Department of Veterans Affairs
Office of Inspector General

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

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Executive Summary

Introduction

The Office of Inspector General (OIG) conducted an audit to evaluate the effectiveness of the Veterans Health Administration's (VHA) management of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The audit objectives were to determine if: (1) VHA oversight of CHAMPVA was adequate; (2) CHAMPVA claim payments were accurate, timely, reasonable, and sufficiently protected from duplication and fraud; (3) CHAMPVA overpayments were adequately billed and collected; and (4) CHAMPVA information management system controls were adequate.

The Veterans Healthcare Expansion Act of 1973 authorized VA to establish CHAMPVA. The program provides healthcare benefits for dependents of veterans rated permanently and totally disabled as a result of service-connected conditions or who died as a result of service-connected conditions. CHAMPVA is essentially a health insurance program where beneficiaries obtain medical services from private providers. Beneficiaries usually pay 25 percent of the cost of medical care up to an annual catastrophic cap of $3,000 plus an annual outpatient deductible of $50 per individual or $100 per family. CHAMPVA pays the remaining 75 percent of the beneficiaries' medical care. In fiscal year (FY) 2006, 285,006 beneficiaries were enrolled in CHAMPVA, and 187,279 (66 percent) used the program.

The Health Administration Center (HAC), located in Denver, CO, is responsible for administering CHAMPVA. HAC staff review claims submitted by beneficiaries and providers to ensure that beneficiaries are eligible for care and that services are covered and medically necessary. In FY 2006, the HAC spent approximately $615.3 million to pay 5.6 million CHAMPVA claims.

Results

The HAC's controls over fraud detection for CHAMPVA payments were generally effective. However, management of CHAMPVA would be more effective if VHA improved its oversight of CHAMPVA and if HAC management improved controls over claim processing and accounts receivable. Without sufficient VHA oversight and strong internal controls, VA does not have reasonable assurance that the HAC manages CHAMPVA in accordance with sound business practices, Federal laws and regulations, and VA policies. Specifically, the audit identified three issues that required management attention:

1. **VHA needed to improve its oversight of the HAC's policy decisions and internal control program.** VHA's Chief Business Office (CBO) did not ensure that HAC

policy changes complied with Federal laws and regulations or were supported by sufficient analyses. Before making changes to policy, the HAC did not disclose the proposed changes to ensure the public could review them and make comments. These policy changes require consultation with the VA Office of General Counsel (OGC) and may require further action. Furthermore, the CBO did not require that the HAC annually certify and document its internal control activities as required by VHA policy. The audit report makes three recommendations—two to develop oversight mechanisms for policy decisions and internal control reviews and one to determine if further action is required to address HAC policy changes.

2. **The HAC needed to improve its claim payment controls to prevent improper payments and identify overpayments that required recovery.** We identified the universe of claim payments greater than $100 the HAC made during the 1-year review period July 2005–June 2006. That universe consisted of 651,991 claim payments totaling $322.9 million, from which we selected a stratified statistical sample of 216 claim payments totaling $8.7 million. Based on our sample review, we found that the HAC made a significant number of eligibility, claim processing, and software programming errors. We also found that the HAC's internal audits did not sufficiently identify claim payment errors. As a result, we estimate that for the 1-year review period, the HAC authorized net overpayments of $12.0 million. In addition, we estimate that the HAC did not identify $5.1 million in claim payments that it should have recovered. To address these issues, the audit report makes three recommendations to provide refresher training, correct programming errors, and expand the coverage of HAC internal audits.

3. **The HAC needed to strengthen its controls to ensure timely establishment and monitoring of accounts receivable and proper supervisory reviews of write-offs.** During the 1-year review period July 2005–June 2006, the HAC established 6,936 accounts receivable valued at $2.5 million. We reviewed a statistical sample of 152 accounts receivable valued at $56,788. In addition, we reviewed all 22 write-offs valued at $25 or more. Based on our sample review, we found that the HAC was not timely in collecting funds and inappropriately wrote off $114,276 in accounts receivable. The HAC did not provide sufficient operational oversight, implement VA fiscal policies, or provide adequate staff training. The audit report makes two recommendations to provide training on VA fiscal policies and procedures and to establish and monitor performance measures in this area.

In addition, the audit identified two minor issues regarding information system access controls; however, the HAC's Chief Information Officer corrected these user and programmer access deficiencies during the audit.

Recommendations

1. We recommended that the Under Secretary for Health develop oversight mechanisms to ensure that future CHAMPVA policy decisions have appropriate risk and cost analyses and comply with Federal laws.

2. We recommended that the Under Secretary for Health consult with the OGC to determine whether further action is required regarding claim filing deadlines and the preauthorization limit for durable medical equipment.

3. We recommended that the Under Secretary for Health develop oversight mechanisms to ensure the HAC conducts effective internal control reviews.

4. We recommended that the Under Secretary for Health provide refresher training and increased management supervision to ensure HAC staff follow procedures for determining and verifying eligibility, processing claims, and identifying overpayments.

5. We recommended that the Under Secretary for Health require the HAC to correct the programming errors in the Claims Processing and Eligibility software.

6. We recommended that the Under Secretary for Health expand the HAC's internal audits to incorporate reviews of eligibility documentation, claim histories, and recovery actions.

7. We recommended that the Under Secretary for Health provide training for HAC staff on VA financial accounting policies and procedures.

8. We recommended that the Under Secretary for Health establish and monitor performance measures for the timely collection of CHAMPVA overpayments.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and recommendations of the report and provided acceptable implementation plans. (See Appendix C, pages 16–25, for the full text of the Under Secretary's comments.) In response to the audit recommendations, the Under Secretary agreed that increasing CBO oversight would be beneficial to CHAMPVA and noted that a recently added position, the Deputy Chief Business Officer for Purchased Care, will have direct supervision over the HAC. The Under Secretary reported that HAC policy analysts have received training on cost analysis development, and four analysts will complete regulation training. He also reported that VHA met with the OGC, and the OGC recommended issuing *Federal Register* notices to inform the public of policy changes concerning durable medical equipment and timely filing. The Under Secretary's planned actions also included

developing and implementing a compliance program that ensures the HAC conducts effective internal control reviews. He stated that his implementation plan included increasing refresher training to ensure that HAC staff correctly determine and verify eligibility matters. The Under Secretary also agreed to correct the programming errors in the Claims Processing and Eligibility software and to expand the HAC's internal audits to incorporate reviews of eligibility documentation, claim histories, and recovery actions. He also reported that the HAC has established a performance goal of 31.5 days to bill first- or third-party debt cases and is monitoring billing and collection activities on a daily basis. We incorporated technical comments provided by the Under Secretary into the report as appropriate. We will follow up on the implementation of the planned improvement actions.

(original signed by:)

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Assistant Inspector General
for Auditing

Introduction

Purpose

The purpose of the audit was to determine if VHA effectively managed CHAMPVA. The four audit objectives were to determine if: (1) VHA oversight of CHAMPVA was adequate; (2) CHAMPVA claim payments were accurate, timely, reasonable, and sufficiently protected from duplication and fraud; (3) CHAMPVA overpayments were adequately billed and collected; and (4) CHAMPVA information management system controls were adequate.

Background

CHAMPVA provides healthcare benefits for dependents of veterans rated permanently and totally disabled as a result of service-connected conditions or who died as a result of service-connected conditions. These veterans are known as CHAMPVA sponsors. The HAC, located in Denver, CO, is responsible for administering CHAMPVA. In this role, the HAC determines eligibility; processes claims; and develops, reviews, and approves CHAMPVA policy. VHA's CBO is responsible for program management of CHAMPVA and supervision of the HAC Director.

Public Law 93-82, The Veterans Healthcare Expansion Act of 1973, authorized VA to establish CHAMPVA.[1] CHAMPVA is essentially a health insurance program where beneficiaries obtain medical services from private providers, such as physicians or hospitals. Beneficiaries usually pay 25 percent of the cost of any inpatient or outpatient care up to an annual catastrophic cap of $3,000 plus an annual outpatient deductible of $50 per individual or $100 per family. Beneficiaries or providers then submit claims to the HAC to request reimbursement for the remaining 75 percent of the cost of care. HAC staff review the claims to ensure that beneficiaries are eligible for care and that services are covered and medically necessary. Reimbursements are based upon the ZIP Code where the services are performed and the type of services provided.

In 2001, Congress enacted Public Law 107-14, The Veterans' Survivor Benefits Improvements Act of 2001, which authorized the extension of CHAMPVA benefits to beneficiaries over the age of 65. Prior to 2001, beneficiaries over the age of 65 were not eligible for CHAMPVA because they were eligible for Medicare. As a result of this extension, the HAC experienced a significant increase in CHAMPVA workload. At the beginning of FY 2002, 96,489 beneficiaries were enrolled. By the end of FY 2006, 285,006 beneficiaries were enrolled—a 195 percent increase in 5 years. Furthermore, of

[1] CHAMPVA benefits are similar to those of the Department of Defense's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a healthcare program for active duty and retired military personnel and their family members. CHAMPUS is now referred to as TRICARE.

the 285,006 enrolled beneficiaries, 187,279 (66 percent) used the program. In FY 2006, the HAC spent approximately $615.3 million to pay 5.6 million CHAMPVA claims and had an administrative budget of $42.9 million. For FY 2007, the HAC expects to pay approximately $690.6 million for an estimated 5.8 million claims.

Scope and Methodology

We conducted the audit from September 2006 through April 2007 and made three onsite visits to the HAC. To address the objectives of the audit, we interviewed HAC senior management and staff involved in CHAMPVA eligibility determination, policy and compliance, claim processing, fiscal operations, and information technology management. We also interviewed VA officials from the OGC and Office of Regulation Policy and Management, VHA officials from the CBO and Chief Financial Office, and officials from the Department of Defense TRICARE Management Activity. We reviewed related Federal regulations and VA and local policies, organizational charts, staffing reports, and workload and performance data. We did not review the appropriateness and quality of care received by beneficiaries under the program.

Statistical Samples of Claim Payments and Accounts Receivable. To evaluate controls over claim payment processing, we used automated data from VA's Financial Management System (FMS) to identify the universe of claim payments greater than $100 the HAC made during the 1-year period July 2005–June 2006. That universe consisted of 651,991 claim payments totaling $322.9 million, from which we selected a stratified statistical sample of 216 claim payments totaling $8.7 million. We determined the sample size using a confidence level of 95 percent, a desired precision rate of 10 percent, and an expected error rate of 15 percent. (See Appendix A, pages 13–14, for more details on our sampling methodology.)

To evaluate whether the HAC adequately billed and collected CHAMPVA overpayments, we also used FMS to identify the universe of accounts receivable established during the 1-year review period. During this period, the HAC established 6,936 accounts receivable valued at $2.5 million. We determined the sample size using a confidence level of 95 percent, a desired precision rate of 10 percent, and an expected error rate (overpayment processing error) of 10 percent. From the universe, we selected a statistical sample of 152 accounts receivable valued at $56,788. In addition, we reviewed all 22 write-offs valued at $25 or more.

We assessed the reliability of FMS automated data by comparing selected data elements to hardcopy claim payment supporting documentation, recovery requests, and electronic claims. The data was sufficiently reliable for the accomplishment of the audit objectives.

Our assessment of internal controls focused only on those controls related to our audit objectives. We conducted the audit in accordance with generally accepted government auditing standards.

Results and Conclusions

Issue 1: Oversight of Health Administration Center Management of the Civilian Health and Medical Program of the Department of Veterans Affairs Needed Improvement

Finding

VHA needed to improve oversight of the HAC's policy development process and internal control program. VHA Manual M-1, Part 1, Chapter 29, states that VHA's CBO is responsible for managing CHAMPVA, supervising the HAC Director, ensuring CHAMPVA policies are consistent with public laws and regulations, establishing centralized reporting requirements, and performing periodic reviews.[2] VHA's oversight was inadequate because the CBO had not implemented effective procedures to monitor CHAMPVA policies, procedures, and controls. Without improved oversight, the HAC does not have the necessary "checks and balances" to ensure effective use of VA resources and compliance with Federal laws and regulations and VA policies.

VHA Did Not Effectively Oversee HAC Policy Decisions. The CBO did not ensure that HAC policy changes complied with Federal laws and regulations or were supported by sufficient analyses. Before making changes to the Code of Federal Regulations, the Administrative Procedure Act (APA) requires Federal agencies to publish proposed rules and revisions in the *Federal Register* to ensure that the public can review them and make comments. HAC management made significant policy changes related to claim filing deadlines and preauthorization limits for healthcare services without public review or the participation of the CBO or officials from other VHA or VA offices, including the OGC and Office of Regulation Policy and Management. Furthermore, HAC management made these decisions without adequate risk or cost analyses. As a result, VHA did not have assurance that CHAMPVA policies complied with laws and regulations or were appropriate.

In 2001, the HAC contracted with a private health benefits organization to review its operational processes and make recommendations for improvement. The consultant expressed concern about adequate external oversight of CHAMPVA. In particular, the consultant emphasized the need for ensuring adequate checks and balances, since the HAC both created and administered CHAMPVA policy. The report also stated that the consultant would be remiss not to note the inherent risks associated with program oversight and administration residing within the same entity. Although the HAC Director

[2] The VHA Manual uses the term "Director, Administrative Services Office of VHA." In 2002, as part of a reorganization, VHA established the CBO, which assumed responsibility for CHAMPVA.

summarized the consultant's report findings for VHA, he provided his opinion that there were checks and balances in place and that the consultant's concern was not an issue.

The following examples illustrate significant policy changes HAC management made without VHA oversight or public review.

> Elimination of Claim Filing Deadlines. In August 2006, the HAC changed a CHAMPVA policy manual to eliminate claim filing deadlines for providers and beneficiaries. The policy change conflicted with an existing Federal regulation pertaining to CHAMPVA—Title 38, Code of Federal Regulations, Section 17.275—that imposed filing deadlines and waiver conditions. In addition, the CBO did not review the HAC's cost analysis, which estimated $2.8 million in annual administrative savings. The HAC based the estimate in part on anecdotal information, but did not estimate the additional costs that could result from eliminating the deadline. Officials from the CBO, OGC, Office of Regulation Policy and Management, and HAC agreed that VA should have published the change in the *Federal Register* for public comment.
>
> Preauthorization Limit for Durable Medical Equipment. In August 2006, the HAC published a CHAMPVA policy manual change that raised the preauthorization limit for durable medical equipment from $300 to $2,000. This change conflicted with Title 38, Code of Federal Regulations, Section 17.273, which set the $300 limit. The HAC did not conduct an adequate cost analysis or consider a HAC Policy and Compliance Division supervisor's concern that durable medical equipment was a high-risk area susceptible to fraudulent claims. Before making the change, a HAC manager asked a VA OGC attorney for an informal opinion as to whether the HAC could make the change to the Code of Federal Regulations and the CHAMPVA policy manual concurrently. The OGC attorney agreed with the HAC that the policy would not be challenged by the public, but advised that legally, the HAC needed to publish the proposed change in the *Federal Register*. Although the OGC attorney expressed this informal opinion, the HAC changed the policy without first publishing it in the *Federal Register* for public comment. As of May 22, 2007, the HAC had not submitted the proposed policy change to the Office of Regulation Policy and Management for publication in the *Federal Register*. OGC staff acknowledged that the CHAMPVA policy change will continue to conflict with the Code of Federal Regulations until the policy change is submitted through the APA process.

The CBO did not review these significant CHAMPVA policies to ensure that the program policies complied with laws and regulations or that the policies were supported

by adequate analyses. Stronger VHA oversight is needed to ensure that the cost impact of policy changes is fully considered and to reduce the risk of legal challenges resulting from not complying with the APA or existing Federal laws.

VHA Did Not Effectively Oversee the HAC's Internal Control Program. The CBO did not have adequate procedures in place to ensure that the HAC had an effective internal control program. According to the Government Accountability Office, internal controls are the first line of defense for safeguarding assets and preventing and detecting errors and fraud. VHA Directive 2001-076 requires that each reporting organization annually certify and document its internal control activities.[3] At a minimum, the organization's management control documentation must provide a sufficient paper trail showing the type and scope of the review, responsible officials, pertinent dates and facts, key findings, and corrective actions taken. These requirements provide assurance that organizations have systems of internal controls in place, regularly evaluate the systems, and make appropriate improvements.

In FYs 2004 and 2005, the HAC did not submit the required internal control certifications, and they did not have sufficient documentation to show that they completed adequate evaluations of their internal control program. In FYs 2003 and 2006, the Director certified the HAC had an effective internal control program; however, HAC management could not provide sufficient documentation to show that they conducted adequate evaluations. For example, the HAC used a spreadsheet to evaluate the controls, but did not have an associated paper trail, and reviewers did not consistently identify how and what areas they reviewed. As a result, VHA did not have assurance that the HAC effectively used VA resources and that CHAMPVA policies complied with Federal laws and regulations. If the HAC had conducted effective internal control reviews, they may have identified the types of issues we found during this audit, such as the need to strengthen controls over policy development, claim payments, and accounts receivable.

Conclusion

VHA needed to improve its oversight of HAC management of CHAMPVA. In our discussions with the Acting Chief Business Officer, he acknowledged that VHA oversight of the HAC, and CHAMPVA in particular, could be improved. The CBO did not effectively monitor HAC policy development and controls. Without this oversight, VHA does not have assurance that HAC controls are effective in managing VA resources and that CHAMPVA policies comply with Federal laws and regulations and are adequately supported or appropriate.

[3] The VHA Directive provides policies and procedures for fulfilling the requirements of the Office of Management and Budget's (OMB's) revised Circular A-123, "Management Accountability and Control," dated June 21, 1995, and the internal control requirements of OMB Circular A-127, "Financial Management Systems," dated July 23, 1993.

Recommendations

1. We recommended that the Under Secretary for Health develop oversight mechanisms to ensure that future CHAMPVA policy decisions have appropriate risk and cost analyses and comply with Federal laws.

2. We recommended that the Under Secretary for Health consult with the OGC to determine whether further action is required regarding claim filing deadlines and the preauthorization limit for durable medical equipment.

3. We recommended that the Under Secretary for Health develop oversight mechanisms to ensure the HAC conducts effective internal control reviews.

The Under Secretary for Health agreed with our finding and recommendations and planned to complete all corrective actions by July 2008. The Under Secretary agreed that increasing CBO oversight would be beneficial to CHAMPVA and noted that a recently added position, the Deputy Chief Business Officer for Purchased Care, will have direct supervision over the HAC. Additionally, the HAC will fill a new data manager position to provide additional support in the development of comprehensive cost analyses. The Under Secretary reported that HAC policy analysts have received training on cost analysis development, and four analysts will complete regulation training. He also reported that VHA met with the OGC, and the OGC recommended issuing *Federal Register* notices to inform the public of policy changes concerning durable medical equipment and timely filing. The Under Secretary's planned actions also included developing and implementing a compliance program that ensures the HAC conducts effective internal control reviews. The VHA Chief Officer for Compliance and Business Integrity will supervise the HAC's compliance officer to assure organizational independence. We consider these planned actions acceptable, and we will follow up on their implementation.

Issue 2: Claim Payment Controls Needed Improvement

Finding

HAC management needed to improve controls over CHAMPVA claim payments to reduce the risk of improper payments and ensure that HAC staff identify payments requiring recovery. OMB defines improper payments as payments made in the wrong amounts or that should not have been made, including duplicate payments, payments for services not received, payments made to ineligible recipients or for ineligible services, and payments without sufficient documentation. Generally, VA should take actions to recover or refund the payments when it identifies improper overpayments and underpayments. In cases of financial hardship or other extenuating circumstances, VA has policies and procedures to waive debts.

Of the 216 claim payments we reviewed, 22 (10 percent) were improper and 6 (3 percent) required recovery due to the HAC receiving additional information about claims after they were paid. Based on these results, we estimate that during the review period the HAC authorized $12.2 million in overpayments and $192,000 in underpayments, for net overpayments of $12.0 million. Additionally, we estimate that the HAC did not identify $5.1 million in claim payments that needed to be recovered.

The HAC made these improper payments and failed to identify payments requiring recovery for three reasons:

- The HAC's claim processing staff did not consistently follow desk procedures for determining and verifying eligibility, processing claims, and identifying payments requiring recovery. We could not determine conclusively why claims processing staff did not consistently follow these procedures. However, contributing factors included staff not understanding medical claim forms or how other insurance coverage affected CHAMPVA eligibility. Also, staff did not select the appropriate types of medical services or set up the vendor file correctly. Although staff received focused claim processing training, additional refresher training and increased management supervision in these areas may increase compliance with established desk procedures.

- The HAC's Claims Processing and Eligibility software contained programming errors that miscalculated the beneficiaries' portions of the cost of care.

- The HAC's internal audits were not sufficient to identify claim payment errors. During the HAC's quarterly internal audits, the auditors only reviewed the accuracy of data entry in the claim processing system and whether payments were correct, based on the information contained in the claims. However, they did not review eligibility documentation, claim histories, and recovery actions, which may have helped them identify the systemic issues addressed above.

HAC Staff Made Eligibility, Claim Processing, and Software Programming Errors that Resulted in Improper Payments. For the 216 payments in our sample, we identified 24 eligibility and claim processing errors, resulting in 22 improper payments (16 overpayments totaling $1.8 million and 6 underpayments totaling $6,920). Of the 22 improper payments, the HAC authorized 21 (95 percent) for CHAMPVA providers and 1 for a CHAMPVA beneficiary.

Eligibility Errors. Four (17 percent) of the 24 errors occurred because claim processing staff did not verify or document CHAMPVA eligibility.

- For two claim payments, staff did not appropriately follow up on a beneficiary reported as Medicare eligible. The beneficiary was ineligible for CHAMPVA care because the beneficiary was Medicare eligible but did not enroll in Medicare Part B.

Public Law 107-14 requires most CHAMPVA beneficiaries who are Medicare eligible to be enrolled in the supplementary medical program, Medicare Part B.

- For one claim payment, staff authorized a payment for a beneficiary who was ineligible for CHAMPVA care because the beneficiary's sponsor was not permanently and totally disabled from a service-connected condition. HAC staff did not follow HAC desk procedures to verify information provided by Veterans Benefits Administration (VBA) staff and did not detect that VBA staff incorrectly identified the sponsor as permanently and totally disabled from a service-connected condition.

- For one claim payment, staff authorized a payment for a beneficiary who was ineligible for CHAMPVA care because the beneficiary and sponsor were divorced.

Processing Errors. Fourteen (58 percent) of the 24 errors occurred because claim processing staff did not ensure that data entry and vendor selections were correct, that medical documentation accompanied claims when required, and that all evidence was considered before releasing a claim for payment.

- For six claim payments, staff made data entry errors, such as not entering all services on a claim or not entering other health insurance information.

- For four claim payments, staff selected the wrong type of medical services or established the vendor file with an incorrect ZIP Code, resulting in payments in the wrong amounts.

- For two claim payments, staff did not obtain skilled nursing and physical therapy documentation required by CHAMPVA policy.

- For two claim payments, staff released the claims for payment even though they had evidence that the beneficiary was incarcerated. CHAMPVA Policy 1-2.3 states that incarcerated beneficiaries are not eligible for CHAMPVA care. The HAC could not determine whether the payments were proper because it did not obtain documentation of the beneficiary's incarceration status until almost 1 year after claim processing staff authorized the payments.

Software Programming Errors. Six (25 percent) of the 24 errors occurred because HAC information technology staff did not program Claims Processing and Eligibility software to correctly calculate the beneficiaries' portions of the cost of care and correctly apply it to their annual catastrophic caps of $3,000. If beneficiaries are not aware that their portions of the cost of care are incorrect, they may pay more out-of-pocket costs than necessary. Two beneficiaries notified the HAC's customer service center that their portions of the cost of care were incorrect, and a HAC staff member noticed that the portion of the cost of care was incorrect for another beneficiary. HAC staff adjusted the three beneficiaries' portions of the cost of care and appropriately applied the correct

amounts to their catastrophic caps; however, HAC staff did not correct the programming errors that led to the miscalculations.

HAC Staff Did Not Identify Overpayments Requiring Recovery. HAC claim processing staff did not consistently identify overpayments that required recovery after receiving additional information about paid claims. Of the 216 claim payments in our sample, the HAC did not identify 6 payments to CHAMPVA providers totaling $339,494 that should have been recovered because the HAC received information that the beneficiaries had other health insurance or that a third party was responsible for the payments. In these situations, CHAMPVA was not the primary payer for medical services.

- The staff did not identify and recover five claim payments where CHAMPVA paid as first payer but should have been second payer because the beneficiary had other health insurance.

- The staff did not identify and recover a claim payment where the beneficiary was involved in a motor vehicle accident and an automobile insurance company was liable as first payer.

Conclusion

The HAC did not implement sufficient claim payment controls to ensure payments were accurate and supported. As a result, the HAC authorized claim payments for ineligible beneficiaries and for the wrong amounts and did not have documentation to support payments. Furthermore, the HAC did not consistently identify CHAMPVA overpayments that required recovery.

Recommendations

4. We recommended that the Under Secretary for Health provide refresher training and increased management supervision to ensure HAC staff follow procedures for determining and verifying eligibility, processing claims, and identifying overpayments.

5. We recommended that the Under Secretary for Health require the HAC to correct the programming errors in the Claims Processing and Eligibility software.

6. We recommended that the Under Secretary for Health expand the HAC's internal audits to incorporate reviews of eligibility documentation, claim histories, and recovery actions.

The Under Secretary for Health agreed with our finding and recommendations and planned to take corrective actions by December 2007. His implementation plan included

increasing refresher training to ensure that HAC staff correctly determine and verify eligibility, process claims, and identify overpayments; reviewing and updating desk procedures; and increasing internal monitoring programs. In addition, to improve eligibility verification controls, the HAC has negotiated a matching agreement with VBA. The Under Secretary also agreed to correct the programming errors in the Claims Processing and Eligibility software and to expand the HAC's internal audits to incorporate reviews of eligibility documentation, claim histories, and recovery actions. We consider these planned actions acceptable, and we will follow up on their implementation.

Issue 3: Accounts Receivable Controls Needed Strengthening

Finding

HAC management needed to strengthen controls over accounts receivable to establish accounts receivable more timely, provide supervisory reviews of write-offs, and better monitor accounts receivable. Without these fundamental accounting controls, the HAC was not timely in collecting funds that could have been used more efficiently and allowed $114,276 in accounts receivable to be written off inappropriately. VA Directive 4800 requires that staff take prompt and aggressive action and implement effective follow-up procedures for the collection of debts owed to VA. However, as previously discussed, in cases of hardship, beneficiaries may request VA to waive a debt. The accounts receivable problems occurred because the HAC's Chief Financial Officer did not provide sufficient operational oversight, implement VA fiscal policies, or provide adequate staff training. The Chief Financial Officer position had a high rate of turnover between FY 2000 and FY 2005, with five Chief Financial Officers during that period. The current Chief Financial Officer stated that when he started in June 2005, his focus was on the budget process and the reorganization of the Financial Management Division (FMD).

HAC Staff Did Not Establish Accounts Receivable Timely. FMD staff took an average of 154 days to establish accounts receivable and issue bills of collection for the reviewed 152 accounts receivable (value = $56,788) established during the 1-year period July 2005–June 2006. This occurred because the HAC had not established performance measures for issuing a bill. Although VA Directive 4800 requires prompt and aggressive action, it does not specify how many days it should take to issue a bill. However, the CBO has a 60-day performance measure for issuing a Medical Care Collections Fund bill of collection, and TRICARE has a 30-day performance measure for issuing a bill. Based on these performance measures, FMD's average number of days to issue a bill was not prompt and aggressive.

HAC Supervisors Did Not Review Write-Offs of Accounts Receivable. FMD supervisors allowed staff responsible for accounts receivable maintenance to write off

receivables without supervisory review, although VA Manual MP-4 prohibits this practice. Without supervisory review, FMD staff wrote off all 22 write-offs we reviewed.[4] We determined that 15 (68 percent) of the 22 were recoverable. During our interviews with the Chief Financial Officer, he stated that the HAC had not implemented or provided training on VA fiscal policies and had not provided adequate supervisory oversight. The 15 write-offs prevented the HAC from collecting $114,276 in overpayments to providers.

HAC Staff Did Not Monitor Accounts Receivable. Thirty-two (21 percent) of the 152 accounts receivable we reviewed had 1 or more problems related to inadequate monitoring. The HAC needed to strengthen monitoring in four areas: (1) ensuring the amounts billed were correct, (2) sending follow-up letters, (3) adjusting accounts receivable timely when payments were received, and (4) following up on established repayment plans. VA Manual MP-4 requires that accounts receivable transactions be accurate, and VA Handbook 4800.1 requires that follow-up letters be sent at 30-day intervals and that financial organizations follow up on delinquent payments under debt repayment plans.

Conclusion

The HAC did not establish accounts receivable timely, provide supervisory reviews of write-offs, or adequately monitor accounts receivable. These problems occurred because the HAC's Chief Financial Officer did not provide sufficient operational oversight, implement VA fiscal policies, provide adequate training to staff, or establish performance measures.

Recommendations

7. We recommended that the Under Secretary for Health provide training for HAC staff on VA financial accounting policies and procedures.

8. We recommended that the Under Secretary for Health establish and monitor performance measures for the timely collection of CHAMPVA overpayments.

While the Under Secretary for Health agreed with our findings and recommendations, he disagreed with the reasons we cited. However, he did not explain the basis for his disagreement or provide alternative causes. As a result, we made no changes to the causes and findings, as they were supported by our audit work.

In response to our recommendations, the Under Secretary reported that before December 2007, the HAC Training Division will provide training for HAC staff on VA

[4] Fifteen write-offs were for CHAMPVA providers, and seven write-offs were for CHAMPVA beneficiaries.

financial accounting policies and procedures. He also reported that the HAC has established a performance goal of 31.5 days to bill first- or third-party debt cases and is monitoring billing and collection activities on a daily basis. He noted that since December 2006, the HAC has reduced the number of bills entered but not issued from 6,168 to 18 as of the week ending July 27, 2007. We consider these planned actions acceptable, and we will follow up on their implementation.

Appendix A

Sampling Methodology and Estimates

Universe of Claim Payments

For the purpose of sample selection, the audit universe consisted of CHAMPVA claim payments greater than $100 made during the 1-year period July 2005–June 2006. VA's FMS listed 651,991 of these payments.

Sample Design

We used statistical stratified sampling techniques to randomly select a sample of 216 claim payments. We assigned each sample claim payment to one of four strata based upon the value of the payment. We determined the sample size using a confidence level of 95 percent, a desired precision rate of 10 percent, and an expected error rate of 15 percent. We used attribute sampling techniques to evaluate the effectiveness of the HAC's controls over payments. In reviewing the sample claim payments, we tested for three attributes:

- Whether the beneficiary was eligible for CHAMPVA.
- Whether the payment amount was correct.
- Whether the payment needed to be recovered.

Sample Results and Estimation

We identified overpayments, underpayments, and unidentified payments requiring recovery in each of four strata. Using SRO-Stats (version 3.0), a statistical software package developed by the Government Accountability Office and designed to assist the user in selecting random samples and evaluating audit results, we calculated point estimates for the number of overpayments, underpayments, and unidentified payments requiring recovery in the universe. To estimate the monetary impact, we multiplied the average value of the errors in each stratum by its point estimate.

For 22 of the 216 claim payments, controls did not effectively prevent improper payments. Additionally, for 6 of the 216 claim payments, controls did not identify payments requiring recovery. The following tables show estimates of sample results to the 651,991 claim payments.

Monetary Estimates Based on Results from 216 CHAMPVA Claim Payments Selected from FMS

Table 1. Overpayment Estimates

Stratum	Value of Claims	Universe Size	Sample Size	No. with Error	Point Estimate (Payments in Error)	Average Value of Error	Estimated Value of Errors (Point Estimate x Average Value)
1	$100.01–$1000.00	608,350	54	2	22,531	$200	$4,506,200
2	$1000.01–$10,000.00	40,799	54	3	2,267	$546	$1,237,782
3	$10,000.01–$80,000.00	2,735	54	4	203	$14,896	$3,023,888
4	$80,000.01+	107	54	7	14	$242,950	$3,401,300
Total		**651,991**	**216**	**16**			**$12,169,170**

Precision +/- 4.9%

Table 2. Underpayment Estimates

Stratum	Value of Claims	Universe Size	Sample Size	No. with Error	Point Estimate (Payments in Error)	Average Value of Error	Estimated Value of Errors (Point Estimate x Average Value)
1	$100.01–$1000.00	608,350	54	0	0	$0	$0
2	$1000.01–$10,000.00	40,799	54	1	756	($74)	($55,944)
3	$10,000.01–$80,000.00	2,735	54	2	101	($1,258)	($127,058)
4	$80,000.01+	107	54	3	6	($1,442)	($8,652)
Total		**651,991**	**216**	**6**			**($191,654)**

Precision +/- 0.2%

Table 3. Unidentified Recovery Payment Estimates

Stratum	Value of Claims	Universe Size	Sample Size	No. with Error	Point Estimate (Payments in Error)	Average Value of Error	Estimated Value of Errors (Point Estimate x Average Value)
1	$100.01–$1000.00	608,350	54	1	11,266	$244	$2,748,904
2	$1000.01–$10,000.00	40,799	54	1	756	$1,523	$1,151,388
3	$10,000.01–$80,000.00	2,735	54	1	51	$11,640	$593,640
4	$80,000.01+	107	54	3	6	$108,694	$652,164
Total		**651,991**	**216**	**6**			**$5,146,096**

Precision +/- 3.5%

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds
4–6	Strengthen eligibility and claim processing controls to reduce the risk of making improper payments.	$12.0 million[5]
4–6	Strengthen overpayment identification processes to ensure recovery of improper payments.	$5.1 million
7	Implement VA policies that will prevent inappropriate write-offs.	$114,276
	Total	$17.2 million

[5] Value shown is net overpayments ($12.2 million in overpayments – $191,654 in underpayments = $12.0 million net overpayments).

Appendix C

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: September 11, 2007

From: Under Secretary for Health (10)

Subj: OIG Draft Report: **Audit of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)**
(Project No. 2006-03541-R8-0222, (WebCIMS 386099)

To: Assistant Inspector General for Auditing (52)

1. I have carefully reviewed your draft report, and I concur with the findings and recommendations. Technical comments on the draft report have been sent under separate cover, for your consideration in preparing the final report.

2. The Health Administration Center (HAC) has had elements of an internal controls program in place for years; however, as your report points out, it has not been uniformly applied throughout the organization. I agree that, in order to effectively identify and manage controls for all key business processes in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), mechanisms for oversight need to be improved, and existing internal controls within the HAC should be expanded.

3. I appreciate your acknowledgment that the HAC's Chief Information Officer has already corrected user and programmer access deficiencies identified during the audit. Further, corrective actions are already in place or are in the process of being implemented for many of the report recommendations. Nonetheless, the attached action plan provides detailed corrective actions in response to each recommendation.

4. Thank you for the opportunity to review this report. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

Michael J. Kussman, M.D.
Michael J. Kussman, MD, MS, MACP

Attachment

Under Secretary for Health's Comments to Office of Inspector General's Report

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommend that the Under Secretary for Health develop oversight mechanisms to ensure that future CHAMPVA policy decisions have appropriate risk and cost analyses and comply with Federal laws.

Concur

We agree that mechanisms for oversight can be improved. To that end, management from the Health Administration Center (HAC), the Office of General Counsel (OGC), and the Chief Business Office (CBO) met on May 30, 2007, to discuss process changes for increased oversight of substantive policy changes.

Prior to the IG audit, all substantive policy changes requiring regulatory action were forwarded to the CBO for review and comment when the regulatory package was complete. It was agreed that increased oversight by the CBO at the time HAC initially considered a substantive policy change would be beneficial.

At the time of the IG audit, a HAC Proposed Policy Initiative (PPI) process was in place to coordinate internal HAC review and comment with the executive leadership team. Modification of the desk procedures will include the CBO in this review, and a request for their concurrence with the recommendation was completed August 2, 2007. Additionally, the PPI format has now been revised to include a discussion of the risks along with the prior PPI requirements. The Deputy Chief Business Officer for Purchased Care (DCBO-PC), a new position recently added within the CBO, will have direct supervision over the HAC. PPIs will be routed through the DCBO-PC for review and additional oversight for substantive policy changes.

A training session on cost analysis development was provided to all policy analysts on June 19, 2007, and follow-up class on this subject occurred

August 9, 2007. Additionally, a new data manager (statistician) position will provide additional support in the development of comprehensive cost analyses. It is anticipated that this position will be filled in October 2007.

Regulation training provided by The Regulatory Group in Washington, DC, was completed by two of the HAC Policy Analysts in July 2007, and two additional analysts are scheduled for the training in September 2007.

In process October 31, 2007

Recommendation 2. We recommend that the Under Secretary for Health consult with the OGC to determine whether further action is required regarding claim filing deadlines and the preauthorization limit for durable medical equipment.

Concur

A meeting was held on May 30, 2007, with representatives from the Health Administration Center (HAC), the Office of General Counsel (OGC), and the Chief Business Office (CBO) to discuss the actions required to resolve these issues. OGC recommended that a Federal Register (FR) Notice be issued in both cases to inform the public of the policy changes impacting durable medical equipment (DME) and timely filing.

On July 26, 2007, a Federal Register (FR) Notice was forwarded to the CBO regarding the claim filing deadlines and waiver conditions. The FR Notice advises the public that from August 30, 2006 to November 20, 2006, the timely filing requirement for CHAMPVA claims had been removed from the policy manual. During this time period (approximately 90 days), the claims processing system continued to deny claims that did not meet the timely filing requirement. However, in this 90-day period, when claims that had been denied for timely filing were submitted for "reconsideration," timely filing was waived and the claim was paid without first ensuring the required criteria for a waiver was met, as required by 38 CFR 17.275(b). The policy manual has since been corrected. Desk procedures were updated to state requests for timely filing waivers must be reviewed and waiver granted only when it is established that the criteria described in 38 CFR 17.275(b) has been met.

The FR Notice for DME was forwarded to CBO on July 26, 2007. The notice advises the public that the preauthorization dollar requirement was changed from $300 to $2,000. A regulatory package to change the preauthorization dollar review was submitted to CBO on May 30, 2007. Payment controls within the claims processing system have remained in place at all times to continue to require review of DME claims submitted with a value of $300 or over to ensure the equipment is medically necessary and appropriate.

Action Pending: Publication of Notices in the Federal Register

In process July 2008

Recommendation 3. We recommend that the Under Secretary for Health develop oversight mechanisms to ensure the HAC conducts effective internal control reviews.

Concur

OMB Circular A-123 encourages the use of external reviews to assess vulnerabilities. The HAC will incorporate the findings of this OIG audit in its annual reporting. An annual certification of written assurance signed by the HAC Director will be submitted to the VHA CFO with supporting

documents on or before September 30, 2007, in compliance with OMB Circular A-123.

The HAC hired a Compliance Officer in February 2007 to develop and implement a compliance program that ensures accountability, control, and promotes continuous improvement. A Compliance Committee has been established to provide oversight for compliance issues and the internal controls program. The Committee meets monthly and reports to the HAC Executive Leadership Team.

To assure that the HAC's CBI Officer will have the organizational independence to effectively perform the role, CBO will implement the external consultant's recommendation from 2001 and arrange for the VHA Chief Officer for Compliance and Business Integrity (CBI), to directly supervise the CBI Officer at the HAC.

The HAC is also conducting a center-wide risk assessment that encompasses all work processes within the HAC. Low, medium, and high vulnerabilities have been identified for each process and controls and recommendations for each risk are being implemented. The completed risk assessment is part of our internal control process for FY 2007.

In process September 30, 2007

Recommendation 4. We recommend that the Under Secretary for Health provide refresher training and increased management supervision to ensure HAC staff follow procedures for determining and verifying eligibility, processing claims, and identifying overpayments.

Concur

We agree with the recommendation to increase refresher training and increase process improvement and management oversight in addition to the controls already in place.

Actions taken to address refresher training:

- Eligibility training: Eligibility Technicians completed refresher training in June 2007 to reinforce procedures and requirements as well as enhance their knowledge of eligibility policy. A monthly sustainment training plan has been developed and began August 2007. The sustainment training is designed to reinforce proper procedures and knowledge of eligibility policy.

- Claims processing training: Refresher training is provided to all voucher examiners on a bi-weekly basis. Additionally, training to all staff within the Suspense Units was provided to address identified deficiencies. Since December 2006, training has been conducted on a variety of topics to include duplicate claims, vendor identification and selection, and other health insurance. Since December 2006, there have been 15 mandatory refresher training sessions for the claims processing staff and bi-weekly training will continue indefinitely.

- Customer service training: Customer Service Representatives (CSR) will be provided focused training on claim processing procedures, claim calculation methodologies, and claim queue management. Once initial training is complete, these topics will be added to the schedule for recurring refresher training. This will enable the CSRs to accurately identify overpayments while in communication with beneficiaries and health care providers.

Actions taken to address increased management supervision/oversight of processes:

- Determining and verifying eligibility. At the time of the IG audit, HAC had the following determination and verification processes in place:

  1. Request for veteran and dependant data from the Veterans Benefits Administration (VBA) using Form 3884 and/or reviewing VBA data bases to obtain veteran and dependant information for all new applications;
  2. Annual verification of approximately 130,000 active files; and
  3. Random verification of 150 files on a monthly basis (1800 per year) that had not been reviewed in the prior year.

- To tighten verification controls, HAC negotiated a matching agreement with VBA which was signed in July 2007. Through the matching agreement, VBA files will be matched to those of CHAMPVA on a monthly basis starting in September 2007. Discrepancies between the data sources will be flagged for HAC's review and action.

- Desk procedures. The IG auditors suggested greater focus be given within HAC to desk procedures and ensuring compliance with those procedures.

  In the Eligibility Section, a quality improvement team has been established to focus on the review and updating of eligibility desk procedures to ensure they are accurate and procedures are clearly and completely explained. The revised desk procedures are, in turn, used for the new hire and monthly sustainment training, and consist of 13 modules with a total of 46 sections. Since the IG audit, three sections of the desk procedures have been updated. Of note is that the IG provided guidance on utilizing the VBA database to determine whether the veteran's permanent and total disability is due to a non-service connected condition. This process has been added to the revised desk procedures and the eligibility technicians have also received training on this process.

  The Claims Processing Division (CPD) has an aggressive review schedule of their desk procedures which contains 12 chapters. Since the IG audit, six chapter updates have been completed and reviewed in the bi-weekly voucher examiner training**.**

- Automated process improvements. The claims processing system utilized for CHAMPVA payments is highly automated. However, manual processes do continue in several areas leaving the

processing of claims vulnerable to errors. CPD identified system vendor file improvements and duplicate claim processing improvements that will improve the quality of claim adjudication. System requirements in these areas have been written and given critical priority status for completion. Of the five related system requirements that have been submitted for programming action, one was released to production July 2, 2007, two have been programmed and are currently in testing, and the remaining two are on schedule for programming and will be completed this calendar year.

- Division internal monitoring programs: An ongoing internal monitoring program has been in place for both eligibility and claims processing for many years to ensure quality and identify areas for refresher training.

  A 3 percent review of eligibility actions completed by each employee had been a standard operating procedure prior to the IG audit. Changes were made to improve the process effective June 29, 2007, by requiring the eligibility supervisors to compile and utilize the findings from these internal reviews for refresher training. This ensures those areas most vulnerable to error are consistently addressed.

  CPD provides a quality review of every voucher examiner's work. All new hires are placed on a 100 percent review of input. When they reach a 90 percent accuracy rate, they are placed on a 50 percent review of work. The percent of work reviewed continues to drop as the accuracy improves. When they reach the accuracy standard for their grade level, 2 percent of their work is reviewed. Their error rate is closely monitored and if the error rate for a voucher examiner is not within standard, the percent of review for that individual will be raised and remedial training for that person is provided.

  CPD also routinely monitors and reports on identified areas of vulnerability within the claims processing activities. The results are provided to the individual employees who were found to have made errors; and the results are also a source for identifying focus areas for the bi-weekly training. To further strengthen this review, a new position was established to focus on the quality monitoring and reporting. It is anticipated that this position will be filled by November 1st and that the employee will complement the existing process by identifying the areas for improvement through training, and also identifying process improvements to eliminate or lessen areas of vulnerability.

  In process December 31, 2007

Recommendation 5. We recommend that the Under Secretary for Health require the HAC to correct the programming errors in the Claims Processing and Eligibility software.

Concur

Several claims were identified during the IG audit in which the catastrophic cap did not correctly calculate. To determine whether all problems related to the catastrophic cap have been resolved or whether a problem continues to exist, a quarterly report has been established to identify claims with potential cost share/catastrophic cap calculation errors. Internal auditors from the HAC Business Process Office (BPO) will review the report to identify claims containing cost share calculation errors. Any errors identified will be referred to the Claims Resolution Unit for appropriate corrective action and to the CIO for review of the system logic to determine if there is a system problem. This procedure is scheduled to be implemented in October 2007.

Additionally, BPO requested an enhancement to the current VistA functionality to enable the Customer Service Representatives (CSRs) and other designated HAC users to access a VistA menu option that lists and tabulates current and past calendar year beneficiary individual and family cost share/catastrophic cap accruals to date. The enhanced functionality will enable the CSRs to more easily identify potential cost share calculation errors and initiate appropriate corrective action. The implementation of this programming enhancement is expected in December 2007.

In process December 31, 2007

Recommendation 6. We recommend that the Under Secretary for Health expand the HAC's internal audits to incorporate reviews of eligibility documentation, claim histories, and recovery actions.

Concur

Periodic internal audits of eligibility and duplicate payments have been completed since 1995. In January 2005, a more formalized quarterly audit of eligibility and claims processing was established. In FY 2007, a quarterly duplicate payment audit was added to the audit schedule.

In addition, processes are currently being updated to include increased review of eligibility documentation, review of claim histories, and recovery actions. The HAC Business Process Office is expanding the quarterly claims audit scope to include verification of current beneficiary eligibility status as it pertains to Medicare coverage and claims payment, review of cost share/catastrophic cap calculation accuracy and review of beneficiary claims history for episode of care payment accuracy. The revised claims audit plan will be completed by September 1, 2007, and implemented effective October 1, 2007.

The quarterly eligibility audit scope is also expanding to more accurately measure eligibility determination performance and ensure that periodic review of active beneficiary eligibility is being performed in accordance with CHAMPVA policy. The size of the audit sample is being increased from 87 files to 150 in accordance with generally accepted audit practices for a statistically valid sample. The revised eligibility audit plan will be completed by September 2007 and implemented effective October 2007.

Action pending: Revise the scope of audit plans for implementation in FY 2008.

In process October 31, 2007

Recommendation 7. We recommend that the Under Secretary for Health provide training for HAC staff on VA financial accounting policies and procedures.

Concur

We concur with the recommendation contained in this report but not with the reasons cited as the cause of the problems associated with accounts receivable (AR) management.

Copies of VA 4800 series handbooks were posted to the HAC financial division internal shared drive for staff to access and review as required in December 2006.

Hard copies of VA's non-healthcare debt guide were provided to all personnel assigned to debt management – completed December 2006.

On December 1, 2006, the HAC CFO implemented write-off procedures essentially requiring that all requests for writing off accounts receivable must be endorsed by the Debt Management Supervisor and forwarded to the CFO for approval, or not, before additional action is taken.

In conjunction with the HAC Training Division, selected financial management staff, to include the new billing supervisor, are developing institutionalized training curriculum around improving staff proficiency in the areas of debt management (VA 4800-series handbooks) and VISTA AR package utilization. We expect the curriculum to be developed by December 2007.

Beginning August 2007, debt management staff will receive formal training on the VA 4800-series handbooks during monthly division meetings in addition to the training described above.

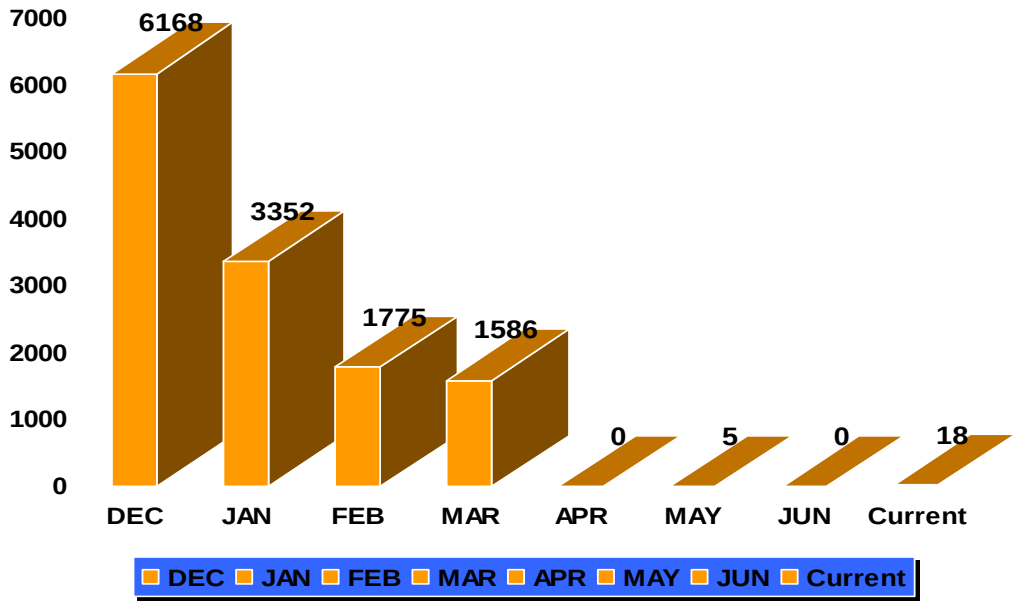
Since June 2006, the Lead AR Tech, has provided on-the-job AR vista package training to most debt management employees. Examples of informal training provided include payment plans, how to hold/stop a bill, entering bills, auditing bills, entering comments on a bill, bill adjustments, and how to print demand letters.

In process December 31, 2007

Recommendation 8. We recommend that the Under Secretary for Health establish and monitor performance measures for the timely collection of CHAMPVA overpayments.
Concur

Untimely Billing

As indicated in the OIG report, the VHA standard is 63 days to bill first or third party debt cases. The HAC has adopted the VA's Best in Class standard for this metric of 31.5 days. Chart 1 depicts the number of bills entered into VistA AR but not yet issued. Additional personnel and management tracking tools have enabled us to make tremendous progress in this area. Since December 2006 we have reduced the number of bills entered but not issued from 6168 to 18 as of the week ending July 27, 2007.



Billing and collection activities are monitored on a daily basis. Management tools were established in May 2006 which track the number of requests received, entered, approved and audited on a daily basis. A check log that accounts for every check received has also been established. The check log is used to identify workload and to reconcile checks received against deposits to ensure and facilitate complete accountability.

Since the time of the OIG visit, billing staff has been increased by 120 percent from 5 to 11 FTE, and our recovery staff by 100 percent from 4 to 8 FTE. As of the end of July 2007, the HAC is issuing bills of collection within 2 days of recoupment request and deposits within 2-working days of receipt.

On January 16, 2007, the HAC entered into an Agency Participation Agreement with the US Department of Treasury to participate in the Paper Check Conversion Over the Counter (PCCOTC) Program. PCCOTC focuses on collection of monies via check at accounts receivable locations. Checks collected are converted into electronic funds transfer (EFT) payments and deposited into our Federal Reserve Bank (FRB) account.

To improve the monitoring of AR in October 2006, the HAC implemented a stringent separation of duty process. The individual entering the AR

cannot approve or audit the account. A second individual must approve the account and a third individual must audit it. Demand letters are computer form letters that are automatically generated at 30, 60 and 90 days after the initial bill is issued.

The HAC does not send these letters when the bill is being disputed by the vendor or Congressional action is pending or the payment was received and has not yet been posted. Those procedures are in compliance with VA's 4800 series Handbooks.

In process August 31, 2007

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Claire McDonald (206) 220-6654
Acknowledgments	Gary Abe Sherry Ware Maria Foisey Amy Mosman Tom Phillips Theresa Zoun

Appendix E

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