VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of
Non-VA Medical Care
Obligations

January 12, 2016
14-02465-47

ACRONYMS

ACI	Accelerated Care Initiative
CBO	Chief Business Office
DRG	Diagnosis Related Group
FBCS	Fee Basis Claims System
FY	Fiscal Year
NVC	Non-VA Care
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

Report Highlights: Audit of VHA's Non-VA Medical Care Obligations

Why We Did This Audit

The Office of Inspector General (OIG) assessed whether the Veterans Health Administration (VHA) adequately managed non-VA medical care miscellaneous obligation cost estimates and related management and system controls. The Non-VA Care (NVC) Program expenditures of about $4.8 billion included $1.9 billion in obligated funds that remained unspent as of the end of fiscal year (FY) 2013. Significant under-or over obligation of these program funds could affect overall VHA operations.

What We Found

VHA medical facilities did not adequately manage the obligations used to purchase NVC. From October 1, 2013, through March 31, 2015, VHA medical facility officials determined that they had overestimated the funds needed to pay for these services by about $543 million. The unnecessary obligation of these funds prevented VHA from using $543 million of the $1.9 billion (29 percent) obligated for NVC for any purpose during FY 2013. This occurred because VHA did not:

- Provide the facilities with adequate tools to reasonably estimate the costs of NVC services.
- Require medical facility staff to routinely adjust cost estimates for individual authorized services to better reflect actual costs.
- Ensure NVC staff adjusted the estimated amount of obligated funds in the Veterans Health Information Systems and Technology Architecture after payments are complete.
- Require facilities to analyze the accuracy of prior year obligation balances.

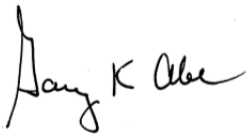
Reducing the over obligation of NVC funds from about 29 to 10 percent would have freed up about $358 million to acquire additional NVC services.

What We Recommended

We recommended the Under Secretary for Health improve cost estimation tools, update system software to ensure unused NVC funds can be periodically deobligated, require facilities to adjust cost estimates for individual authorized services, and monitor VA medical facility NVC obligation estimates.

Agency Comments

The Under Secretary for Health provided a responsive action plan to address our recommendations. We will follow up on VA's its implementation until all proposed actions are completed.



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INTRODUCTION

Objective

The objective of the audit was to evaluate the adequacy of non-VA medical care miscellaneous obligation cost estimates and related management and system controls.

Non-VA Care Program

The purpose of the Non-VA Care (NVC) Program is to assist veterans who cannot easily receive care at a VA medical facility. The program pays the costs for eligible veterans who receive medical services from non-VA providers when VA medical facilities are unable to provide specific services or to provide services economically, due to the veteran's distance from the VA medical facilities.

Program Management

The VHA's Chief Business Office (CBO) is aligned under the Deputy Under Secretary for Health for Operations and Management and is responsible for managing the NVC Program. VA medical facilities independently authorize individual episodes of care and medical follow-ups under the NVC Program in their areas. Beginning on October 1, 2014, the *Veterans Access, Choice, and Accountability Act of 2014* (VACAA) transferred NVC Program payment responsibilities from local medical facilities to CBO and separated NVC funding from other VHA Medical Services appropriation funds.

Program Workload and Expenditures

According to VHA data, total annual NVC Program disbursements have increased from about $4.4 billion in fiscal year (FY) 2010 to about $5.6 billion in FY 2014. During the same period, the number of patients seen under the program increased from roughly 952,000 to about 1.3 million.

Miscellaneous Obligations

VA uses the "Obligation or Change in Obligation" (VA Form 1358) to estimate the funding requirements needed to ensure that it does not overspend for a variety of goods and services, including NVC outpatient services, inpatient care, dental services, and nursing home care. VA is required to:

- Ensure funds are available to cover an obligation and expenditure prior to entering into an agreement for services
- Verify that funds are available and authorized prior to recording the obligation in the financial system
- Monitor to ensure all transactions are properly tracked
- Certify goods were received prior to approving payments
- Close any remaining balances within 30 days following the end of the month or fiscal year, in which all expected activity has been completed

Other Information

- Appendix A provides pertinent background information.
- Appendix B provides details on our scope and methodology.
- Appendix E provides comments by the Under Secretary for Health.

RESULTS AND RECOMMENDATIONS

Finding 1 VA Medical Facilities Overestimated the Funds Needed To Pay for Approved Non-VA Care by $543 Million

VA medical facilities did not adequately manage the obligations used to purchase NVC. As of September 30, 2013, VA medical facilities had $1.9 billion in various obligations for NVC services that remained undisbursed. From October 1, 2013, through March 31, 2015, VA medical facility officials determined that they had overestimated, and thus overobligated, the $1.9 billion by about $543 million. Medical facilities did not routinely analyze the obligation of these funds to reflect better estimates of potential costs. The unnecessary obligation of these funds prevented VHA from using $543 million of the $1.9 billion (29 percent) obligated for NVC to obtain care for veterans during FY 2013. VA medical facilities overobligated funds for NVC because VHA did not:

- Provide the facilities with adequate tools to accurately estimate costs of NVC services.
- Require medical facility staff to routinely adjust cost estimates for individual authorized services to better reflect actual costs.
- Ensure medical facility staff adjusted the estimated amount of obligated funds in the Veterans Health Information Systems and Technology Architecture (VistA) after any payments are complete.
- Require facilities to analyze the accuracy of prior-year obligation balances.

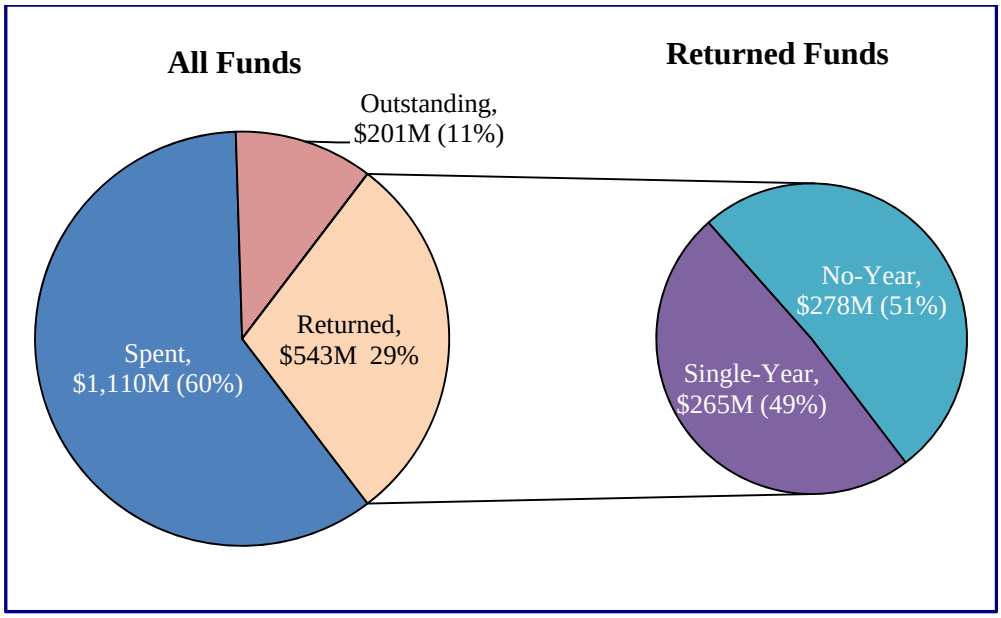
If VHA does not improve NVC obligation management, VA medical facilities are likely to continue to overobligate funds, thus reducing the amount of money facilities have available to spend on NVC. The $543 million deobligated and returned to the local fiscal offices consisted of about $278 million of no-year funds and about $265 million of single-year funds. Overobligating no-year funds delays the availability of these funds and overobligating single-year funds puts the funds at risk of not being available for any purpose due to expiration of the appropriation. However, beginning in FY 2015, VACAA effectively prohibited VHA from using no-year funds for NVC, which puts all overobligated NVC funds at risk of not being available for any purpose.

Reducing the overobligation of NVC funds to better reflect a more precise estimate of the potential costs from about 29 to 10 percent would have freed up about $358 million for additional NVC services. Based on VHA's calculated average, NVC services cost about $4,515 per veteran in FY 2013. Freeing up $358 million had the potential to provide additional access to NVC services for more than 79,000 veterans.

NVC Obligations Overestimated by $543 Million

At the end of FY 2013, VA medical facilities had overestimated the amount of funds needed to pay for NVC, thus preventing the facilities from using about $543 million during FY 2013. At the end of FY 2013, about $1.9 billion of the NVC funds that the VA medical facilities had obligated to pay for NVC services remained undisbursed. From October 1, 2013, through March 31, 2015, the facilities used about $1.1 billion of the $1.9 billion to pay NVC claims, deobligated and returned $543 million unused ($278 million of no-year funds and $265 million of expired single-year funds), and retained the remaining $201 million to pay outstanding NVC bills. Unnecessarily reserving funds in NVC obligations prevented the facilities from using about $543 million during FY 2013 to obtain medical care for veterans. Figure 1 shows the status of the $1.9 billion obligated to pay for NVC services at the end of FY 2013, as of March 31, 2015.

Figure 1. Status of $1.9 Billion of NVC Obligations as of March 31, 2015 *(dollars in millions)*



Source: OIG Analysis of VA's Financial Management System Data

VHA used two types of appropriations to fund NVC during our audit period, single-year and no-year funds.

Single-year funds expire at the end of the fiscal year in which the funds were appropriated. These expired funds retain their fiscal year identity and are only available to pay for obligations properly incurred during the original appropriation period. After 5 years, obligated and unobligated balances for these funds are canceled, the expired account is closed, and all remaining funds are returned to the Department of the Treasury and are thereafter no longer available to VHA for any purpose.

No-year funds do not expire. Before FY 2015, VA medical facilities were allowed to use funds received from billing private insurance under the Medical Care Collections Fund Program for NVC. These funds could be used to authorize additional medical services regardless of when they were deobligated and returned to the fiscal office. However, VACAA prohibited the use of no-year funds for NVC beginning on October 1, 2014, which meant that any no-year funding that was deobligated and returned to local fiscal offices and remained unused at the beginning of FY 2015 could no longer be used to authorize additional NVC.

Beginning in FY 2015, VACAA also required CBO to use special use funds to pay for NVC services, which, once returned, cannot be reauthorized for medical services after the fiscal appropriation year ends. VACAA also limited a facility's ability to transfer funds between NVC and other Medical Services obligations, such as medical salaries. These changes increased the importance of accurately estimating NVC obligations to maximize the NVC funds available for needed services and to minimize the amount of funds returned to medical facility fiscal offices.

This example demonstrates how no-year NVC funds could not be re-used for medical care:

Example 1

We identified almost $1.5 million in no-year funds obligated by a VA medical facility for contract dialysis and contract nursing home care at FY 2013 year-end. In December 2014, these funds still had not been used but remained obligated. If these funds had been deobligated and returned to the fiscal office prior to October 1, 2014, they could have been used to provide access to NVC for veterans who needed care.

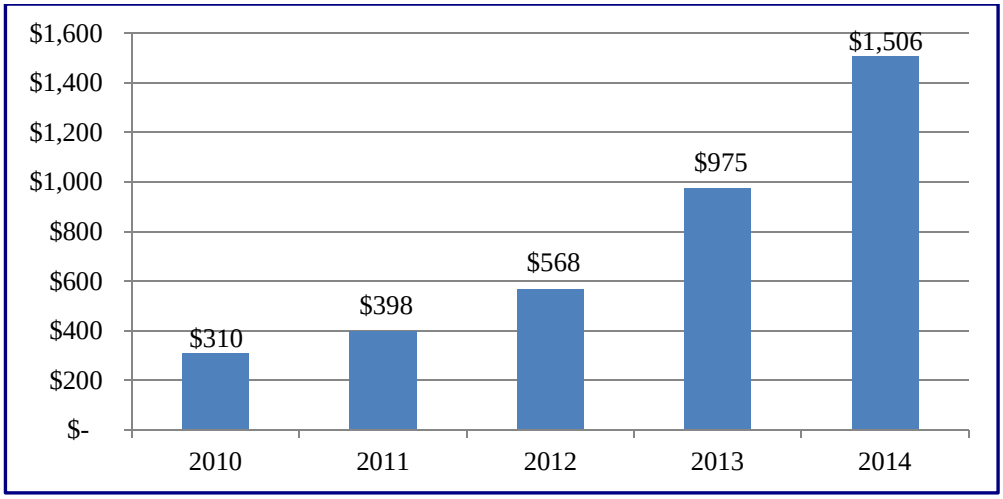
$1.5 Billion of Expired Medical Services Funds at Risk of Being Returned to the Treasury

The issue of overobligating funds is not confined to NVC. VA has significant and rising amounts of Medical Services funds expiring each year. VA reported that, at the end of FY 2014, it had more than $1.5 billion of expired FY 2010 through FY 2014 Medical Services appropriated funds.[1] This amount included the $265 million of expired single-year NVC funds that were deobligated and returned to medical facility fiscal offices.

[1] VA's Medical Services obligations for FY 2013 of $44.3 billion included funds for medical personnel services and benefits, NVC, pharmaceutical drugs, and other related costs.

Figure 2 shows the amount of expired funds VA reported for FY 2010 through FY 2014 rising from $310 million to slightly more than $1.5 billion.

Figure 2. Expired Medical Services Funds by Fiscal Year
(dollars in millions)



Source: "VA SF133 Report on Budget Execution" for Medical Services FYs 2010 Through 2014.

VHA Needs Improved Cost Estimation Tools

VHA did not provide medical facilities with adequate tools to reasonably estimate NVC obligations. The facilities we visited used a combination of methods that were ineffective at ensuring NVC cost estimates were reasonable. The methods used to calculate estimated costs included Medicare or contract rates, historical costs, and the optional cost estimation tools provided by CBO. The accuracy of estimates varied widely among these methodologies.

Medicare or Contracted Rates

VA pays the Medicare rate or a contracted rate for most NVC services. For the types of services for which the precise cost per service is known, estimating the cost is a straightforward calculation of multiplying the rate by the number of services authorized. However, for other types of services, medical facility staff frequently do not know the exact billing code, or the associated cost, that a non-VA provider will bill. Providers use a series of codes whose costs are based on the complexity associated with each type of service. For example, a simple endoscope procedure might cost about $150. However, the same physician might bill almost $585 if polyps were removed during the procedure.

Historical Cost

Some medical facilities developed cost tables showing the average cost of the most common types of services purchased by the facility to estimate NVC obligations. The medical facilities that thoroughly analyzed the historical costs of previous NVC authorizations produced reasonably accurate cost tables. However, this analysis was time-consuming and not standardized because NVC staff had to use different data systems to identify

the historical costs and did not have standardized procedures to assist in calculating the average costs. The medical facilities that did not analyze historical costs, but instead relied on cursory reviews and personal experience, did not produce reliable cost tables.

CBO Cost Estimation Tools Inadequate

CBO staff developed outpatient and inpatient cost-estimation tools in the form of a template spreadsheet analysis to assist medical facility NVC staff in estimating each authorized outpatient or inpatient service cost. However, use of the tools was optional and these tools were inadequate to reasonably estimate costs.

Outpatient Tool

The accuracy of the outpatient tool estimates depended on NVC staff manually categorizing each service. Each facility independently defined categories and there was no consistency within or between facilities. For example, at a VA medical facility, NVC staff entered at least 19 descriptions for veterans authorized for chiropractic care to treat lower back pain. These descriptions included "low back pain," "lower back pain," and "chronic lbp."

The lack of standardized categories and manual data entry errors caused NVC staff to summarize the cost data inconsistently and prevented medical facilities from creating reliable historical cost categories to reasonably estimate costs. Moreover, this tool does not adequately compensate for varying numbers of authorized visits. This is problematic because the total cost for a series of 10 treatments would be 5 times greater than a series of 2 treatments by a medical specialist, such as a physical therapist.

Inpatient Tool

The inpatient tool uses the Diagnosis Related Group (DRG) code rates paid by Medicare. However, the tool was not well-designed because the DRG payment rates are computer-generated using a complex formula with information that is not available to facility staff until they receive the claim. This makes manually predicting a veteran's DRG and estimating accurate costs prior to receiving the claim problematic. Because it might take several months to receive all of the claims for an inpatient stay, estimating the costs prior to receiving the claims is critical to being able to accurately estimate costs at fiscal year-end. For example, a veteran's admission to an emergency room because of chest pain might result in a wide range of services and costs. The veteran might be diagnosed with anxiety and released home with medication or the veteran might be diagnosed with a more serious condition, such as cardiac disease, and be admitted for surgery.

To ensure NVC funding is used efficiently, it is important that authorization estimates are reasonably accurate before funds are obligated. To accomplish this, CBO must establish an automated process to more accurately estimate costs based on the availability of data including a veteran's length of stay, primary diagnosis, and the major procedures performed. Automating the estimation process would give CBO the ability to perform more analytical steps than the NVC staff can perform manually, and refine the estimation

process over time—thereby improving the estimates provided to the NVC staff simply by updating the system tool. Although VHA has taken some steps to automate these systems, VHA needs to improve the cost estimation tools available to VA medical facilities to ensure adequate NVC cost estimates are produced consistently.

Cost of Individual Authorized Services Not Actively Monitored and Adjusted

VHA did not require VA medical facilities to perform ongoing reviews and adjust the costs estimated for the services authorized for each veteran, to better reflect actual costs, especially toward the end of the fiscal year. We reviewed 598 obligations that had about $200 million of unspent funds at the end of FY 2013 in 38 service lines at 8 randomly selected facilities. The service lines included Inpatient, Outpatient, Contract Dialysis, Homemaker Home Health Aide, and Nursing Home Care.

We found that 19 of the 38 service lines that thoroughly analyzed the historical costs of NVC authorizations and actively monitored overall NVC obligation estimates had obligated about $32.8 million and returned only about $2.5 million of their FY 2013 year-end balances (8 percent). The 19 service lines that did not perform these procedures had obligated about $166.9 million and returned about $62.0 million of their FY 2013 year balances (37 percent).

Table 1 compares the performance of service lines that analyzed and adjusted NVC obligations with those that did not.

Table 1. Comparison of Service Lines That Employed Methods That Resulted in More Accurate Estimates With Those That Did Not

Analyzed and Adjusted Obligation	Service Lines	FY 2013 Year-End Funds Obligated *(in millions)*	Returned Amount *(in millions)*	Returned Percent
Performed	19	$32.8	$2.5	8%
Not Performed	19	$166.9	$62.0	37%
Total	**38**	**$199.7**	**$64.5**	

Source: OIG Analysis of VHA Provided Data

VHA needs to implement a mechanism to ensure that VA medical facilities perform ongoing reviews and adjust cost estimates for individual authorized services to better reflect actual costs.

System Control Limits Facilities' Ability To Deobligate Unused Funds

The total obligation amounts for both NVC inpatient and outpatient services are adjusted manually in VistA. However, the Fee Basis Claims System (FBCS) prevents NVC staff from adjusting the estimated amount of obligated funds for each authorized NVC inpatient service in VistA after any payment has been made. This occurs despite an interface between FBCS and VistA, which automatically deducts the actual cost for authorized NVC

inpatient services from the estimated amount of obligated funds. This means that to identify and track the differences between the original estimate and the actual cost, NVC staff are required to manually adjust the total obligation amount to reflect those differences. For example:

Example 2

> In October 2012, a veteran went to a local emergency room and was admitted as an inpatient for chest pain. The NVC staff estimated the 2-day hospital stay would cost $10,500. The actual cost totaled about $4,600. FBCS would not permit NVC staff to reduce the authorization estimate to reflect the actual total paid amount of almost $4,600. Thus, over $5,900 remained obligated after paying the claim.

To reconcile an initial obligation estimate, facility staff are required to manually reduce overestimated obligations. In the previous example, once staff had identified the over obligation, they would need to manually deobligate the unused $5,900. Only at that point would the funds become available for authorizing additional NVC care.

This manual adjustment could potentially be automated by adding a *completed* indicator in FBCS signaling final payment for an authorized service had been made. The system could then automatically deobligate the unused portion of the authorized cost from the obligation. VHA needs to update FBCS software to allow inpatient authorizations to be periodically adjusted when the scope of patient care is fully known, as well as allow the system to automatically deobligate unused funds when NVC staff indicate the services associated with this authorization have been paid in full.

Adding a *completed* indicator would also enable NVC staff to more easily identify incomplete authorizations and give them more time to focus their review efforts on determining why authorizations have unpaid balances. For example, an authorization may not be used if a veteran refuses or no longer needs an authorized service, in which case the facility may find it beneficial to follow up with the veteran to ensure he or she has received the needed medical care.

VHA Did Not Monitor Accuracy of Prior-Year Obligation Balances

VHA did not require facilities to analyze the accuracy of prior-year obligation balances to monitor a facility's effectiveness in managing its NVC obligation balances. None of the facilities we audited had performed a "look-back analysis" to determine the amount of funds they had transferred into or out of each NVC obligation after fiscal year-end. This type of analysis could identify which NVC obligations resulted in the largest transfers and which would need focused efforts to improve facility management of year-end obligation balances.

OIG's 2015 report, *Audit of VA's Financial Statements for Fiscal Years 2014 and 2013* (Report No. 14-01504-32, November 12, 2014), also found that VA did not have an adequate process to validate the amount of goods and

services received but not yet paid. We reported that NVC obligations might not fairly represent the services provided to the veterans and that, to address the issue, VA should initiate a look-back analysis, particularly to improve the monitoring and correction of obligation balances at fiscal year-end.

Specifically requiring each VA medical facility to perform a look-back analysis of NVC obligations, with CBO monitoring the results of that analysis, would enable CBO to identify best practices and establish target levels. Identifying facilities that need to improve their NVC obligation estimates would facilitate CBO's efforts to reduce over-obligations for NVC services. VHA needs to implement a mechanism to monitor, from year to year, how effectively VA medical facilities are estimating NVC obligations.

$358 Million Could Improve Veterans Access to Care

If medical facilities had improved their estimation to an approximate 10 percent variance from the initial authorization, VHA would have had almost $358 million in additional funds available to provide other medical services to veterans during FY 2013. Based on VHA's calculated average amount paid per unique veteran of $4,515, the additional $358 million could have provided NVC services to more than 79,000 additional veterans during FY 2013. In FY 2014, VHA established the Accelerated Care Initiative (ACI) and allocated $423 million to ensure veterans who waited more than 30 days to see a VA medical provider were authorized to receive NVC.

We analyzed the NVC funds transferred by all facilities and found a strong correlation between the amount of NVC funds returned and ACI funds used. The five facilities that returned the most funds to their fiscal offices after FY 2013 year-end accounted for over $124 million of the $543 million in NVC funds returned to local fiscal offices (23 percent). The same five facilities used fewer ACI funds, or about $59 million of the returned $124 million (48 percent). All five facilities would have had sufficient funds, had the NVC miscellaneous obligations been managed more effectively.

Table 2 shows the ACI funds used by the five facilities that returned the most NVC funds to their fiscal offices.

Table 2. Funds Returned From NVC and Compared With Accelerated Care Initiative Funds Used *(dollars in millions)*

Facility	Returned NVC Funds	ACI Funds Obligated FY 2014	ACI as Percentage of Returned NVC*
St. Louis HSC, MO	$34.1	$10.7	31%
Tennessee Valley, TN	$27.8	$17.2	62%
Portland, OR	$25.8	$8.0	31%
New Orleans HCS, LA	$20.2	$12.4	61%
Dallas, TX	$16.1	$10.8	67%
Total	**$124.0**	**$59.1**	**48%**

Source: VA OIG Analysis of VHA Provided Data

**Note: All percentages are rounded*

Conclusion

VHA did not effectively estimate the amount of obligations needed to purchase NVC and significant under-or over obligation of these program funds could affect overall VHA operations. VA medical facilities obligated $543 million more NVC funds than was needed, which prevented the facilities from using these funds during FY 2013.

Reasonably estimating the amount of funds needed to pay for authorized services allows VA medical facility management to make the best use of its funds by ensuring there are sufficient funds available to pay for the authorized services. It also ensures that excessive funds are not obligated, thus preventing them from being used to provide additional services for veterans.

VHA did not provide the facilities with adequate cost estimation tools and VA medical facility staff did not adequately adjust cost estimates or analyze the accuracy of prior-year balances. Therefore, VHA is at risk of continuing to allow excessive amounts of NVC funds to go unused. Establishing targets and reducing the over obligation of NVC funds from about 29 to 10 percent would have freed up about $358 million, which may have provided additional access to NVC services for more than 79,000 veterans during FY 2013.

Recommendations

1. We recommended that the Under Secretary for Health improve cost estimation tools to ensure adequate Non-VA Care cost estimates are produced consistently.

2. We recommended that the Under Secretary for Health implement a mechanism to ensure that VA medical facilities perform ongoing reviews and adjust cost estimates for individual authorized services to better reflect actual costs.

3. We recommended that the Under Secretary for Health update Fee Basis Claims System software to ensure inpatient authorizations can be periodically adjusted when the scope of patient care is fully known.

4. We recommended that the Under Secretary for Health update Fee Basis Claims System software to allow the system to automatically deobligate unused funds when Non-VA Care staff indicate payments for the authorized services are complete.

5. We recommended that the Under Secretary for Health implement a mechanism to monitor how effectively VA medical facilities are estimating Non-VA Care obligations.

Management Comments

CBO will improve cost estimation tools by issuing a patch in FBCS to use actual local payments at each facility to develop different local cost estimates. Business requirements will be developed to provide near real-time cost estimations that eliminate the need for manual data entry.

CBO now requires all VISN Directors to certify monthly that VAMCs perform ongoing reviews of their FBCS authorizations for the previous month, which includes confirmation that the estimate is valid, the purpose of visit code and numbers of visits is accurate, and the correct obligation was used. To assist VAMCs in identifying authorizations that may not be used, a report will be developed to identify all FBCS authorizations with no activity greater than 120 days past its expiration date.

VHA will implement a required monthly reconciliation tool for every VAMC that will assist in identifying incorrect FBCS authorization estimates based on a change in Veteran required care. The tool will also identify variances between FBCS authorization estimates and FMS obligation estimates, indicating where there are excess funds that should be deobligated. VAMCs will be required to document these variances as a part of the monthly reconciliation report. A business requirements document for a new software system will be developed to ensure the capability to edit both inpatient and outpatient authorization estimates, along with integration of the new software system with VISTA/ IFCAP and FMS.

Finally, VHA instituted a mechanism for monitoring how effectively VA medical facilities are estimating Non-VA Care obligations. As of November 12, 2015, the Deputy Under Secretary for Health for Operations and Management required all VISN Directors to certify to CBO on a monthly basis that reconciliations of FBCS authorization estimates to FMS obligation estimates are completed, along with reviews of cost estimate accuracy, purpose of visit code, number of visits, and assurance obligation number used is valid.

OIG Response The Under Secretary for Health provided a responsive action plan and comments to address our recommendations. We will monitor VA's progress and follow up on its implementation until all proposed actions are completed.

Appendix A Background

Appropriations

Congress appropriates funds to be used within a specific time frame separately from funds that can be used indefinitely. Single-year funds may only be used to pay for obligations incurred during the appropriated fiscal year and cannot be used to authorize new costs after the end of the appropriated year, including new NVC services. These funds must be transferred to the Department of the Treasury if not used after 5 years. If obligated funds exceed the expected need, they are returned from the obligation to the local fiscal office. Funds returned after fiscal year-end are "expired" and can only be used to cover costs of other obligations with insufficient funds from the same fiscal appropriation year.

No-year funds do not expire at the end of the appropriation year and remain available indefinitely to address other needs. Prior to FY 2015, VA medical facilities were allowed to use Medical Care Collections Funds, which are no-year funds, to provide NVC.

Organizational Structure and Program Responsibilities

Responsibility for the NVC Program falls under the National Non-VA Medical Care Program Office, which is in the VHA's Chief Business Office. The National Non-VA Medical Care Program Office is responsible for providing guidance and direction nationwide for program regulations, policies, and procedures. Business compliance oversight of the NVC Program occurs locally in accordance with standards, directives, and guidance issued by the VHA Office of Compliance and Business Integrity.

To record NVC obligations, VA uses the "1358 Obligation or Change in Obligation" (VA Form 1358), which provides an estimate of funding requirements for non-VA medical care. VA is required to ensure that funds are available to cover the obligation and expenditure prior to entering into an agreement to purchase medical services. Once NVC services are approved, the respective budget and/or finance office is responsible for verifying that funds are available, authorized, and the obligation is recorded in the financial system.

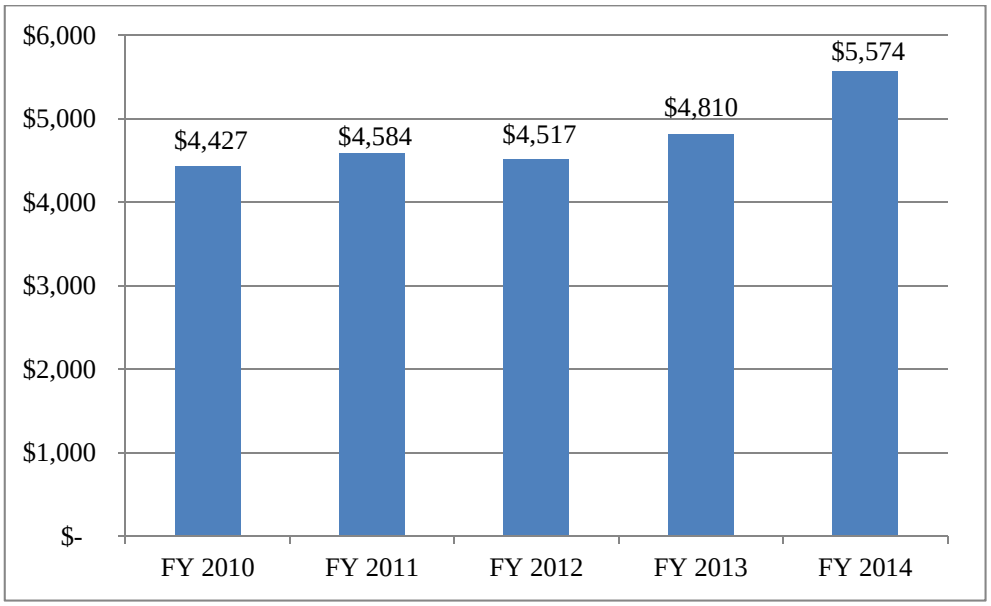
The NVC Program responsibilities are shared as follows:

- **National NVC Program Office:** Manages the NVC Program, under the VHA's Chief Business Office and is located at the Health Administration Center in Denver, CO
- **Chief Financial Officer:** Oversees all financial management activities related to VA's operations, including Miscellaneous Obligations
- **VA Medical Facilities:** Ensure Miscellaneous Obligations are properly managed and are sufficient to pay the facilities' legal obligations and perform formal, periodic reviews of the NVC Program

Non-VA Care Expenditures

According to VHA data, the total NVC Program expenditures have grown from about $4.4 billion in FY 2010 to about $5.6 billion in FY 2014. We audited the five largest service lines in the NVC Program. In FY 2013, these service lines—Inpatient, Outpatient, Nursing Home Care, Contract Dialysis, and Homemaker Home Health Aide—accounted for about 92 percent of the total NVC obligations. Figure 3 shows the total NVC expenditures for FY 2010 through FY 2014.

Figure 3. Non-VA Care Program Expenditures FY 2010 Through FY 2014
(*dollars in millions*)



Source: VHA Support Service Center Provided Data

Appendix B Scope and Methodology

Scope

We conducted our audit from August 2014 through November 2015. Our audit focused on evaluating the adequacy of non-VA medical care miscellaneous obligation cost estimates, and related management and system controls at eight VA facilities. Our audit universe included more than 10,000 obligations outstanding at the end of FY 2013 valued at $7.3 billion. Because obligations remain open after fiscal year-end to pay for the services authorized under the obligation, we included all open obligations in our universe. This also included obligations from prior fiscal years. We did not assess compliance with financial reporting requirements for obligations because this was out of the scope of this audit.

Methodology

We reviewed applicable laws, VA regulations, policies, and guidelines. We interviewed VHA management and staff to obtain an understanding of their NVC cost estimating procedures. To evaluate whether the 598 sampled obligations were properly developed and estimated, we reviewed a statistically random sample of authorized services for 590 veterans who were paid using obligations with outstanding balances at the end of FY 2013. To assess the accuracy of cost estimates, we compared payment records with the estimates listed in FBCS and other payment tracking systems.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any potential fraud. We did not identify any instances of fraud during this audit.

Data Reliability

In performing our audit work, we relied on computer-processed financial data obtained from VistA. In addition, we assessed the reliability of FBCS and VistA data by evaluating whether clarity of authorizations and related obligations was considered for each of our eight sampled sites. Specifically, we determined that the category of care was adequately supported by the Computerized Patient Record System consult data, and that the paid amounts in the data were consistent with the payment report data recorded in VistA. Additional data reliability tests included steps to identify any missing data in key fields and compared obligation numbers and paid amounts in VistA with those in FBCS. Based on these tests and assessments, we concluded the data were sufficiently reliable to use to meet the audit's objective of evaluating the adequacy of non-VA medical care miscellaneous obligation cost estimates.

Government Standards

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

To determine whether VA medical facilities effectively managed obligations to purchase non-VA medical care, we sampled eight facilities that used NVC services during FY 2013.

Population

We included five service lines in our universe:

- Outpatient
- Inpatient
- Contract Dialysis
- Nursing Home Care
- Homemaker Home Health Aide

This was accomplished by evaluating the sum of the service line obligations as a percent of the total obligations. The selected service lines comprised 10,026 miscellaneous obligations and equaled 92 percent of the total NVC obligations of $7.9 billion.

Sampling Design

We randomly selected eight sample facilities and designed our sample to ensure that all facilities had a chance of being selected. We selected our sample using probability proportional to size sampling methodology based on the dollar value variance between the obligation amounts for the five selected service lines at FY 2013 year-end and the obligation amounts for the same obligations on May 14, 2014.

We selected two certainty sites based on the largest dollar variance, with the remaining six sampled facilities selected based on a stratified, systematic, probability proportional to size (variance of dollar value adjustments) approach.

The sample was based on two strata, negative variance and positive variance (selection of four facilities from the negative stratum, and two facilities from the positive stratum).

We used the actual variance from September 30, 2013, through March 31, 2015, for our audit results. We only used the sample to select our sites to validate the policies and procedures in place during our audit period.

Table 3 lists the number of obligations evaluated, the total amount of NVC unspent funds obligated at the end of FY 2013, and the amount of funds returned or added to NVC obligations from October 1, 2013, through March 31, 2015, in descending order of Returned (Added) NVC amount for each of the eight facilities selected in our sample.

Table 3. Obligation Estimate Accuracy at Each Sampled Facility
(dollars in millions)

Facility	Number of NVC Obligations Evaluated	Unspent NVC Funds Obligated at FY 2013 Year-End	Returned (Added) NVC Amount	Returned (Added) Percent
SE Louisiana HCS, New Orleans, LA	45	$91.2	$34.1	37.4%
VA St. Louis HCS, St. Louis, MO	146	$22.8	$17.4	76.4%
Minneapolis VA HCS, Minneapolis, MN	181	$28.7	$9.0	31.5%
Clement J. Zablocki VAMC, Milwaukee, WI	40	$16.1	$8.3	52.0%
Michael E. DeBakey VAMC, Houston, TX	21	$17.0	$4.8	28.0%
Cheyenne VAMC Cheyenne, WY	102	$4.8	$0.8	16.9%
Fargo VA HCS Fargo, ND	29	$6.3	($1.3)	(20.4%)
VA Southern Nevada HCS, Las Vegas, NV	34	$12.7	($8.7)	(68.6%)
Total	**598**	**$199.7**	**$64.5**	**32.3%**

Source: OIG Analysis of VHA Provided Data
HCS=Health Care System, VAMC=Veterans Affairs Medical Center

Note: Column total differences due to rounding

Appendix D Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–5	Strengthen program controls to ensure excessive program funds are not over-obligated at fiscal year-end.	$358,000,000	$0
	Total	**$358,000,000**	**$0**

Appendix E Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: December 7, 2015

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Veterans Health Administration (VHA) Non-VA Medical Care Obligations, (Project Number 2014-02465-R8-0119) (VAIQ 7658691)

To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with recommendations made to the Veterans Health Administration.

2. Attached is the action plan for recommendations 1, 2, 3, 4, and 5. VHA considers recommendation 5 fully implemented and requests closure.

3. If you have any questions, please contact Karen M. Rasmussen, M.D., Director, Management Review Services (10AR) at VHA10ARMRS2@va.gov.

(original signed by:)

David J Shulkin, M.D.

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Veterans Health Administration Audit of Non-VA Medical Care Obligations

Date of Draft Report: November 5, 2015

Recommendations/ Actions	Status	Target Completion Date

Recommendation 1. We recommended that the Under Secretary for Health improve cost estimation tools to ensure adequate Non-VA Care cost estimates are produced consistently.

VHA Comments: Concur

The Veterans Health Administration (VHA) Chief Business Office (CBO) will improve cost estimation tools to ensure more consistent cost estimates for Non-VA care are produced.

VHA's CBO will issue a patch to the Fee Basis Claims System (FBCS), which will enhance the cost estimation tool currently available. This patch will use actual payments, local to each facility thereby accounting for different locality rates to develop the cost estimate. This enhancement also allows the cost estimate to be built in the FBCS software and entered versus the current process of having to leave FBCS to run the cost estimate and then come back into FBCS to manually enter the amounts.

Additionally, CBO will develop business requirements document for a future state solution using a Predictive Analytics model to provide near real-time cost estimations utilizing patient history and care locality information in addition to claim data available in the Program Integrity Tool Repository.

To complete this action plan, VHA will provide the following documentation:
1) FBCS Patch implementation confirmation
2) Business requirements document

Status	Target Completion Date
In process	October 2016

Recommendation 2. We recommended that the Under Secretary for Health implement a mechanism to ensure that VA medical facilities perform ongoing reviews and adjust cost estimates for individual authorized services to better reflect actual costs.

VHA Comments: Concur

To ensure VA medical facilities perform ongoing reviews to more accurately adjust estimates for individual authorized services and better reflect actual costs, VHA issued a memorandum to Veterans Integrated Service Networks (VISNs) on November 12, 2015, requiring every VISN to certify monthly that its Veterans Affairs Medical Centers (VAMCs) have reviewed their FBCS authorizations for the previous month. This review includes confirming that the FBCS estimate is valid, the purpose of visit code is accurate, the number of visits is accurate, and the correct obligation number was used.

Furthermore, VHA's CBO will develop a report to identify all FBCS authorizations with no activity greater than 120 days past its "Authorized To" date (expiration date) for VAMCs to use as a tool for identifying authorizations, which may not be used.

To complete this action, VHA will provide the following documentation:

1) A copy of the memorandum issued to VISNs on November 12, 2015
2) Two samples of report identifying unused authorizations

Status	Target Completion Date
In process	October 2016

Recommendation 3. We recommended that the Under Secretary for Health update Fee Basis Claims System software to ensure inpatient authorizations can be periodically adjusted when the scope of patient care is fully known.

VHA Comments: Concur

VHA concurs that software to ensure inpatient authorizations can be periodically adjusted when the scope of care is fully known will result in more accurate reflection of actual costs.

VHA will implement the monthly reconciliation tool required to be completed by every VAMC, which will assist in identifying FBCS authorization estimates that are incorrect or high/low simple based on a change in care required by the Veteran. VAMCs are required to identify and document these variances as part of the monthly reconciliation report, which is kept on file and available for both internal and external reviewers.

VHA will develop a business requirements document for a new software system as part of the Care in the Community (CITC) future state. Ensuring the capability to edit both inpatient and outpatient authorization estimate will be one of the requirements, along with integration of this new system to both Veterans Health Information Systems and Technology Architecture/ Integrated Funds Control, Accounting and Procurement (VISTA/IFCAP) and Financial Management System (FMS) to reduce as many of the manual processes as possible.

To complete this action, VHA will provide the following documentation:

1) CBO will provide sample facility monthly reconciliation reports
2) Business requirements document for a new software system with capability to edit inpatient and outpatient authorization estimate

Status	Target Completion Date
In process	October 2016

Recommendation 4. We recommended that the Under Secretary for Health update Fee Basis Claims System software to allow the system to automatically deobligate unused funds when Non-VA Care staff indicate payments for the authorized services are complete.

VHA Comments: Concur

VHA concurs that the ability to automatically deobligate unused funds when Non-VA Care staff indicate payments for the authorized services are complete will result in more accurate reflection of actual costs.

To address this recommendation, VHA will implement the monthly reconciliation tool required to be completed by every VAMC, which will assist stations in identifying variances between FBCS authorization estimates and FMS obligation estimates, indicating where there are excess funds, which can be deobligated or adjusted in either FBCS (outpatient) or FMS.

VHA will develop a business requirements document for a new software system as part of the Care in the Community (CITC) future state. Ensuring the capability to edit both inpatient and outpatient authorization estimates will be one of the requirements, along with integration of this new system to both VISTA/IFCAP and FMS to reduce as many of the manual processes as possible.

To complete this action, VHA will provide the following documentations:

1) CBO will provide a sample of facility monthly reconciliation reports
2) Business requirements document for a new software system with capability to edit inpatient and outpatient authorization estimate

Status	Target Completion Date
In process	October 2016

Recommendation 5. We recommended that the Under Secretary for Health implement a mechanism to monitor how effectively VA medical facilities are estimating Non-VA Care obligations.

VHA Comments: Concur

VHA instituted a mechanism for monitoring how effectively VA medical facilities are estimating Non-VA Care obligations. The monitoring mechanism requires each VISN Director to certify on a monthly basis, that their assigned stations have completed and documented the reconciliations of Fee Basis Claims System (FBCS) authorization estimates to Financial Management System obligation estimates, and reviews of FBCS authorizations ensuring the accuracy of the cost estimate, purpose of the visit code, number of visits, and the obligation number is valid. VISN Director certifications are to be submitted to the Chief Business Officer for Purchased Care. On November 12, 2015, the Deputy Under Secretary for Health for Operations and Management required all VISN Directors to initiate this monitoring mechanism. VHA considers this monitoring mechanism fully implemented and requests closure of this recommendation. Supporting documentation will be provided separately.

Status	Target Completion Date
Complete	November 2015

Veterans Health Administration
December 2015

Appendix F Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Matthew Rutter, Director Maria Afamasaga Kevin Day William Diaz Marisa Fantasia Barry Johnson Keila Pero Thomas Phillips

Appendix G Report Distribution

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