

VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS



Veterans Health Administration

*Audit of Non-VA Inpatient
Fee Care Program*

August 18, 2010
09-03408-227

ACRONYMS AND ABBREVIATIONS

CBO	Chief Business Office
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CTC	Cost-to-Charge
DRG	Diagnosis Related Group
FBCS	Fee Basis Claims System
USC	United States Code
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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Report Highlights: Audit of Non-VA Inpatient Fee Care Program

Why We Did This Audit

The OIG conducted this audit to assess the accuracy of payments made for pre-authorized inpatient fee service and assess the efficiency of processing fee service claims.

What We Found

VA Medical Centers (VAMCs) improperly paid 28 percent of inpatient fee claims during the 6-month period of January 1, 2009 through June 30, 2009. The improper payments occurred because VHA's policies for determining eligibility for inpatient fee care did not provide adequate guidance on how to determine eligibility for inpatient fee care or were not understood by fee staff. Other payment errors occurred because fee staff did not have accurate and timely information to determine correct payments, and the VAMC did not have sufficient controls to detect clerical errors.

We estimate that VHA made net overpayments of \$120 million on inpatient care for veterans in FY 2009 or \$600 million in improper payments over the next 5 years. For each of our sample items, we found sufficient VAMC medical documentation to convince us that the veteran received the services paid for by VHA. Efforts are needed to reduce the cost associated with processing claims and the time it takes to process claims by improving processing efficiencies. Inefficiencies occurred because of the Fee Program's decentralized structure and its labor-intensive payment system.

VHA and OIG agree there will be general cost savings and efficiencies realized with consolidating the Fee Program's claim

processing system and achieving economies of scale. The specific cost savings depends on the actual consolidation strategy VA selects and on how well VA implements the chosen strategy. As a result, we have conservatively used the lowest projection to estimate cost savings of \$26.8 million in FY 2009 and to estimate cost savings of \$134 million over the next 5 years.

What We Recommended

We recommended the Under Secretary for Health establish guidance on how to determine eligibility, reduce improper payments, and improve claims processing efficiencies for inpatient fee care.

Agency Comments

The Under Secretary for Health has agreed to address all of our audit recommendations and concurs with our estimate of questioned costs in net overpayments and that there are cost savings associated with consolidating the Fee Program's claim processing system. The Under Secretary plans to establish guidance and mandate training for VHA staff, develop an audit tool to reduce improper payments, initiate recovery of overpayments and reimbursement of underpayments identified in this audit, and develop a pilot program to improve payment processing efficiencies. We will monitor the implementation of these planned actions.

(original signed by:)

BELINDA J. FINN
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INTRODUCTION

- Objective** This audit assessed the accuracy of payments made for pre-authorized inpatient fee service and assessed the efficiency of processing fee service claims.
- Description of the Fee Program** The purpose of the Non-VA Fee Care Program is to assist veterans who cannot easily receive care at a VAMC. The Program pays the medical care costs of eligible veterans who receive care from non-VA providers when the VAMCs are unable to provide specific treatments or provide treatment economically because of their geographical inaccessibility. Fee care may include dental services, outpatient care, inpatient care, emergency care, and medical transportation. Pre-authorized inpatient services consist of non-emergency and emergency care.
- Program Management** VHA's Chief Business Office (CBO) is aligned under the Deputy Under Secretary for Health for Operations and Management and is responsible for the management of the Non-VA Fee Care Program. Although Veterans Integrated Service Networks (VISNs) have operational authority and responsibility for their Fee Programs, most VAMCs independently administer the Fee Program for their areas.
- Program Costs** Total annual fee payments for the Non-VA Fee Care Program have grown from about \$1.6 billion in FY 2005 to about \$3.8 billion in FY 2009. Inpatient Fee Program expenditures have increased 126 percent over the past 4 years from about \$461 million in FY 2005 to \$1 billion in FY 2009. During this period, pre-authorized inpatient fee costs increased 142 percent from about \$306 million in FY 2005 to \$740 million in FY 2009. The number of patient discharges has also increased 82 percent from 35,085 in FY 2005 to 63,713 discharges in FY 2009.
- Recent OIG Audit** The OIG issued *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program* (Report No. 08-02901-185, August 3, 2009). The audit concluded that VHA needed to strengthen controls over outpatient fee care and make regulatory changes to address outpatient facility charges. The audit found that VHA improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other less frequent payment errors. As a result, VHA overpaid \$225 million and underpaid \$52 million to fee providers in FY 2008, or about \$1.1 billion in overpayments and \$260 million in underpayments over the next 5 years. That audit, the first in a series of audits to review VHA's Non-VA Fee Care Program, provided substantial evidence that the Fee Program is a high-risk program with insufficient controls.

VHA's Evaluation of Current Claims Processing System To understand the current fee system in detail, the CBO initiated the Indiana University/Purdue University Fee Service Evaluation Project¹, which was published in February 2010. The project's purpose was to benchmark best practices within thirteen VHA claims processing sites; collect in-depth process performance information; and evaluate overall efficiency, operations management, and cost metrics.

One of the study's major findings was that consolidated claim processing sites' cost to process claims was lower than non-consolidated sites' cost to process claims. The study attributed consolidated sites lower processing costs to economies of scale with a larger, more experienced staff processing a high volume of claims. The direct fee staff cost per claim ranged from a high of \$29 at a non-consolidated site to a low of \$4 at a consolidated site. Therefore, the study concluded that site consolidation was a prime target for improving process efficiency within non-VA-care. Although the study's cost analysis used different review methodologies than we used in this audit, it closely supported the reasonableness of our audit cost estimates and the opportunity to improve current economies of scale through consolidation of fee payment processing and achieve better use of funds.

¹ Veterans Integrated Service Network 11 VA Center for Applied Systems Engineering, *Fee Process Evaluation*, February 5, 2010

RESULTS AND RECOMMENDATIONS

Finding 1 **VHA Needs To Improve the Accuracy of Pre-Authorized Inpatient Fee Payments**

The audit found that VAMCs improperly paid 28 percent² of pre-authorized inpatient fee claims. VAMC staff did not properly authorize inpatient fee care because VHA policies did not provide adequate guidance on how to determine eligibility or fee staff did not understand them. In addition, other payment errors occurred because fee staff did not have accurate and timely information to determine correct payments, and the VAMC did not have sufficient controls to detect clerical errors. As a result, we estimate that VHA made improper payments resulting in net overpayments of \$120 million³ in FY 2009 or \$600 million over the next 5 years.

VHA Needs To Improve Eligibility Determination for Inpatient Fee Care

For the 6-month period of January 1, 2009–June 30, 2009, we estimate that VAMCs improperly paid 13 percent of all inpatient claims by authorizing non-emergency and emergency inpatient fee care for veterans ineligible for this care. These veterans were enrolled in the VA health care system and were eligible for other VA health care, such as outpatient services. VAMC fee staff authorized non-emergency inpatient fee care for veterans ineligible for this care because VHA policy did not adequately address how fee staff should determine eligibility. In addition, VAMC fee staff authorized emergency inpatient fee care for veterans ineligible for this care because fee staff did not understand the eligibility criteria. As a result, we estimate that VHA improperly authorized a total of \$106.6 million for pre-authorized non-emergency and emergency inpatient care in FY 2009 or \$533 million over the next 5 years.

VHA Eligibility Policy Inadequate

We estimate that VAMCs improperly paid 9 percent of all inpatient fee claims by authorizing non-emergency inpatient fee care for veterans who were not eligible for this care. These errors occurred because VHA's policy did not adequately address how to determine eligibility for non-emergency inpatient fee care. As a result, we estimate that VAMCs overpaid \$91.4 million in FY 2009.

² The combined error rate for authorization and improper payment errors was 30 percent (13 percent plus 17 percent). To prevent double counting in calculating the overall estimated error rate, we only counted each claim once, regardless of whether the claim contained one or multiple errors.

³ Although we found both underpayments and overpayments, we combined them into one net estimated amount because underpayments were too infrequent to estimate a separate total underpayment amount with reasonable precision.

Title 38 of the United States Code (USC) §1703 establishes clinical access criteria and individual eligibility criteria for non-emergency fee care. VHA must ensure that both criteria are met before authorizing inpatient care.

Clinical Access Criteria—The statute authorizes the use of fee care only if VHA: (1) does not have the clinical capability, (2) does not have capacity, or (3) facilities are geographically inaccessible for the veteran.

Individual Eligibility Criteria—Once the clinical access criteria is met, a VAMC must determine whether the veteran is eligible based on individual eligibility criteria, such as treatment of service-connected conditions or referral from a VA facility for an emergency condition the VA cannot treat. (See Appendix A for additional individual eligibility criteria.)

VHA policy governing inpatient fee care eligibility, VHA Manual M-1, Part I, Chapter 21 dated January 12, 1995, does not clearly state that both clinical access *and* veteran eligibility criteria must be met to approve non-emergency inpatient fee care. Instead, it only states that the care must meet clinical access criteria and be authorized in advance. Although VAMC fee staff understood the clinical access criteria, they incorrectly believed all properly enrolled veterans were eligible for non-emergency inpatient care. The following example illustrates this type of error.

A VAMC pre-authorized knee surgery, which met the clinical access criteria, for a non service-connected veteran. According to the Chief of Surgery at the VAMC, the VAMC authorized this non-emergency procedure to reduce their orthopedic surgery waitlist. However, the VAMC fee staff did not review the veteran's individual eligibility before or after the Chief of Surgery authorized the procedure. Although evidence supports that services were provided, the veteran did not meet the individual eligibility criteria, and the VAMC improperly paid the fee provider \$12,343. Thus, VHA lacks assurance that payments made without proper eligibility review effectively meet the requirements prescribed in Title 38 USC §1703 and that budgetary resources are used as intended.

VAMCs Incorrectly Determined Eligibility for Inpatient Emergency Care

We estimate that VAMCs improperly paid 4 percent of all inpatient fee claims by authorizing emergency care for veterans who were ineligible for this care. These errors occurred because fee staff did not understand the individual eligibility criteria for emergency inpatient fee care, such as the authorized treatment must be related to a service-connected disability. As a result, we estimate that VAMCs overpaid \$15.2 million for emergency fee care in FY 2009.

VA may authorize payment for an eligible veteran's emergency care if the treatment is of such a nature that a delay would be hazardous to life or

health. Unlike non-emergency care, a VA clinician does not authorize emergency care in advance. However, the veteran must meet the same individual eligibility criteria as required for non-emergency care in Title 38 USC §1703, and the VA must be notified within 72 hours of the veteran's admission to the non-VA facility.

Although the CBO has issued procedure guides on determining emergency inpatient eligibility, fee staff did not properly apply the guidance because they did not understand the individual eligibility criteria for emergency inpatient fee care. The following example illustrates this type of error.

A non-VA facility provided emergency cardiac care to a veteran with a 10 percent service-connected disability for scar tissue and notified the VAMC within 72 hours of the veteran's admission. The VAMC clinical staff correctly determined that the emergency care met the clinical access criteria. However, to meet individual eligibility criteria for inpatient care, the treatment must be for a service-connected disability. The veteran was ineligible for emergency inpatient care because his cardiac care was not related to his service-connected disability. While there was evidence that the services were provided, the VAMC improperly paid the fee provider \$9,133.

We understand VHA's commitment to provide timely and quality inpatient care to eligible veterans. However, when VHA does not have the capability to provide the necessary care, then VHA is obligated to provide fee care within current regulatory authority. Without an adequate VHA policy for determining eligibility of non-emergency inpatient fee care, and adequate training for determining eligibility of emergency inpatient fee care, VAMCs will continue to authorize fee care for ineligible veterans. VHA will also continue to lack assurance that it appropriately uses resources. More importantly, VHA cannot ensure that some veterans will have access to care that other veterans do not because of VHA's inconsistent application of eligibility criteria in authorizing inpatient fee care.

**VHA Needs To
Reduce Fee Care
Payment Errors**

For the 6-month period of January 1, 2009–June 30, 2009, we estimate that VAMCs paid improper amounts for 17 percent of pre-authorized inpatient fee claims. VAMCs made three types of payment errors, they did not: (1) know where to find inpatient transfer information needed to determine when to apply per diem payment methodology, (2) utilize Preferred Pricing Program rates because the Program process was not timely, and (3) pay other proper rates because fee staff were provided with inaccurate rate information or made clerical errors. As a result, we estimate that VHA made net overpayments of \$13.3 million in FY 2009 or \$66.5 million over the next 5 years.

Table 1 below summarizes improper payment errors by type.

Type of Error	Rate of Error	Estimated FY 2009 Payment Errors
Per Diem Payments Not Made	2%	\$3.0 million
Preferred Pricing Program Rates Not Used	4%	\$5.6 million
Other Payment Errors	11%	\$4.7 million
Total Payment Errors	17%	\$13.3 million

Source: OIG analysis of inpatient fee care payments.

Proper Per Diem Payments Not Made

We estimate that VAMCs improperly paid 2 percent of all inpatient fee claims by not applying the per diem payment methodology. These errors occurred because fee staff were not aware that inpatient transfer information needed to determine when to apply the per diem payment methodology was available in the veteran’s electronic health record. As a result, we estimate that in FY 2009 VAMCs made net overpayments of \$3 million.

Title 38 CFR §17.55 provides authority for VA to use the Centers for Medicare & Medicaid Services’ (CMS) Diagnosis Related Group (DRG) based prospective payment system for those hospitals that accept Medicare. The DRG rate consists of a CMS predetermined payment rate and the average length of stay. The hospital does not receive more than the DRG payment if the inpatient care exceeds the average length of stay.

To determine when to use the per diem payment methodology, fee staff must know whether the veteran was discharged home or transferred to another facility. If the non-VA hospital discharges a veteran, VA pays the DRG amount. If the non-VA hospital transfers the veteran to a VAMC, VA pays a portion of the DRG amount, commonly referred to as a per diem payment. VA calculates per diem payments by dividing the DRG rate by the average length of stay. The resulting per diem rate is multiplied by the number of days the veteran was hospitalized to arrive at the per diem payment.

Although invoices included discharge and transfer information, fee staff normally confirmed the accuracy of the information. This practice proved appropriate because we found several instances of inaccurate invoice information. Fee staff at the sites we visited used various sources to confirm a veteran’s discharge or transfer, such as addendums to existing medical notes, e-mail notes, and utilization review notes. However, many fee staff were unaware that the veteran’s electronic health record had an Admission/Discharge Clinical Report that contained information on when a veteran was admitted as an inpatient to a VAMC. As a result of not utilizing this information, fee staff did not correctly apply the per diem payment

methodology to claims for veterans who had transferred to a VAMC. The following example illustrates this type of error.

A non-VA facility admitted a veteran for care, and the next day the facility transferred the veteran to the VAMC. However, according to the invoice, the facility discharged the veteran to their home. The fee staff used the invoice information because they could not find any documents that indicated the veteran was transferred to the VAMC even though this information was in the veteran's electronic health record. As a result, they paid the DRG amount of \$5,323. Since the veteran only spent 1 day at the non-VA facility and the average length of stay for the DRG was 5.5 days, fee staff should have paid the per diem amount of \$968. This resulted in an overpayment of \$4,355.

**Preferred Pricing
Program Rates
Not Used**

We estimate that VAMCs improperly paid 4 percent of all inpatient fee claims by not utilizing VHA's Preferred Pricing Program contract network rates. These errors occurred because the Preferred Pricing Program process was not timely in providing payment rates. As a result, we estimate that VAMCs overpaid \$5.6 million in FY 2009.

VHA's Preferred Pricing Program allows VAMCs to share in savings available through contract network rates from provider networks for a variety of health care services, including outpatient care, inpatient care, behavioral health, ancillary, and other services. VHA policy requires that fee offices submit all claims over \$150 through the Preferred Pricing Program.

When a VAMC receives a claim, the fee staff determine the rate the non-VA facility is normally paid. They are then required to photocopy, batch, and mail the claim to the Preferred Pricing Program because the current Fee Program's payment processing system cannot send or receive this information electronically. The Program examines the claim and applies a network rate if the claim was from a network provider. The Pricing Program mails this information back to the VAMC, and the Fee staff compares the Program's network rate with the rate the facility is normally paid and pays the lower rate.

Fee staff did not always use the Preferred Pricing Program because the time needed to process these claims made it difficult for the VAMC to meet VHA's performance standard of processing 95 percent of claims within 30 days of receipt. Fee staff stated it took too long to photocopy, batch, and mail the claims to the Program and then wait as long as 10 days for the results to return. The following example illustrates this type of error.

A VAMC paid \$12,017 to a non-VA provider for hospital services. Although the claim exceeded the \$150 threshold, the VAMC did not

send it to the Preferred Pricing Program. Fee staff explained they did not send claims to the Program because of the added payment processing time. We sent a copy of the invoice to the Program, and the Program provided a network rate of \$10,400. The VAMC overpaid the non-VA provider \$1,617 because the VAMC did not use the network rate.

Other Payment Errors

We estimate that VAMCs improperly paid 11 percent of all inpatient fee claims by: (1) calculating incorrect cost-to-charge (CTC) payment rates because VAMCs did not receive or use the correct CTC rate, (2) paying incorrect rates to facilities with local contracts because local contracting and fee offices did not adequately coordinate contract information, and (3) making inadvertent clerical errors because the payment process lacked sufficient controls to detect errors before paying claims. As a result, we estimate that VAMCs made net overpayments of \$4.7 million in FY 2009.

Medicare Exempt Hospital Payment Errors

VAMCs incorrectly calculated the payment to Medicare exempt facilities. CMS does not establish a DRG payment rate for Medicare exempt facilities such as psychiatric hospitals, designated cancer centers, and rehabilitation units. Instead, VA pays these inpatient facilities a percentage of the billed amount, commonly referred to as a CTC rate. During our period of review in FY 2009, the CTC rate was 49.3 percent.

Fee staff incorrectly calculated the payment rate to Medicare exempt facilities either because the National Fee Program Office provided the VAMCs with an incorrect CTC rate for FY 2009 or because fee staff did not understand the CTC rate was for the fiscal year rather than the calendar year. The following example illustrates this type of error.

A VAMC referred a veteran to a local inpatient psychiatric facility. The facility billed the VAMC \$30,275 following the veteran's discharge in November 2008. The fee staff used the FY 2008 CTC rate of 51 percent and paid the facility \$15,440. The fee staff should have used the FY 2009 rate of 49.3 percent, which would have resulted in a proper payment amount of \$14,926. This error caused a \$514 overpayment for inpatient services.

Contract Payment Errors

VAMCs did not consistently apply contract rates negotiated between VAMCs and non-VA providers. VAMC contracting offices established contracts with local providers to provide various inpatient services. However, fee staff paid expired contract rates or non-contract rates instead.

Fee offices did not apply the proper contract rates because of inadequate coordination between the contracting office and the fee office to ensure fee staff had access to current contract information. The following example illustrates this type of error.

Fee staff at a VAMC paid a non-VA provider an expired contract rate of \$45,306 for performing an angioplasty. The VAMC did not renew the contract and allowed it to expire. Since the contract no longer applied, the VAMC should have paid the DRG rate of \$41,848. The fee staff paid the expired contract rate because they did not know that it had not been renewed, resulting in an overpayment of \$3,458.

We reported this same issue in *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*. We made the recommendation to develop and publish detailed procedures to ensure fee staff had access to all contract information needed to accurately pay fee claims. VHA implemented our recommendation after the period of this review, and we will continue to monitor the results of their implementation plan.

Clerical Payment Errors

VAMCs made clerical payment errors, such as not selecting the lower of available rates. These errors went undetected because of the absence of automated or manual controls to detect errors before paying claims. The following example illustrates this type of error.

A non-VA provider claimed \$14,078 for hospital services. Although the fee staff determined the correct payment rate was \$6,924, they inadvertently paid the billed amount instead. Without an automated or manual control, the error went undetected, and the VAMC made an overpayment of \$7,154.

Inadequate Payment Processing System Contributes to High Error Rate

In addition to the specific causes above, the Fee Program's inadequate payment processing system, Veterans Health Information Systems and Technology Architecture (VistA) Fee, contributed to the high rate of payment errors. The Fee Program is very complex, and VistA Fee requires fee staff to use significant time and judgment to ensure they make the correct payments. The volume of claims processed and the manual nature of VistA Fee also make detection and correction of payment errors difficult and very labor-intensive.

VHA is aware of these issues and has concerns about the shortcomings of VistA Fee. VHA plans to improve VistA Fee by installing a Commercial Off-the-Shelf integrated claims processing and management system, Fee Basis Claims System (FBCS), at all fee sites.⁴ VHA expects to complete fielding by December 2010.

VHA expects FBCS to electronically submit claims to the Preferred Pricing Program. This should reduce the time required to prepare the claims for

⁴ VAMCs in VISN 6 implemented a similar system late in FY 2009. (See Appendix A for more details.)

submission and eliminate several days of waiting time for claims to return. It should also enforce the use of the Preferred Pricing Program for all eligible claims. VHA also expects FBCS to reduce payment errors by alerting fee staff when a per diem or CTC payment is miscalculated or a lower rate is available. However, monitoring FBCS to ensure it is functioning as anticipated is critical to the ability of FBCS to reduce improper fee payments identified in this audit.

Conclusion

VHA faces significant challenges in addressing Fee Program financial vulnerabilities. In August 2009, we reported that VHA improperly paid 37 percent of outpatient fee claims, and in this audit we found VHA improperly paid 28 percent of inpatient fee claims. These two audits identified improper payments of \$1.5 billion over 5 years. The combined results of our two audits provide substantial evidence that VHA must act to improve the accuracy of inpatient fee care payments. Without an effective program to reduce improper payments, VHA does not have reasonable assurance that VAMCs are appropriately utilizing resources to serve the health care needs of veterans and are accurately reporting financial information that impacts future planning and allocating of health care resources.

Recommendations

1. We recommended that the Under Secretary for Health establish guidance on how to determine eligibility for pre-authorized non-emergency inpatient fee care.
2. We recommended that the Under Secretary for Health develop and implement mandatory training to ensure fee staff understand the eligibility criteria for emergency inpatient fee care.
3. We recommended that the Under Secretary for Health establish guidance on where to find inpatient transfer information needed to determine when to apply the per diem payment methodology.
4. We recommended that the Under Secretary for Health develop and implement a quality control mechanism to periodically assess whether the Fee Basis Claim System is functioning as anticipated in addressing the types of payment errors identified by this audit.
5. We recommended that the Under Secretary for Health instruct the eight sampled VAMCs to initiate recovery of overpayments and reimbursement of underpayments identified in our audit sample of payments reviewed.

**Management
Comments and
OIG Response**

The Under Secretary for Health agreed with the finding, recommendations, and monetary benefits and provided acceptable implementation plans. The Under Secretary stated that VHA's CBO will review all procedure guides to clearly

define eligibility for pre-authorized non-emergency inpatient fee care and the National Fee Program Office will develop a user guide to aid in the determination of veteran eligibility for all care not provided by VA.

The CBO will develop core competencies that will be supported by mandatory training and will issue updated procedure guides regarding guidance on finding inpatient transfer notes in the Computerized Patient Record System for veterans transferred from non-VA facilities to VA facilities. The National Fee Program Office is currently developing an audit tool to assist with mitigating improper payments and the Non-VA Care Program Office is developing a federated Risk Management Program. The CBO will work with the eight sites to initiate recovery of overpayments and reimbursement of underpayments.

We will monitor VHA's implementation of planned actions. Appendix F contains the full text of the Under Secretary's comments.

Finding 2 VHA Needs To Improve Claims Processing Efficiency

VHA needs to reduce the Fee Program's cost per claim and claims processing time. The Fee Program's claims processing inefficiencies occurred because of its decentralized structure and use of a labor-intensive payment processing system. The specific cost savings depends on the actual consolidation strategy VA selects and on how well VA implements the chosen strategy. We conservatively estimate that these current program inefficiencies cost VHA \$26.8 million in FY 2009 and could cost about \$134 million over the next 5 years.

Comparisons of Organizational Structures

We selected Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) as a benchmark because it is similar to the Fee Program and is also managed by the CBO. For example, CHAMPVA processes and pays the health care claims it receives for services performed by non-VA providers by using similar CMS rate schedules.

CHAMPVA covers most health care services necessary for spouses, surviving spouses, or children of veterans rated permanently and totally disabled or veterans who died from VA-rated service-connected disabilities. CHAMPVA is responsible for its policy, training, claims authorizations, claims processing, and other support activities at one central location.

Conversely, the National Fee Program Office is responsible for policy and program support of the Fee Program but does not have formal authority to enforce policy requirements. The Fee Program's highly decentralized structure places responsibility on the VISNs and VAMCs to develop local policies and procedures, conduct most training of staff, authorize fee care, pay fee claims, and provide program oversight.

Comparisons of Payment Processing Systems

Although the Fee Program and CHAMPVA both utilize VistA as their claims payment system, CHAMPVA has further automated much of its system by developing software that integrates with VistA. This software automates claims processing by incorporating such features as electronically transferring claims data into the processing system, applying business rules that select the correct payment methodology and proper payment rate schedule, and calculating the correct payment.

In contrast, the Fee Program's VistA Fee is a labor-intensive system that requires fee staff to make many decisions in the payment process. For example, VistA Fee requires staff to manually enter data, understand all established business rules, decide the correct payment methodology, determine the correct payment rate schedule, and calculate the correct payment. It has too few edit checks to verify that the payment is correct.

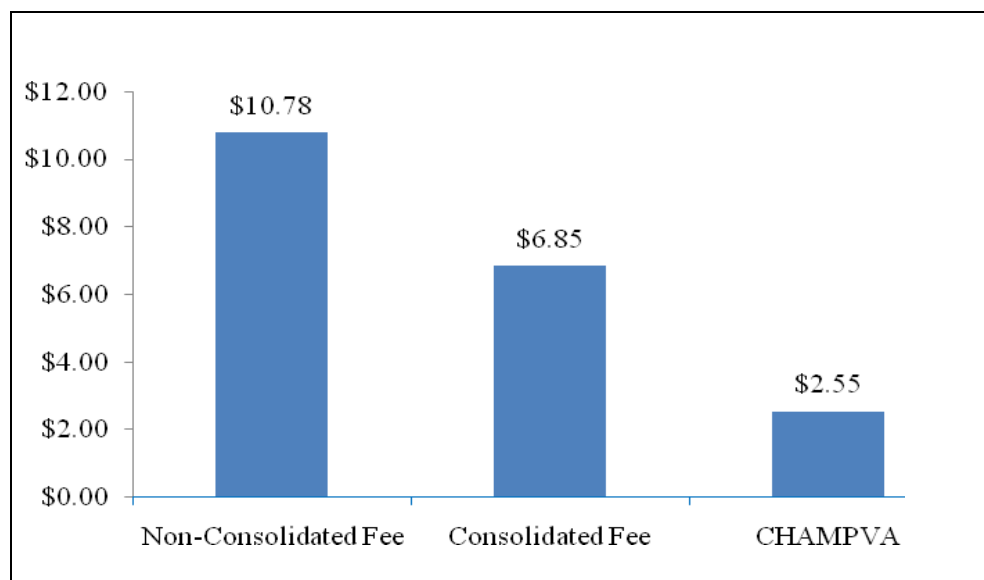
As mentioned before, the CBO has begun fielding FBCS to address the urgent need to improve VistA Fee. The CBO views FBCS as an interim solution to address VistA Fee limitations and currently has 22 system change requests pending at VA’s Office of Information and Technology to improve payment processing and program oversight. For example, the CBO has a request to implement an integrated health benefits and claims processing system to improve management and performance of the Fee Program. However, according to National Fee Program officials, getting the changes implemented has been problematic. The CBO submitted some of these change requests in June 2005, and the requests remain unimplemented because of its low priority status in the Office of Information and Technology’s backlog of work.

Fee Direct Labor Cost About Four Times Higher than CHAMPVA

We estimate that the average direct labor cost per paid claim for the Fee Program was \$9.96 compared to CHAMPVA’s average cost per paid claim of \$2.55 in FY 2009, a difference in cost of \$7.41.

In addition, non-consolidated sites, which processed fee payments for a single VAMC, had an average cost per claim of \$10.78. Consolidated sites, which processed claim payments for all VAMCs within a VISN, had an average cost per claim of \$6.85, or about one third less than a non-consolidated site. When further compared to CHAMPVA’s average cost per claim of \$2.55, non-consolidated sites paid about four times more per claim than CHAMPVA, and consolidated sites paid more than twice as much per claim as CHAMPVA. Table 2 below illustrates the difference in direct labor costs of paying a claim at the three types of sites in FY 2009.

Table 2. Fee Program and CHAMPVA Average Cost Per Paid Claim



Source: *OIG analysis of Fee Program and CHAMPVA claim and pay data.*

To validate the reliability of our estimates of the average direct fee staff cost per claim for the Fee Program, we compared our estimates to the estimates of the average direct fee staff cost per claim of the CBO Indiana University/Purdue University Fee Service Evaluation Project. We determined that our estimates were more conservative than the CBO study's estimates of the average direct fee staff cost per claim for non-consolidated sites, consolidated sites, and CHAMPVA. For example, the CBO study estimated that the average direct labor cost per claim for CHAMPVA was \$1.39, while we estimated the average direct labor cost per claim cost was \$2.55. (See Appendix B for more detailed information on the CBO Indiana University/Purdue University Fee Service Evaluation Project.)

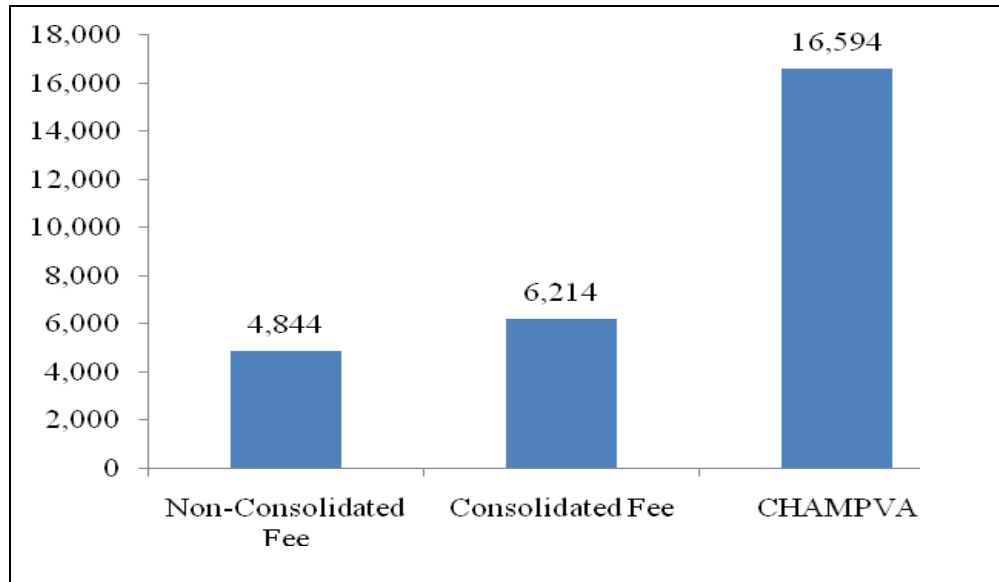
Lower Cost Per Claim Through Economies of Scale

The Fee Program's higher cost per claim, when compared to CHAMPVA, occurred because the Fee Program's decentralized organizational structure does not take advantage of economies of scale. An economy of scale is the relationship between the size of a production unit and the lowest possible cost of a product, in this case the number of claims paid by each claims processing staff member. Better specialization, improved technology, and discovery of new resources or better implementation of existing ones all can increase output and lead to improved economies of scale.

Non-consolidated sites required higher staffing levels to pay the same number of claims. Each staff member at a non-consolidated site paid an average of 4,844 claims in FY 2009, while each staff member at a consolidated site paid an average of 6,214 claims, or about 30 percent more claims. By comparison, a CHAMPVA staff member paid an average of 16,594 claims in FY 2009, and was more than three times as productive as a staff member at a non-consolidated site and more than twice as productive as a staff member at a consolidated site.

Table 3 below illustrates the difference in the average number of claims paid per staff member at the three types of sites in FY 2009.

Table 3. Fee Program and CHAMPVA Claims Paid Per Employee



Source: *OIG analysis of Fee Program and CHAMPVA claim and pay data.*

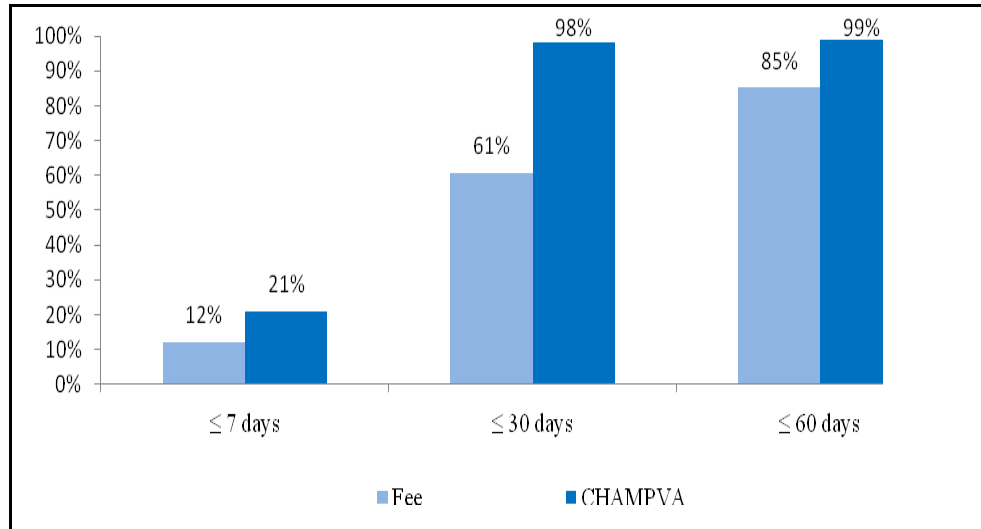
As an example of economies of scale, one of the consolidated sites we visited had 45 claims processing staff that supported 10 separate VAMCs in their VISN and paid about 424,000 claims, or on average about 9,400 claims per employee in FY 2009. In contrast, 1 of the non-consolidated sites we visited had 20 claims processing staff that supported just 1 VAMC and paid about 51,000 claims, for an average of about 2,600 claims per employee in FY 2009.

VAMCs Need To Improve Claim Processing Timeliness

The Fee Program paid 61 percent of its claims within 30 days of receipt, while CHAMPVA paid 98 percent of its claims within 30 days of receipt in FY 2009.

Table 4 below illustrates the difference in the timeliness of the two programs.

Table 4. Fee Program and CHAMPVA Timeliness by Days



Source: OIG analysis of Fee Program and CHAMPVA claims data.

VHA policy requires that the Fee Program and CHAMPVA process 95 percent of claims within 30 days of receipt. If VHA does not pay claims within 30 days of receipt, VHA is required to pay interest on care provided under contract, and providers are likely to re-submit claims. This creates more workload for VHA and increases the chances of duplicate payments. In addition, veterans’ access to care may be affected. For example, at one VAMC, fee staff stated that extensive payment backlogs resulted in non-VA providers stating they would no longer accept VA patients if payment timeliness did not improve.

Unlike claims processing costs, we found no significant difference in timeliness between non-consolidated and consolidated sites. This is because both types of sites use VistA Fee, which requires labor-intensive procedures to process a claim. For example, all fee sites must photocopy, batch, and mail claims to the Preferred Pricing Program.

The Fee Program’s VistA Fee is less automated than CHAMPVA’s payment processing system. Without improvements in VistA Fee, Fee Program staff will continue to perform more manual processing steps and make more decisions on payment methodologies and payment rate schedules.

Along with improvements to claims processing efficiency, an automated claims processing system will reduce the number of payment errors. Developing the payment system to apply Fee Program business rules and algorithms to determine payment methodologies and payment rates will

reduce the likelihood of fee staff making improper payments, such as calculation and other clerical payment errors.

Decentralized Fee Program Structure Inadequate

VHA could make substantial improvements in the Fee Program by evaluating the current organizational structure and payment processing system. In addition to not being an efficient structure to process claims, the decentralized structure of the Fee Program does not effectively enable the National Fee Program Office to ensure that the 136 program sites adequately develop local policies or procedures, research claims, review eligibility criteria, and apply correct payment methodologies. Consolidating fee payment processing would result in improved payment controls by allowing for more standardized practices and oversight.

Consolidating Major Functions

The CBO has already consolidated, or is in the process of consolidating, a number of its primary business functions to increase the CBO's control over its programs. The CBO has established the Health Eligibility Center to centralize VHA's health care eligibility verification and enrollment processing services and is currently consolidating VAMC revenue programs into seven regional Consolidated Patient Account Centers. Additionally, the Health Administration Center centrally manages similar VA health benefit programs for veterans and their family members, such as the Foreign Medical Program and CHAMPVA. Prior to consolidation, the CHAMPVA program was managed at the VAMC level and experienced problems similar to those the Fee Program is currently experiencing, such as with authorizing care, standardizing policies and procedures, training staff, and developing management controls.

VHA needs to review alternatives to the Fee Program's current organizational structure to consider whether an alternative structure would be more effective. Consolidation of processing activities is one solution but not necessarily the only solution. At a recent hearing of the House Committee on Veterans' Affairs Subcommittee on Health, the Subcommittee asked whether it would be better to contract the Fee Program payment process to a third party. TRICARE, the Department of Defense's healthcare program, currently contracts their payment processing to a third party. The TRICARE contractors expect to process about 75 percent of their claims electronically, which is much more efficient than the Fee Program's manual processing of claims.

Conclusion

The Fee Program's high cost to process claims and difficulty of meeting VHA's timeliness performance standard are the result of complex issues that VHA must face to improve program efficiency across a dispersed network of fee processing sites. To improve the efficiency of the Fee Program and to ensure that veterans benefit from sound business practices, VHA needs to evaluate alternative organizational models and payment processing options.

- Recommendation** 6. We recommended that the Under Secretary for Health evaluate alternative organizational models and payment processing options to identify mechanisms to improve payment processing costs and timeliness.

**Management
Comments and
OIG Response**

The Under Secretary for Health agreed with the finding and recommendation and provided an acceptable implementation plan. VA has submitted requests through the VA Office of Information and Technology procurement process for a complete systems modernization for this critical business process. In addition, the Under Secretary stated VHA is in the process of deploying the Fee Basis Claims System and is developing a pilot program for one Veterans Integrated Service Network to partner with the Financial Service Center for processing of all non-VA fee claims.

The Under Secretary for Health agreed there will be general cost savings and efficiencies associated with consolidating the fee program's claim processing system. However, VHA cannot validate specific savings as noted in the report because an actual national consolidation strategy has not been specified or determined and the computation of savings related to consolidation is less exact.

OIG agrees that the specific cost savings depends on the actual consolidation strategy VA selects and on how well VA implements the chosen strategy. As a result, we have conservatively used the lowest projection to estimate cost savings of \$26.8 million in FY 2009 and to estimate cost savings of \$134 million over the next 5 years. We will monitor VHA's implementation of planned actions. Appendix F contains the full text of the Under Secretary's comments.

Appendix A Background

Eligibility Criteria Title 38 USC §1703 authorizes VHA to pay non-VA facilities for inpatient care provided to certain eligible veterans. For a veteran to be eligible, the care must be for least one of the following:

- A service-connected disability
- A disability for which the veteran was discharged or released from active duty
- A disability that is permanent and total in nature from a service-connected disability
- Treatment of a medical emergency that poses a serious threat to the life or health of a veteran receiving care in a VA facility or following the care in a non-VA facility until the veteran can be safely transported to a VA facility
- A woman veteran
- Diagnostic services necessary for determining eligibility for a VA benefit or service
- A disability associated with and aggravating a service-connected disability
- A disability of a veteran participating in a vocational rehabilitation program
- Treatment of a medical emergency that poses a serious threat to the veteran's life or health which developed during authorized travel to the hospital, or during authorized travel after hospital discharge
- A disability of a veteran receiving VA contract nursing home care and who requires emergency treatment in a non-VA facility

**VA Office of
General Counsel
Opinion**

In 1997, a VA Office of General Counsel opinion affirmed that veterans must meet Title 38 USC §1703 clinical access and individual eligibility criteria before VA may consider using fee care. Additionally, the Office of General Counsel advised that VA would need legislative action to provide inpatient fee care to veterans other than those eligible under Title 38 USC §1703.

Over the past 3 years, the CBO has submitted three legislative proposals to VA to expand eligibility, including expanding pre-authorized non-emergency inpatient fee care. According to VA officials, the proposals were not included in VA's legislative request to the Office of Management and Budget because of the projected costs (estimated at \$18.5 billion over a 10-year period).

FBCS

VHA expects to complete fielding of FBCS at all sites except the consolidated VISN 6 site by December 2010. VISN 6 implemented a separate pilot project with functions similar to FBCS in May 2009. VISN 6 had not implemented the system long enough for us to obtain sufficient claims processing data to compare the claims processing efficiency at FBCS sites and the VISN 6 site.

FBCS is an integrated claims processing and management system designed to address some of the current VistA Fee's weaknesses, such as repetitive data entry and lack of integration with other systems. VistA Fee was developed over 20 years ago and was not designed for the complexity and volume of claims that VHA now processes. Some of the functions of FBCS are to:

- Convert paper handling into electronic data processing
- Provide integrated, automated claim reviews to identify potential payment errors
- Provide electronic claim flow to enhance distribution of work
- Provide management reports to monitor claim processing

**Documentation
Supported
Services Provided**

For each of our sample items, we found sufficient VAMC medical and administrative documentation to convince us that the veteran received the services paid for by VHA.

Appendix B Scope and Methodology

Scope

We reviewed a statistical sample of claims from our audit universe of all pre-authorized inpatient fee claims for improper payments paid between January 1, 2009–June 30, 2009. We based our definition of an improper payment on the Office of Management and Budget’s Circular A-123 criteria.

To assess the accuracy of payments made for pre-authorized inpatient fee service, we reviewed relevant laws, regulations, policies, and procedures related to the Fee Program. We reviewed a statistical sample from the universe of all claims paid under the Fee Program. We also interviewed staff from the Chief Business Office, National Fee Program Office, and at the sampled fee payment processing sites.

To assess the efficiency of processing fee care claims we obtained FY 2009 claims processing cost and timeliness data from 34 payment processing sites and from CHAMPVA. We interviewed staff from the National Fee Program Office and CHAMPVA.

Methodology

We used cluster sampling to statistically project cost savings and to minimize the number of invoices reviewed at the sites visited. We used the VAMC as the cluster and the sampling unit consisted of pre-authorized inpatient fee claims paid during our review period. We selected eight sites: Lebanon, PA; Columbia, SC; Tampa, FL; Madison, WI; New Orleans, LA; Denver, CO; Sacramento, CA; and Iowa City, IA. Of these eight sites, New Orleans and Denver were each part of a consolidated payment processing site, VISN 16 and 19, respectively.

Additionally, we compared the methodology and results of the CBO initiated the Indiana University/Purdue University Fee Service Evaluation Project to our audit methodology and results. The project’s purpose was to benchmark best practices within thirteen VHA claims processing sites; collect in-depth process performance information; and evaluate overall efficiency, operations management, and cost metrics.

To assess the efficiency of processing fee care claims, we determined the average direct fee staff cost per paid claim. Our audit and the CBO study determined cost per claim by only considering direct fee staff labor costs.

Although the study’s cost analysis used different review methodologies than we used in this audit, it closely supported the reasonableness of our audit cost estimates and the opportunity to improve current economies of scale through consolidation of fee payment processing and achieve better use of funds. For example, we determined the average direct fee staff cost for non-consolidated sites, consolidated sites, and CHAMPVA were \$10.78,

\$6.85, and \$2.55, respectively. The CBO study determined the average direct labor cost for non-consolidated sites, consolidated sites, and CHAMPVA were \$10.99, \$5.74, and \$1.39 respectively.

***Reliability of
Computer-
Processed Data***

To test the reliability of computer-processed data, we compared the VistA Fee System data elements relevant to our review for each of our 791 sample items with paper records, Computerized Patient Record System records, and third-party sources. We concluded that the data was sufficiently reliable for the audit objectives.

***Compliance with
Government Audit
Standards***

We conducted our audit work from September 2009–June 2010. Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix C Statistical Sampling Methodology—Claims Payments

Approach To evaluate the accuracy of inpatient fee payments, we selected a representative sample of inpatient claims for review. We reviewed each sample claim to determine if the veteran was eligible for inpatient fee care and if the payment was accurate.

Population The population consisted of 32,380 non-VA inpatient fee claims valued at approximately \$386.2 million that were paid during the 6-month period January 1, 2009–June 30, 2009.

Sampling Design We conducted a three-stage random sample of all claims identified in our population. The first stage consisted of eight VISNs, the second stage consisted of one VAMC from each of the eight selected VISNs, and the third stage consisted of a sample of invoices within each selected VAMC. Each sample item consisted of a single inpatient fee claim. The first-stage sample was determined using probability proportional to size methodology where facilities with more invoices had a proportionally higher probability of being selected into the sample.

We considered payment of inpatient fee claims to be improper if any of the following conditions were met:

- Veteran was ineligible for the service
- Payment was to an ineligible or incorrect vendor
- Payment was for an ineligible service
- Payment was for a service not received
- Payment included a duplicate payment
- Payment amount was incorrect
- Payment lacked sufficient documentation

Projections and Margins of Error Our review of 791 inpatient fee claims valued at \$10.6 million identified 235 payment errors valued at \$1.6 million. We reviewed each error with clinical and fee staff at each payment processing site. The staff agreed that each error used to calculate our error rates and cost savings was an improper payment. We found 181 overpayments valued at \$1.7 million and 54 underpayments valued at about \$25,000. The number of underpayments was too small for us to estimate with reasonable precision a separate total underpayment amount.

Tables 5 and 6 that follow show population projections and their margins of error based on a 90 percent confidence interval. The margin of error and confidence interval are indicators of the precision of the projections. Table 5 presents the estimated total error rate for improper payments. Repeated sampling of this universe would result in a projected error rate between 25.6 and 30.8 percent in 90 percent of the cases.

Table 5. Summary of Improper Payments—Error Rates

Type of Error	6-Month Projection	Margin of Error Based On a 90% Confidence Interval	90% Confidence Interval		Sample = 791
			Lower 90%	Upper 90%	
Authorization Errors					
– Non-Emergency Authorization	9.3%	1.8%	7.5%	11.1%	73
– Emergency Authorization	3.5%	1.0%	2.5%	4.5%	28
Total Authorization Errors	12.8%	2.0%	10.7%	14.8%	101
Payments Errors					
– Per Diem Payments Not Made	2.1%	0.8%	1.2%	2.9%	16
– Preferred Pricing Program Rates	4.3%	1.0%	3.3%	5.3%	34
– Other Payment Errors	10.5%	1.8%	8.7%	12.3%	84
Total Payment Errors	16.8%*	2.2%	14.6%	19.0%	134
Total Improper Payment Errors	28.2%**	2.6%	25.6%	30.8%	224**
*Note: The total payment error rate does not equal the sum of the components due to rounding.					
**Note: The total estimated improper payment error rate does not equal the sum of the estimated components (authorization errors and payment errors) because some claims contained multiple types of errors and were only counted once in calculating the total improper payment error rate.					

Table 6 presents the estimated total net overpayments for improper payments. Repeated sampling of this universe would result in a projection approximately between \$46.6 and \$69.6 million in 90 percent of the cases. The FY 2009 projection is an extrapolation of the 6-month projection. We projected the FY 2009 improper payment amount over the next 5 year period consistent with our policies.

Table 6. Summary of Improper Payments—Net Overpayments

Type of Error	6-Month Projection	Margin of Error Based On a 90% Confidence Interval	90% Confidence Interval		FY 2009 Projection
			Lower 90%	Upper 90%	
Authorization Errors					
– Non-Emergency Authorization	\$45,703,946	\$11,222,727	\$34,481,218	\$56,926,673	\$91,407,892
– Emergency Authorization	\$ 7,610,927	\$ 4,474,712	\$ 3,136,215	\$12,085,639	\$ 15,221,854
Total Authorization Errors	\$53,314,873	\$11,624,685	\$41,690,188	\$64,939,557	\$106,629,746
Payment Errors					
– Per Diem Rate Not Applied	\$ 1,509,641	\$ 1,257,796	\$ 251,845	\$ 2,767,436	\$ 3,019,282
– Preferred Pricing Program Rates	\$ 2,807,008	\$ 1,127,663	\$ 1,679,344	\$ 3,934,671	\$ 5,614,016
– Other Payment Errors	\$ 2,328,785	\$ 2,188,482	\$ 140,304	\$ 4,517,267	\$ 4,657,570
Total Payment Errors	\$ 6,645,434	\$ 2,614,765	\$ 4,030,668	\$ 9,260,199	\$ 13,290,868
Total Improper Payment Errors*	\$58,083,947	\$11,515,426	\$46,568,521	\$69,599,373	\$116,167,894
*Note: The total estimated improper payment error (dollar value) does not equal the sum of the estimated components (authorization errors and payment errors). To prevent double counting in calculating the overall estimated improper payment error rate, we only counted each claim once, regardless of whether the claim contained one or multiple errors.					

Appendix D Statistical Sampling Methodology—Efficiency

Approach To evaluate the efficiency of the Fee Program claims processing system, we selected a representative sample of fee processing sites for review. We reviewed each sample site to determine the average direct costs to process a claim and the number of claims processed by each staff member.

Population The population consisted of 111 fee processing sites that processed a total of 4.9 million claims.

Sampling Design We conducted a stratified random sample of 107 non-consolidated sites and 4 consolidated sites. We reviewed cost and claims data from 30 randomly selected non-consolidated sites plus all 4 consolidated sites. These sites included the 6 non-consolidated sample sites we randomly selected for our claims review and an additional 24 non-consolidated sites selected using probability proportional to size methodology based on the number of claims processed at each site.

Each sample item consisted of a claims processing site. We calculated a direct labor cost per paid medical claim and a total number of paid medical claims processed per staff member for each site. We weighted the results in our projection by the number of medical claims paid at each site.

We calculated our average cost per claim for the Fee Program and CHAMPVA by dividing each site's FY 2009 direct labor costs for claims processing by the total number of FY 2009 medical claims paid at each site.

The Fee Program and CHAMPVA have different authorization processes. Therefore, we eliminated all costs for fee and CHAMPVA staff not directly related to claims processing, such as VAMC clinical staff time used to authorize outpatient fee care.

To assess the efficiency of claims processing, we compared the average cost and average percentage of claims paid at 7, 30, and 60-day intervals at non-consolidated and consolidated payment processing sites and CHAMPVA.

Projections and Margins of Error The 34 fee processing sites we sampled processed 2.6 million claims out of the total 4.9 million claims processed. Table 7 shows the population projection and margin of error based on a 90 percent confidence interval. The margin of error and confidence interval are indicators of the precision of the projection. Table 7 that follows presents the estimated total cost savings for claims processed in FY 2009. Repeated sampling of this universe would result in a projection approximately between \$26.8 and \$46.3 million in 90 percent of the cases. The specific cost savings depends on the actual

consolidation strategy VA selects and on how well VA implements the chosen strategy. As a result of our review of the CBO study and our cost analysis, we have conservatively used the lowest projection of program inefficiencies to estimate cost savings of \$26.8 million in FY 2009 and to estimate cost savings of \$134 million over the next 5 years.

Table 7. Summary of Efficiency

	12-Month Projection	Margin of Error Based On a 90% Confidence Interval	90% Confidence Interval	
			Lower 90%	Upper 90%
Claims Processed Per Non-Consolidated Fee Staff	4,844	899	3,946	5,743
Claims Processed Per Fee Staff All Sites	5,438	940	4,499	6,378
Cost Per Claim				
– Fee Program Cost Per Claim	\$9.96	\$1.98	\$7.98	\$11.94
– CHAMPVA Cost Per Claim	\$2.55	0	\$2.55	\$2.55
– Difference	\$7.41	\$1.98	\$5.43	\$9.39
Cost Savings for Claims Processed in FY 2009	\$36,576,464	\$9,773,468	\$26,802,996	\$46,349,932
Note: The cost savings were calculated by subtracting the CHAMPVA cost per claim from the Fee Program cost per claim, then multiplying the result by the 4,936,095 claims processed by the Fee Program in FY 2009.				

Appendix E Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1-2	Establish eligibility determination guidance to reduce authorization errors over 5 years.		\$533 million
3-5	Strengthen controls to reduce improper fee care payments over 5 years.		\$ 67 million
6	Evaluate organizational models and payment processing options to improve program efficiency over 5 years.	\$134 million	
	Total	\$134 million	\$600 million

Appendix F Agency Comments

Department of
Veterans Affairs

Memorandum

Date: July 2, 2010
From: Under Secretary for Health (10)
Subj: OIG Draft Report, Audit of Non-VA Inpatient Fee Care Program, (WebCIMS 40508)
To: Director, Seattle Audit Operations Division (52SE)

1. I have reviewed the draft report and concur with the recommendations.
2. VHA concurs with the report's recommendations that the Under Secretary for Health will:
 - **Establish guidance on how to determine eligibility for pre-authorized non-emergency inpatient fee care.** VHA's Chief Business Office (CBO) will review all procedure guides to clearly define eligibility for pre-authorized non-emergency inpatient fee care. In addition, VHA's National Fee Program Office (NFPO) will develop a user guide to aid in the determination of Veteran eligibility for all care not provided by the Department of Veterans Affairs (VA).
 - **Develop and implement mandatory training to ensure fee staff understand the eligibility criteria for emergency inpatient fee care.** CBO will develop core competencies that will be supported by mandatory training offered through VA's Learning Management System (LMS).
 - **Establish guidance on where to find inpatient transfer information needed to determine when to apply the per diem payment methodology.** CBO will issue updated procedure guides regarding guidance on finding inpatient transfer notes in Computerized Patient Record System (CPRS) from non-VA facilities to VA facilities.
 - **Develop and implement a quality control mechanism to periodically assess whether the Fee Basis Claims System is functioning as anticipated in addressing the types of payment errors identified by this audit.** VHA's NFPO is currently developing an audit tool to assist with mitigating improper payments.
 - **Instruct the eight sampled VA medical centers to initiate recovery of overpayments and reimbursement of underpayments identified in our audit sample of payments reviewed.** VHA's CBO will work with the eight sites to initiate recovery of overpayment and reimbursement of underpayments.

- **Evaluate alternative organizational models and payment processing options to identify mechanisms to improve payment processing costs and timeliness.** VHA is in the process of deploying the Fee Basis Claims System and is developing a pilot program for one Veterans Integrated Service Network to partner with the Financial Service Center for processing of all non-VA fee claims.

3. Thank you for the opportunity to review the draft report. A complete action plan to address the report's recommendations is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)

Robert A. Petzel, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

**OIG Draft Report, Audit of Non-VA Inpatient Fee Care Program,
(WebCIMS 440508)**

Date of Draft Report: June 2010

<u>Recommendations/ Actions</u>	<u>Status</u>	<u>Completion Date</u>
-------------------------------------	---------------	----------------------------

Recommendation 1. We recommend that the Under Secretary for Health establish guidance on how to determine eligibility for pre-authorized non-emergency inpatient fee care.

VHA Comments

Concur

VHA’s Chief Business Office (CBO) has a number of procedure guides to determine eligibility for claims processing procedures. In addition:

- CBO will review all existing procedure guides to clearly define eligibility for pre-authorized non-emergency inpatient fee care.
- The National Fee Program Office (NFPO) is actively working with the Department of Veterans Affairs (VA), Office of General Counsel (OGC) on a Handbook re-write that will address eligibility for pre-authorized non-emergency inpatient fee care.
- The NFPO will also develop a user guide to aid in the determination of Veteran eligibility for all non-VA care.

In process December 30, 2010

Recommendation 2. We recommend that the Under Secretary for Health develop and implement mandatory training to ensure fee staff understand the eligibility criteria for emergency inpatient fee care.

VHA Comments

Concur

VHA has communicated the importance of payment accuracy through several mechanisms. For example:

- National live meeting training has been conducted by NFPO covering a variety of claims processing topics.

- The NFPO Policy and Procedure Division has updated 23 Procedure Guides which are available on the National Fee Web site.
- CBO has developed a national fee training strategy and a time-phased implementation plan that has significantly expanded programs that were provided to VHA field users during 2009-2010. This included:
 - a. Increased numbers and variety of in-residence courses for Fee staff, VHA Program Managers, and Clinical Utilization Review of Fee claims.
 - b. Monthly Live-Meeting mini-courses delivered via internet.
 - c. Annual National Satellite Broadcast training conferences targeted toward business managers, Fee managers, and Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC)-level management.

To address the recommendation specifically:

- CBO has developed core competencies that will be supported by mandatory and initial training programs that will be offered through VA's Learning Management System (LMS) program.
- NFPO has developed "VistA Fee Tutorials" which are also available for Fee Staff education on the LMS System.

In process December 30, 2010

Recommendation 3. We recommend that the Under Secretary for Health establish guidance on where to find inpatient transfer information needed to determine when to apply the per diem payment methodology.

VHA Comments

Concur

CBO has procedure guides posted on the Fee Program intranet site dedicated to assist the field in processing claims that require the use of per diem payment methodology. CBO will review these procedure guides to ensure accuracy. Additionally, updated procedure guides will be issued regarding guidance on finding inpatient transfer notes in the Computerized Patient Record System (CPRS) from non-VA facility to VA facility. NFPO Communications and Training Division will develop training which is targeted toward this issue to ensure that guidance is understood and used by the field sites.

In process December 30, 2010

Recommendation 4. We recommend that the Under Secretary for Health develop and implement a quality control mechanism to periodically assess whether the Fee Basis Claim System is functioning as anticipated in addressing the types of payment errors identified by this audit.

VHA Comments

Concur

NFPO created an audit tool which is in the final stages of development that will assist in mitigating improper payments. The Non-VA Care Program Office is aligning to the CBO Enterprise Risk Management Office (ERM) Strategic Direction and Goals by developing a federated Risk Management Program. Also, the Non-VA Care Risk Management Program holds monthly Risk Review Boards and Quarterly Risk Summit Conferences to coordinate with our stakeholders and internal auditing agencies: Compliance and Business Integrity (CBI); Management Quality Assurance Service (MQAS); and VHA Chief Financial Officer (CFO) Financial Assistance Office (FAO).

In process December 30, 2010

Recommendation 5. We recommend that the Under Secretary for Health instruct the eight sampled VAMCs to initiate recovery of overpayments and reimbursement of underpayments identified in our audit sample of payments reviewed.

VHA Comments

Concur

CBO will work directly with the eight sites to develop an action plan for completing the necessary recoupment and reimbursements associated with the cases reviewed by the Office of Inspector General (OIG).

In process December 30, 2010

Recommendation 6. We recommend that the Under Secretary for Health evaluate alternative organizational models and payment processing options to identify mechanisms to improve payment processing costs and timeliness.

VHA Comments

Concur

A number of initiatives in business process improvement and enhanced system solutions are either in development or have already been deployed.

- VA has submitted requests through the VA Office of Information and Technology procurement process for a complete systems modernization to provide automation support for this critical business process.
- VHA is in the process of deploying the Fee Basis Claims Systems as an interim technical support solution. VHA is also developing a pilot program for one VISN to partner with the Financial Services Center (FSC) for processing of all non-VA Fee claims.
- VHA will continue to assess alternatives for improving administration of the Fee program to include opportunities for consolidation of the claims processing function.

In process

December 30, 2010

Veterans Health Administration

July 2010

**Department of
Veterans Affairs**

Memorandum

Date: July 27, 2010
From: Under Secretary for Health (10)
Subj: OIG Draft Report, Audit of Non-VA Inpatient Fee Care Program, (WebCIMS 440508)
To: Director, Seattle Audit Operations Division (52SE)

1. I have been asked to concur on the monetary benefits estimates mentioned in the report. The Veterans Health Administration (VHA) concurs with the estimates pertaining to net over-payments due to improper payments. However, while VHA concurs in principle that consolidation of the fee program's claim processing will generate savings and efficiencies, we are unable to validate the specific cost savings estimates developed by the Office of Inspector General.
2. VHA concurs with the report's projected estimate of questioned costs of \$600 million in net over-payments over the next 5 years should no corrective action be taken. To address this matter and help reduce authorization errors, VHA's National Fee Program Office is developing a user guide to aid in the determination of Veteran eligibility for all care not provided by the Department of Veterans Affairs.
3. VHA expects that there will be general cost savings and efficiencies associated with consolidating the fee program's claim processing system. However, VHA cannot validate specific savings as noted in the report because an actual consolidation strategy has not been specified or determined and the computation of savings related to consolidation is less exact.
4. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

(original signed by:)

Robert A. Petzel, M.D.

Appendix G **OIG Contact and Staff Acknowledgments**

OIG Contact	Gary Abe, 206-220-6651
Acknowledgments	Barry Johnson Lee Giesbrecht Todd Groothuis Issa Ndiaye Matt Rutter Orlando Velasquez Theresa Zoun

Appendix H Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
Office of General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans
Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans
Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

This report will be available in the near future on the OIG website at <http://www.va.gov/oig/publications/reports-list.asp>. This report will remain on the OIG website for at least 2 fiscal years after it is issued.