benefits. The PMCs began processing EVRs, including UME claims, in FY 2002. More than 165,000 EVRs were mailed to beneficiaries in January 2002. By mid-February 2002, the PMCs had processed more than 102,000 EVRs.

[11] GAO report number GAO/HRD-91-94 (VA Needs to Verify Medical Expenses Claimed by Pension Beneficiaries) issued July 1991.

Appendix III

SUMMARY OF RANDOM SAMPLE RESULTS

SAMPLING PLAN

Audit Universe

Initial research and discussions with VBA officials found that, with the exception of CMEDs, IP and parents' DIC cases involving UME claims could not be isolated. As a result, the initial audit universe consisted of all active IP and parents' DIC claims as of September 30, 2000. Due to lack of materiality for potential losses, we did not review any cases where the monthly award was equal to or less than $200.

The PPV program was established in September 1993 to systematically verify UME claims. Each month, the Hines Benefits Delivery Center randomly selects about 1 percent (this was reduced to ½ percent beginning January 2002) of the active IP cases and sends a C&P master record printout to the VARO of jurisdiction and a copy to C&P Service in VACO. The VARO must then verify the UME claims. Once verification is completed, staff in VACO is notified that: (1) proof was received, (2) proof was not received and an accounts receivable was established, or (3) UMEs were not a factor. To evaluate the PPV program, we identified all the cases where VACO received notice that provider proof was received in CY 2000 or where notice was pending as of December 31, 2000.

Sample Design

The purpose of the IP and parents' DIC case review was to address the following objectives:

- Evaluate the effectiveness and efficiency of VBA's procedures for verification of UME claims.
- Identify the extent of unsupported UME claims and processing errors.
- Determine the extent of any potential program fraud.
- Determine causes and identify solutions to any deficiencies identified.

The purpose of the PPV case review was to evaluate the effectiveness of the PPV program in verifying UME claims and determine if appropriate support for PPV is maintained in C&P claims files.

VBA's 1 percent sampling of IP claims for the PPV program found that only about 25 percent of the cases involved UME claims. As a result, the audit universe was stratified in an effort to isolate cases involving UME claims and potential program fraud. The table at the top of next page reflects the stratum control identifier, strata attributes, number of cases in the universe, and number of cases in the sample as determined by the OIG Statistician based on sampling objectives and strata attributes.

Appendix III

Random Sample Cases

Stratum Control Identifier	Strata Attributes	Number of Cases In Universe	Number of Cases In Sample
S2	IP with retro increase indicator and continuing medical expenses	12,313	51
S3	IP with retro increase indicator and no continuing medical expenses	11,863	30
S4	IP and continuing medical expenses	58,786	195
S5	Remaining IP cases	255,009	212
S6	Parents' DIC cases	4,602	12
	Total IP and Parents' DIC Cases	**342,573**	**500**
PR	Provider Proof Received in CY 2000	654	62
PP	Provider Proof Pending at End of CY 2000	1,032	99
	Total C&P Claims Files Reviewed		**661**

SAMPLE RESULTS

The primary objective of the random sample of 500 IP and parents' DIC cases was to determine if there was evidence of a UME claim in the claims file. Once those cases involving UME claims had been isolated, claims file reviews were conducted to determine the accuracy of the processing, extent of supported claims, and extent of potential program fraud. Our initial review of the 500 cases identified 328 cases where a UME claim had been submitted or where there was evidence that the beneficiary was paying Medicare (Part B) premiums, which is the one exception to the general rule that UMEs must be specifically claimed to reduce income. Sample results for each stratum are presented in the table on the next page.

Appendix III

Random Sample Results

Stratum Identifier	Cases In Sample	Was there a UME Claim or Evidence of UMEs?[12]		Results of Cases With Errors		Potential Fraud Referred to OI[13]
S2	51	UME Claimed Evidence of UME	51 0	Overpayment Underpayment	11 9	0
S3	30	UME Claimed Evidence of UME	16 4	Overpayment Underpayment	1 4	1
S4	195	UME Claimed Evidence of UME	195 0	Overpayment Underpayment	32 31	5
S5	212	UME Claimed Evidence of UME	30 26	Overpayment Underpayment	5 31	3
S6	12	UME Claimed Evidence of UME	6 0	Overpayment Underpayment	1 0	0
Total	**500**	**UME Claimed** **Evidence of UME** **Total UMEs**	**298** **30** **328**	**Overpayment** **Underpayment** **Total Cases**	**50** **75** **125**	**Total** **9**

PROJECTION TO POPULATION (90 percent confidence level)

Because the universe was stratified, projection to the population will not always equal 100 percent due to scaling of the observed rate of occurrence to the relative strata size to population. This scaling also results in a varying precision rate for each stratum. For purposes of presentation and clarity, sample results for each stratum have been combined. Future at risk lifetime amounts were calculated using VBA's life expectancy table for net worth determinations. The annual dollar impact was multiplied by the number of years from the life expectancy table and scaled to the relative strata size to the population. We did not calculate or project lifetime benefits on cases where the claimant had died, the claim had been terminated for other reasons, or claims that had one-time errors such as mathematical errors. Also, the estimates do not include future increases in VA benefits, income, or UME claims. Sample results are as follows:

Attribute: Was there a UME claim? (+ or – 3.0 percent)

Point Estimate (Midpoint):

Population (IP and parents' DIC monthly benefit greater than $200)	342,573
Times Projected Rate of Occurrence (298 cases scaled based on strata)	.338
Equals Potential Number of Cases with UME claims	115,790
Lower Limit Point Estimate (115,790 – 10,317)	105,473
Upper Limit Point Estimate (115,790 + 10,317)	126,107

[12] VA Manual M21-1, Part IV, Section 16.31 b. (9) states that Medicare (Part B) premiums paid to the Social Security Administration are deductible medical expenses and if there is evidence of these premiums a deduction is allowable without a specific claim from the claimant. This is an exception to the general rule that all deductible UMEs must be specifically claimed.

[13] Potential fraud cases were referred to the OIG OI for determination and investigation of fraud.

Appendix III

Point Estimate For Annual Amount of 115,790 UME Claims	
Estimated Average Annual UME Amount	$3,580
Times Potential Number of Cases	115,790
Equals Estimated Annual Amount of UME claims	$414,528,200
Lower Limit Estimate (105,473 x $3,580)	$377,593,340
Upper Limit Estimate (126,107 x $3,580)	$451,463,060
Point Estimate For Annual Amount of Income Reported on EVRs	
Estimated Average Income Reported on EVRs	$6,626
Times Potential Number of Cases	115,790
Equals Estimated Annual Amount of Income Reported	$767,224,540
Lower Limit Estimate (105,473 x $6,626)	$698,864,098
Upper Limit Estimate (126,107 x $6,626)	$835,584,982
Point Estimate For Annual Amount of Increase in Benefits as Result of UME Claim	
Estimated Average Increase in Benefits	$2,077
Times Potential Number of Cases	115,790
Equals Estimated Annual Amount of Increase in Benefits	$240,495,830
Lower Limit Estimate (105,473 x $2,077)	$219,067,421
Upper Limit Estimate (126,107 x $2,077)	$261,924,239

Attribute: Was there evidence that claimant could have filed a UME claim? (+ or – 2.8 percent)

Point Estimate (Midpoint):	
Population (IP and parents' DIC monthly benefit greater than $200)	342,573
Times Projected Rate of Occurrence (30 cases scaled based on strata)	.096
Equals Potential Number of Cases with UME claims	32,887
Lower Limit Estimate (32,887 – 9,578)	23,309
Upper Limit Estimate (32,887 + 9,578)	42,465
Point Estimate For Annual Amount of 30 UME Claims Not Processed	
Estimated Average Annual UME Amount That Could Have been Claimed	$525
Times Potential Number of Cases	32,887
Equals Estimated Annual Amount of UME Claims	$17,265,675
Lower Limit Estimate (23,309 x $525)	$12,237,225
Upper Limit Estimate (42,465 x $525)	$22,294,125

Appendix III

Point Estimate For Annual Amount of Income Reported (per Target or EVR)

Estimated Average Income Reported on EVRs	$4,659
Times Potential Number of Cases	32,887
Equals Estimated Annual Amount of Income Reported	$153,220,533
Lower Limit Estimate (23,309 x $4,659)	$108,596,631
Upper Limit Estimate (42,465 x $4,659)	$197,844,435

Point Estimate For Annual Amount of Increase in Benefits as a Result of UME Claim

Estimated Average Annual Potential Increase in Benefits	$127
Times Potential Number of Cases	32,887
Equals Estimated Annual Amount of Increase in Benefits	$4,176,649
Lower Limit Estimate (23,309 x $127)	$2,960,243
Upper Limit Estimate (42,465 x $127)	$5,393,055

Summary Point Estimate for Number of Cases in Population With UME Claims is 148,677 (115,790 + 32,887).

Attribute: Was there processing errors that resulted in overpayment or underpayment of benefits? (+ or – 5.4 percent)

Point Estimate (Midpoint):

Population (estimated cases with UME claims based on 328 in sample)	148,677
Times Projected Rate of Occurrence (125 cases scaled based on strata)	.467
Equals Potential Number of Cases with UME Claims	69,432
Lower Limit Estimate (69,432 – 8,132)	61,300
Upper Limit Estimate (69,432 + 8,132)	77,564

Processing Errors That Resulted in Overpayment (O/P) of Benefits in 50 Cases (+ or – 3.5 percent)

Point Estimate (Midpoint):

Population (estimated cases with UME claims based on 328 in sample)	148,677
Times Projected Rate of Occurrence (50 cases scaled based on strata)	.128
Equals Potential Number of Cases with O/P of Benefits	19,031
Lower Limit Estimate (19,031 – 5,205)	13,826
Upper Limit Estimate (19,031 + 5,205)	24,236

Appendix III

Estimated O/P Amount of Benefits as a Result of Processing Errors

Point Estimate For Annual O/P of Benefits	
Estimated Average Annual O/P of Benefits	$2,027
Times Estimated Number of Cases	19,031
Equals Estimated Annual O/P Amount of Benefits	$38,575,837
Lower Limit Estimate (13,826 x $2,027)	$28,025,302
Upper Limit Estimate (24,236 x $2,027)	$49,126,372
Point Estimate For Lifetime O/P of Benefits	
Estimated Average Annual O/P of Benefits	$2,501
Times Estimated Average Life Expectancy	10.5
Sub Total	$26,261
Times Estimated Number of Cases	11,027
Equals Estimated Lifetime O/P Amount of Benefits	$289,574,534
Lower Limit Estimate (6,952 x $2,501 x 10.5)	$182,562,996
Upper Limit Estimate (15,101 x $2,501 x 10.5)	$396,559,811

Processing Errors That Resulted in Underpayment (U/P) of Benefits in 75 Cases (+ or – 5.4 percent)

Point Estimate (Midpoint):	
Population (estimated cases with UME claims based on 328 in sample)	148,677
Times Projected Rate of Occurrence (75 cases scaled based on strata)	.339
Equals Potential Number of Cases with U/P of Benefits	50,402
Lower Limit Estimate (50,402 – 8,034)	42,368
Upper Limit Estimate (50,402 + 8,034)	58,436

Estimated U/P Amount of Benefits as a Result of Processing Errors

Point Estimate For Annual U/P of Benefits	
Estimated Average Annual U/P of Benefits	$340
Times Estimated Number of Cases	50,402
Equals Estimated Annual U/P Amount of Benefits	$17,136,680
Lower Limit Estimate (42,368 x $340)	$14,405,120
Upper Limit Estimate (58,436 x $340)	$19,868,240

Appendix III

Point Estimate For Lifetime U/P of Benefits	
Estimated Average Annual U/P of Benefits	$306
Times Estimated Average Life Expectancy	10.5
Sub Total	$3,213
Times Estimated Number of Cases	45,715
Equals Estimated Lifetime U/P Amount of Benefits	$146,882,295
Lower Limit Estimate (37,784 x $306 x 10.5)	$121,399,992
Upper Limit Estimate (53,646 x $306 x 10.5)	$172,364,598

Attribute: Was there potential program fraud identified that resulted in O/P of benefits? (+ or – 2.4 percent)

Potential Fraud That Resulted in O/P of Benefits (+ Or – 5.3 percent)

Point Estimate (Midpoint):	
Population (estimated cases with UME claims based on 328 in sample)	148,677
Times Projected Rate of Occurrence (9 cases scaled based on strata)	.037
Equals Potential Number of Cases with Potential Fraud	5,501
Lower Limit Estimate (5,501 – 3,607)	1,894
Upper Limit Estimate (5,501 + 3,607)	9,108

Estimated Potential Fraud O/P Amount of Benefits

Point Estimate For Annual O/P of Benefits	
Estimated Average Annual O/P of Benefits	$8,298
Times Estimated Number of Cases	5,501
Equals Estimated Annual O/P Amount of Benefits	$45,647,298
Lower Limit Estimate (1,894 x $8,298)	$15,716,412
Upper Limit Estimate (9,108 x $8,298)	$75,578,184

Estimated Lifetime Potential Fraud O/P of Benefits

Estimated Average Annual O/P of Benefits	$11,003
Times Estimated Average Life Expectancy	10.5
Sub Total	$115,532
Times Estimated Number of Cases	4,814
Equals Estimated Lifetime O/P Amount of Benefits	$556,171,048
Lower Limit Estimate (1,300 x $11,003 x 10.5)	$150,190,950
Upper Limit Estimate (8,329 x $11,003 x 10.5)	$962,261,864

Appendix III

Summary of O/Ps:

Processing Errors	Annual	$49,126,372	Lifetime	$396,559,811
Potential Fraud		$75,578,184		$962,261,864
Total Over Paid		$124,704,556		$1,358,821,675

Appendix IV

MONETARY BENEFITS IN ACCORDANCE WITH IG ACT AMENDMENTS

REPORT TITLE: Audit of Veterans Benefits Administration Benefit Payments Involving Unreimbursed Medical Expense Claims

REPORT NUMBER: 00-00061-169

Recommendation Number	*Category/Explanation Of Benefits*	*Cost Avoidance*
1 (a).	Enhancing processing of UME claims to ensure that beneficiaries receive the benefits they are entitled to receive by establishing performance criteria for processing UME claims and holding responsible officials accountable for performance deficiencies that are identified.	
	• Estimated annual benefit payments involving UME claims that could be potentially avoided.	$124.7 million
	• Estimated annual benefit payments involving UME claims that potentially would be paid.	($19.9 million)
Total		$104.8 million

Note: Based on the stratified statistical sampling approach used, we believe that the estimated annual dollar impact figures represent a conservative estimate of the expected level of impact to the Department of processing errors and potential program fraud identified. *(Details are presented in Appendix III on pages 14-21)*.

Appendix V

UNDER SECRETARY FOR BENEFITS COMMENTS

Department of
Veterans Affairs

Memorandum

Date: September 20, 2002

From: Under Secretary for Benefits (20)

Subj: Draft Report of Audit of Veterans Benefits Administration Payments Involving Unreimbursed Medical Expense Claims

To: Assistant Inspector General for Auditing (52)

1. This is in response to your memorandum of August 1, 2002, concerning your draft report on procedures for verification of unreimbursed medical expense (UME) claims. Our responses to the specific recommendations are shown below.

2. Overpayments and underpayments should be significantly reduced due to the establishment of the Pension Maintenance Centers and the greater quality and consistency that will result from consolidation of the pension workload at those centers.

3. **Recommendation 1a. Enhance processing of UME claims to ensure that beneficiaries receive the benefits they are entitled to receive by establishing performance criteria for processing UME claims and holding responsible officials accountable for performance deficiencies that are identified.**
Concur. We agree that the processing of UME claims is an essential part of pension and Parents' DIC claims processing and that accuracy is very important. VBA's consolidation of pension maintenance activities into three pension maintenance centers has as one of its stated objectives enhanced performance of program integrity functions. Consistency and improved quality in administration of the program are also key goals. One of the measures by which the pension centers will be measured in the coming year is the execution of program integrity efforts of which unreimbursed medical expenses are a part.

4. **Recommendation 1b. Prepare a notification letter to all beneficiaries in the Improved Pension and Parents' DIC programs that informs them of:**

The potential to claim UMEs for Medicare (Part B) premiums.

The importance of only claiming these UMEs if they are not reimbursed by the State or other third party.

Concur. The "Medical Expenses" paragraph of VA form 21-0287 will be amended to

Appendix V

UNDER SECRETARY FOR BENEFITS COMMENTS

2.

Assistant Inspector General for Auditing (52)

read as follows: "You can report medical expenses that you had to pay including Medicare (Part B) premiums. Do not report any amounts paid by insurance, Medicaid or anyone else. You can only report the amount that you paid. We're enclosing a form for you to use to report these expenses. But remember, we must receive your report of medical expenses before the end of the next calendar year. For example, medical expenses paid in 2002 must be received by December 31, 2003."

5. **Recommendation 1c. Require a Share system Social Security information inquiry be completed on all EVRs and UME claims to verify claimed Medicare (Part B) premium expenses and make adjustments as appropriate.**
Concur. A pending change to M21-1, part IV, par 16.31m(8) will include the following language: "Place a copy of a Share system Social Security print in the claims file each time an award is processed to allow a UME deduction for Medicare premiums."

6. **Recommendation 1d. Increase the Provider Proof Verification program sample selection process back to one percent and monitor results to determine the number of UME cases that are actually being selected and how many cases did not have acceptable support for UMEs. Consider requiring support of UME claims for all beneficiaries if a need is established by Provider Proof program monitoring.**
Concur. A Project Initiation Request (PIR) to increase the Provider Proof Verification program sample selection process back to one percent is in concurrence. The C&P Service currently monitors results of the Provider Proof program to determine how many cases did not have acceptable support for UMEs. This monitoring will continue. We will consider requiring support of UME claims for all beneficiaries if a need is established by Provider Proof program monitoring.

7. **Recommendation 1e. Establish VBA policy to require support for future UME claims for a 3-year period where acceptable support was not received under the Provider Proof program**.
Concur. We are amending M21-1 part IV, par. 16.31m(6) to provide that documentary proof of medical expenses will be required for a 3 year period from the date it is determined that acceptable documentation of prior medical expenses was not received under the Provider Proof program.

8. **Recommendation 1f. Modify the BDN system so that UME claims and costs can be identified for review. Capture of this automated information would help ensure that higher cost claims (UME claims over $15,000) could be identified and verified.**

Appendix V

UNDER SECRETARY FOR BENEFITS COMMENTS

3.

Assistant Inspector General for Auditing (52)

Concur. During discussions between OIG and VBA representatives it was agreed that we would not modify BDN. However, we are amending M21-1, part IV, par. 16.31b(1)(c) to read as follows: "Telephone the nursing home to verify that claimed nursing home fees in excess of 15,000 per year were paid by the claimant without reimbursement. Document the call on a Report of Contact."

9. **Recommendation 1g. Recover UME related beneficiary overpayments identified by the audit and make payments to beneficiaries for benefits they are entitled to receive.**
Concur. We will review every case and make a decision.

10. We recognize the problems identified by the audit. We have consolidated pension processing at the Pension Maintenance Centers to address these problems. Our reviews are consistent with the OIG findings and adjustments are being made.

/s/
Daniel L. Cooper

Appendix VI

REPORT DISTRIBUTION

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- Ranking Democratic Member, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
- Staff Director, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
- Staff Director, House Committee on Veterans' Affairs

Appendix VI

Chairman, House Committee on Government Reform, Subcommittee on National Security, Veterans' Affairs and International Relations
Ranking Member, House Committee on Government Reform, Subcommittee on National Security, Veterans' Affairs and International Relations

This report will be available in the near future on the VA Office of Audit web site at http://www.va.gov/oig/52/reports/mainlist.htm *List of Available Reports*. This report will remain on the OIG web site for two fiscal years after it is issued.