VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of Medical Care Collection Fund Billings for Non-VA Care

May 25, 2011
10-02494-176

ACRONYMS AND ABBREVIATIONS

CBO	Chief Business Office
CPAC	Consolidated Patient Account Center
MCCF	Medical Care Collection Fund
OIG	Office of Inspector General
PCRR	Potential Cost Recovery Report
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

Report Highlights: Audit of the Medical Care Collection Fund Billings for Non-VA Care

Why We Did This Audit

Veterans Health Administration (VHA) increasingly relies on non-VA care, often referred to as "fee care," to provide medical services to veterans who cannot easily receive care at VA medical facilities. We conducted this audit to determine the extent to which VHA's Medical Care Collection Fund (MCCF) Program bills third-party health insurers for non-VA care. We wanted to identify potential opportunities for VHA to increase third-party revenue.

What We Found

VHA missed opportunities to increase MCCF revenue by not billing third-party insurers for 46 percent of billable fee care claims. This occurred because VHA did not have an effective process to identify billable fee claims and lacked a system of controls to maximize the generation of MCCF fee care revenue.

VA medical facilities used two processes for identifying billable fee claims and we concluded that both processes were ineffective and unreliable. We also found that two of the eight VA medical facilities we reviewed did not routinely review fee claims to identify billable fee care. Furthermore, we determined that medical facilities that are a part of a regional Consolidated Patient Account Center (CPAC) were no more successful in identifying billable fee claims than facilities that have not yet transitioned to the CPAC model. As a result, we estimate that with an improved process and system of controls VHA could increase third-party revenue by $110.4 million annually or by as much as $552 million over the next 5 years.

What We Recommended

We recommended that the Under Secretary for Health reengineer and implement a standardized business process for identifying billable fee claims, publish management policies and procedures to support the business process, provide training to fee and revenue staff on how to use the business process, establish separate collection goals for fee care third-party revenue, and monitor third-party billing for fee care.

Agency Comments

The Under Secretary for Health agreed with our recommendations and potential monetary benefits and plans to complete all corrective actions by March 31, 2012. We consider these planned actions acceptable and will follow up on their implementation.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

The audit determined the extent to which Veterans Health Administration's (VHA's) Medical Care Collection Fund (MCCF) Program billed third-party health insurers for non-VA care. We wanted to identify potential opportunities for VHA to increase third-party revenue.

The MCCF Program

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 MCCF Program. The purpose of the MCCF Program is to recover costs of medical care that VA provides to veterans who have private health insurance, referred to as third-party insurance. The Balanced Budget Act of 1997 authorized VA to collect and deposit third-party health insurance payments in its MCCF, which VA could then use to supplement its medical care appropriations. Under the MCCF Program, VA bills third-party health insurers for nonservice-connected medical services provided by VA or non-VA care, often referred to as "fee care." VA bases its insurance billing rates on reasonable charges, which are the amounts that insurers would pay private sector health care providers in the same geographic area for the same services.

Consolidated Patient Accounting Centers

VHA is in the process of establishing seven regionalized centers called Consolidated Patient Account Centers (CPACs) to improve billing and collection functions. Under the CPAC model, a small number of CPAC staff work at each VA medical facility to identify, support, and forward billable claims to the regional CPAC, while a larger number of staff located at the CPAC perform MCCF billing, collections, and management functions. As of January 1, 2011, three CPACs were fully operational. VHA expects the remaining four CPACs to be operational by the end of FY 2012.

Program Revenue

Total MCCF third-party revenue increased 27.2 percent over the last 3 years from approximately $1.5 billion in FY 2008 to $1.9 billion in FY 2010. This represents 69 percent of the total $2.8 billion revenue collected by the MCCF Program in FY 2010. The potential for third-party revenue from the Fee Care Program increased significantly over this same 3-year period. From FY 2008 through FY 2010, Fee Care Program expenditures grew by 43 percent, from $3.0 billion in FY 2008 to $4.4 billion in FY 2010. VHA does not report how much of its third-party revenue is generated from VA care and how much is generated from fee care.

RESULTS AND RECOMMENDATIONS

Finding VHA Could Significantly Increase Third-Party Insurance Revenue for Fee Care

VHA missed opportunities to increase MCCF revenue by not billing third-party insurers for 46 percent of billable fee care claims. This occurred because VHA did not have an effective process to identify billable fee claims and lacked a system of controls to maximize the generation of MCCF fee care revenue. As a result, we estimate that with an improved process and a system of controls VHA could increase third-party revenue by $110.4 million annually (5.8 percent of total third-party revenue for FY 2010) or by as much as $552 million over the next 5 years.

Improve Identification of Billable Fee Care

Under the MCCF Program, VHA is authorized to bill a veteran's third-party health insurer for health care provided at VA and non-VA medical facilities. Generally, VA considers a veteran's health care billable if the treatment is nonservice-connected and the veteran's third-party health insurer covers the treatment. After treating a veteran, the fee provider bills the VA medical facility, and the facility's fee staff processes the payment. The MCCF staff then identifies which fee payments can be billed to veterans' third-party insurers. Under the regional CPAC model, the small number of CPAC staff located at the medical facility are responsible for identifying billable claims.

We found that VA medical facilities used two processes for identifying billable fee claims and both were ineffective and unreliable at the eight sites we reviewed. Furthermore, we found that medical facilities that are a part of a CPAC were no more successful in identifying billable fee claims than facilities that have not yet transitioned to the CPAC model. We determined that the eight sample sites were not taking consistent actions to identify billable fee claims. Revenue staff at three facilities used the Potential Cost Recovery Report (PCRR) and revenue staff at three other facilities reviewed copies of paid fee invoices to identify billable fee claims. The remaining two VA medical facilities did not routinely review fee claims to identify billable fee care. Table 1, on the next page, shows the percentage of errors for the two processes and the sites that did not have a review process.

Table 1

Percentage of Errors in Sample by Type of Process

Identification Process	Sites	Number of Errors	Number of Billable Claims Reviewed	Error Rate (Percent)
PCRR	3	103	225	46
Fee Invoice	3	82	225	36
No Review	2	140	150	93
All Sites	**8**	**325**	**600**	**46***

Source: VA OIG

*Note: Although dividing the 325 errors by the 600 sample items yields an error rate of 54 percent, we used a statistical methodology whereby we weighted the overall rate based on the volume of paid claims for each sampled facility resulting in an estimated error rate of 46 percent. Appendix C explains more on our statistical methodology.

PCRR Process Not Identifying 46 Percent of Billable Claims

VA medical facility revenue staff at three sites used the PCRR to identify billable fee care. The sites that used this process did not identify 103 (46 percent) of the 225 billable claims reviewed in our sample. The PCRR lists claims that fee staff have designated as potentially billable when they enter fee authorization information into the Veterans Health Information Systems and Technology Architecture (VistA). The reliability of the information of the PCRR depends on the fee staffs' determination whether the claim is potentially billable or not billable. If the fee staff does not designate the claim as potentially billable, the claim will not appear on the PCRR. Facility revenue staff manually review each claim on the PCRR to determine if the facility could bill third-party insurers.

We determined that the current PCRR process was ineffective and unreliable. Most errors at facilities using the PCRR were for billable claims that were listed on the PCRR but were not identified as billable by facility revenue staff. Of the 103 errors at the three sites using the PCRR, 78 (76 percent) were for billable claims that were on the PCRR. The following example illustrates this type of error.

> Revenue staff at one VA medical facility did not bill a veteran's third-party insurer for a urological surgery fee claim that was on the PCRR. The revenue manager could not explain why revenue staff had not processed the claim for billing. The facility revenue office did not have written guidance for reviewing fee claims, did not document fee claim reviews, and did not periodically assess the

effectiveness of its fee claims reviews. As a result, VHA missed an opportunity to bill $12,275 to the veteran's third-party insurer.

In addition, fee staff incorrectly determined whether a claim was potentially billable or not billable, thus affecting the accuracy and reliability of the PCRR. Of the 103 errors at the three sites using the PCRR, 25 (24 percent) were for billable claims that fee staff did not designate as potentially billable on the PCRR. The following example illustrates this type of error.

> Revenue staff at one VA medical facility did not identify billable fee claims for 5 months of a veteran's outpatient dialysis treatment because the claims did not appear on the PCRR. This occurred because fee staff at this facility did not identify the five claims as potentially billable during the payment process. As a result, VHA missed an opportunity to bill $73,183 to the veteran's third-party insurer.

Process Did Not Identify 36 Percent of Billable Claims

VA medical facility revenue staff at three sites used copies of fee invoices to identify billable fee care. The sites that used this process did not identify 82 (36 percent) of the 225 billable claims reviewed in our sample. This process consisted of fee staff providing copies of paid invoices to the facility revenue staff. The revenue staff manually reviewed each invoice to determine if the facility could bill third-party insurers. However, we determined this process was also ineffective and unreliable because revenue staff did not receive all paid invoices or did not bill all billable claims. The following example illustrates this type of error.

> Revenue staff at one VA medical facility reviewed copies of fee invoices to identify billable claims and did not identify a billable fee claim for a veteran's knee surgery. The facility revenue manager was unable to determine the reason the bill had not been identified as billable. We could not determine if the error occurred because the revenue staff did not receive a copy of the fee invoice or received the invoice, but did not bill. Neither the fee office nor the revenue office maintained records of which fee invoices were sent to the revenue office. As a result, VHA missed an opportunity to bill $11,350 to the veteran's third-party insurer.

93 Percent of Billable Claims Not Identified

VA medical facility revenue staff at two locations did not review fee claims to bill third-party insurers. Consequently, these locations did not identify 140 (93 percent) of the 150 billable fee claims reviewed. Although these two sites did not routinely review fee claims, revenue staff identified 10 claims by exception when fee staff provided copies of the fee claims.

At the first VA medical facility, the facility revenue supervisor told us that they had not routinely reviewed billable fee claims in at least 4 years. This occurred because the revenue staff had sufficiently identified and billed insurers for VA-provided care, enabling the facility to meet its annual

revenue goals for those years. Furthermore, the Chief Financial Officer, who supervised the facility revenue office, stated she did not know that the revenue office was not reviewing billable fee claims.

At the second VA medical facility, the revenue staff did not review fee claims for a 5-month period when they stopped receiving copies of potentially billable fee invoices from the fee office. The facility revenue supervisor stated he did not monitor reviews of billable fee claims because the medical facility had been meeting its FY 2010 revenue goal. The Chief of the Patient Administration Service, who supervised the facility revenue office, stated he did not know that the revenue office was not reviewing billable fee claims.

Reasons for Missed Billing Opportunities

VHA missed opportunities to increase MCCF revenue because of the following reasons.

- Lack of an effective process to identify billable fee claims
- Ineffective policies and procedures
- Inadequate training of fee staff
- Lack of fee revenue goals
- Lack of an effective monitoring program

The United States Government Accountability Office's *Standards for Internal Control in the Federal Government* states that controls are an integral part of an organization's planning, implementing, reviewing, and accounting for Government resources and achieving effective results. Management controls, such as establishing policies and procedures, ensuring a trained staff, validating performance measures, and monitoring of operations, are fundamental requirements in the Federal Government.

Develop an Effective and Reliable Process

The use of the PCRR and copies of paid fee invoices were ineffective and unreliable in identifying billable fee claims. Revenue offices used one of the two described processes because VHA had not established an effective standard process and published adequate procedural guidance to identify billable fee care. MCCF Program officials acknowledge that current guidance is inadequate. With an estimated 46 percent error rate, a reengineered process to identify billable fee claims would increase the effectiveness of revenue offices to collect third-party revenue. Any reengineered process should address the identification of third-party insurance and service-connection and establishment of an audit trail.

VHA missed opportunities to increase MCCF revenue because of the lack of adequately trained fee staff. We interviewed fee supervisors to understand how their staff determined whether veterans' conditions were service-connected for the care they received or had billable insurance. Fee supervisors told us their staff were not trained to determine whether fee

claims were billable; yet the reliability of the information of the PCRR depends on the fee staffs' determination whether the claim is potentially billable. An official from the National Fee Program Office confirmed fee staff do not receive specific procedural guidance and training to make these decisions. To avoid fee staff identifying billable fee claims, some medical facilities used the process of sending paid fee invoices to the revenue office to identify billable fee claims. This caused missed billing opportunities because the process did not have sufficient controls to ensure the revenue office received all paid fee invoices.

Goals Need To Be Established

Missed opportunities to increase MCCF revenue also occurred because fee revenue goals had not been established for facility revenue offices. CBO officials established annual revenue goals for each VA medical facility based on the CBO's Integrated Collections Forecasting Model. The model determines each facility's goals by considering historical workload and collection rates, best practices, and systemic changes. However, these goals did not result in effective efforts by revenue offices to identify and bill all potentially billable fee claims. This is because the current revenue goals do not distinguish between third-party insurance revenue for VA-provided care and fee care. Appendix A contains more detailed discussion of CBO's revenue goals.

We discussed this issue with CBO officials who told us they were aware of significant differences between large annual increases in VA fee care expenditures and smaller increases in collections of third-party insurance revenue from fee care. They stated that a major reason for this difference could be the problem of revenue offices not identifying and billing all potentially billable fee claims.

Monitoring Needs To Be Improved

Another reason VHA missed opportunities to increase MCCF revenue was because of the lack of monitoring during the course of normal operations. We found little evidence that revenue supervisors at the VA medical facilities were conducting periodic reviews of their staff's identification of billable fee claims, such as consistently reviewing the PCRR or fee invoices to determine whether their staff had correctly identified billable claims. In addition, the Compliance and Business Integrity Office and CBO's Revenue Cycle Enhancement Teams conducted limited reviews of third-party billing of fee care.

At the eight medical facilities, we only found one Compliance and Business Integrity Office official conducting regular reviews of the collection of third-party billing of fee care. Although the facility had an error rate of 29 percent, it was achieving results that were significantly better than most medical facilities in our sample. Furthermore, CPACs were not monitoring the reliability of the claims identification process at the three CPAC sites we visited.

Effect of Missed Billing Opportunities

Because VHA lacks an effective process and a system of controls, VHA does not have reasonable assurance they are maximizing third-party billing of fee care. We estimate that VHA can increase its revenue by approximately $110.4 million annually (5.8 percent of total third-party revenue for FY 2010) or by as much as $552 million over the next 5 years.

Conclusion

VHA has increasingly relied on the Fee Care Program to provide care to veterans who cannot easily receive care at a VA medical facility. This change in VHA's delivery of medical care to veterans is shown by the 43 percent growth of fee care in the past 3 years. To help meet its increasing demands for providing medical care to veterans, VHA needs to maximize its revenue collection. By implementing an effective process for identifying billable fee claims and augmenting that process with a system of controls, VHA can increase its revenue by approximately $110.4 million annually or by as much as $552 million over the next 5 years and improve its capability to provide care to our nation's veterans.

Recommendations

Recommendation 1: We recommended that the Under Secretary for Health reengineer and implement a standardized business process to ensure billable fee claims are identified.

Recommendation 2: We recommended that the Under Secretary for Health publish management policies and procedures to ensure the business process for identifying billable fee claims is followed.

Recommendation 3: We recommended that the Under Secretary for Health provide training to fee and revenue staff to ensure they understand how to use the business process for identifying billable fee claims.

Recommendation 4: We recommended that the Under Secretary for Health establish separate collection goals for fee care third-party revenue.

Recommendation 5: We recommended that the Under Secretary for Health establish a facility revenue monitoring program that periodically tests the reliability of the business process for identifying billable fee claims.

Management Comments and OIG Response

The Under Secretary for Health agreed with our recommendations and potential monetary benefits and provided an acceptable corrective action plan. In his initial comments dated April 28, 2010, the Under Secretary stated that the CBO has recognized the need to enhance business processes for identifying billable fee claims and has begun a pilot project at two facilities to identify best practices. CBO plans to reengineer its business processes by standardizing procedures for capturing fee workload, fee billing reports, and communications protocols between fee and revenue staff.

After reengineering its business processes, CBO will update its procedural guidebooks, develop internal controls and monitors, add training modules for revenue staff, and update its fee claims processing guidance with instructions on identifying potentially billable claims. CBO will also develop a facility monitoring program and test the reliability of its reengineered business processes. In his revised comments dated May 10, 2010, the Under Secretary stated that CBO plans to institute a process of establishing third-party collection goals for fee care using historical ratios of fee collections to total third-party collections as a baseline. VHA plans to complete these corrective actions by March 31, 2012. We consider these planned actions acceptable and will follow up on their implementation. Appendix E contains the full text of the Under Secretary's comments.

Appendix A Background

MCCF Office Organization and Functions

In the past, VA medical facilities have been responsible for all MCCF revenue operations. However, VHA established two regional CPACs to date and is in the process of establishing five additional CPACs throughout the United States to integrate and standardize business processes and to improve billing and collection activities. The MCCF third-party billing process has five functional areas.

- Identifying veterans with billable insurance
- Assigning codes to medical procedures
- Conducting pre-authorization and utilization reviews
- Billing
- Collecting of revenue

Under the CPAC model, VA medical facility staff code potential third-party insurance claims, while CPAC staff located either at the VA medical facility or at the central CPAC facility identify billable insurance, perform insurance verification, preauthorization and utilization reviews, and billing and revenue collection functions.

Fee Basis Claim System

The Fee Basis Claims System was developed to convert paper handling of fee claims into electronic data processing that allows for automated workload assignments, improved claim flow, and data capture for reporting. The CBO completed deployment of the Fee Basis Claims System to all fee payment sites, with the exception of Veterans Integrated Service Network (VISN) 6, in November 2010. VISN 6 uses a separate fee software system. We did not review Fee Basis Claims System or VISN 6's software as part of our audit. The CBO initiated a 6-month pilot program in February 2011 to develop a report that identifies potentially billable claims. However, CBO has not issued policies and procedures for this report.

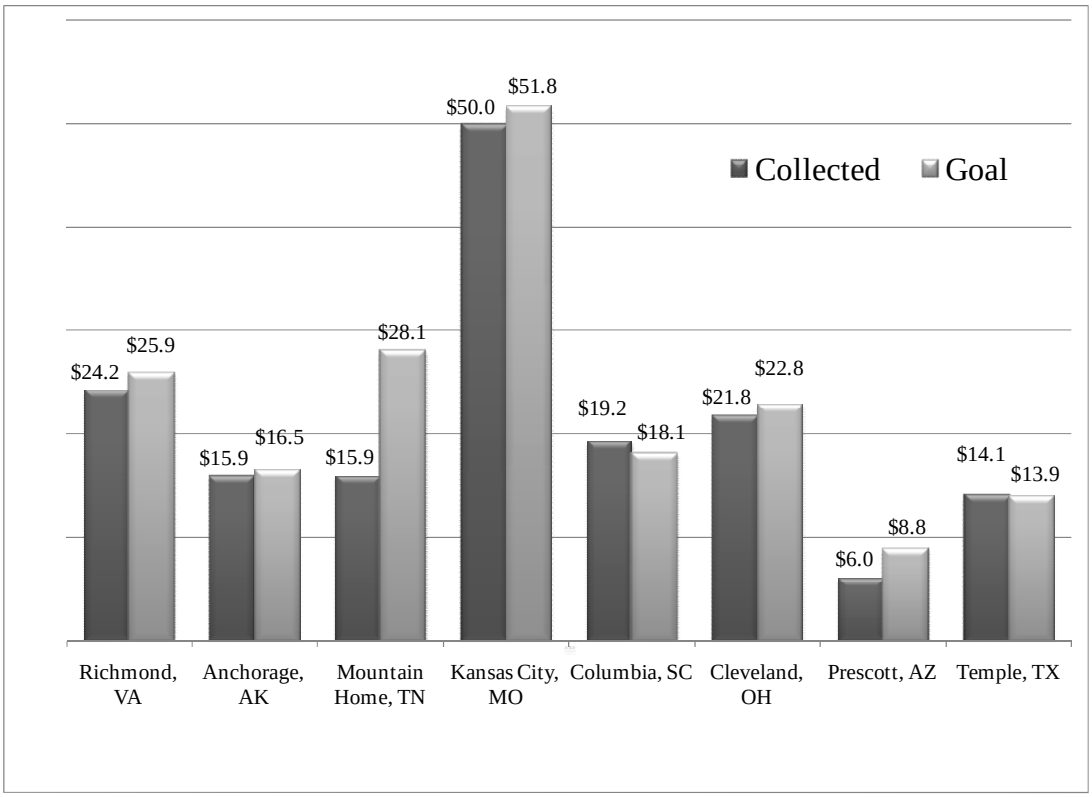
VHA Methodology

The CBO establishes annual revenue collection goals each fiscal year for each VA medical facility using a statistically driven model, the Integrated Collections Forecasting Model. The CBO's general expectation is to sustain and improve each prior year's performance. The Integrated Collections Forecasting Model equation consists of three parts: projected annual workload, historical billing rate per workload unit, and historical collection rate per dollar billed. VHA's Enrollee Health Care Projection Model projects annual workload. The projection model forecasts medical care costs for veteran enrollees using historical costs for both VA and fee care and a variety of other factors.

The following figure shows FY 2010 revenue goals and collections for the eight sample VA medical facilities.

Figure

Third-Party Insurance Revenue Goals and Collections (FY 2010)



Source: VHA CBO Revenue Operations Business Information Office

Note: Richmond, Mountain Home, and Columbia are medical facilities under CPACs.

Appendix B Scope and Methodology

Audit Scope

We conducted our audit work from August 2010 through March 2011. Our review was limited to those activities relating to identification of potentially billable fee claims for third-party insurance billing. We did not assess the effectiveness of processes used by VHA to identify veterans' insurance policies, such as self-reporting by veterans of their third-party insurance.

Methodology

We identified and reviewed applicable Federal laws, Federal regulations, previous OIG and Government Accountability Office audits, and VHA policies related to the MCCF Program. In addition, we interviewed CBO, VISN, and VA medical facility officials, and facility fee and revenue staff. We obtained relevant documentation at eight randomly selected VA medical facilities. We evaluated the processes and local procedures used to identify potentially billable third-party insurance and related controls.

We selected a statistical sample of billable claims from our audit universe of all outpatient and inpatient fee claims over $250 paid from October 1, 2009, through March 31, 2010. We used cluster sampling to estimate missed revenue and to minimize the number of invoices reviewed at each site. The VA medical facility was the cluster and the sampling unit consisted of non-emergency outpatient and inpatient fee claims paid during our review period. We selected three CPAC sites and five nonconsolidated sites for our review. Table 2 lists the eight VA medical facilities.

Table 2

Medical Facilities Selected

Facility Name	Facility Location	CPAC Affiliation
Hunter Holmes McGuire VA Medical Center	Richmond, VA	Mid-Atlantic CPAC
Alaska VA Healthcare System	Anchorage, AK	Non-CPAC
James H. Quillen VA Medical Center	Mountain Home, TN	Mid-South CPAC (as of 3/1/2010)
Heartland Health Care System	Kansas City, MO	Non-CPAC
William Jennings Bryan Dorn VA Medical Center	Columbia, SC	Mid-Atlantic CPAC
Louis Stokes Cleveland VA Medical Center	Cleveland, OH	Non-CPAC
Northern Arizona VA Health Care System	Prescott, AZ	Non-CPAC
Central Texas Veterans Health Care System	Temple, TX	Non-CPAC

Source: OIG

At each site, we reviewed a statistical sample of billable claims from our audit universe of all outpatient and inpatient fee claims paid during our review period. We based our definition of a billable claim on Title 38 of the United States Code §1729, which defines a veteran's care as billable if the care was nonservice-connected and the care was covered under the veteran's third-party insurance.

To determine billable fee claims, we used a two-step methodology whereby we first determined whether the veteran had billable third-party insurance, and then we determined whether the veteran was service-connected for the episode of care. When we found claims where the veteran had third-party insurance and was nonservice-connected for the episode of care, we considered the fee claim to be billable. For each billable claim, we determined whether revenue staff had properly billed third-party insurers and the reasons revenue staff did not bill billable claims. To calculate missed revenue, we determined the Reasonable Charge for each treatment code identified in each station's VistA ChargeMaster file. We then calculated VA's expected reimbursement by multiplying the resulting charge by CBO's FY 2010 average collection rate of 34.7 percent.

Reliability of Computer-Processed Data

We used computer-processed data from VistA to determine veteran service-connected condition, third-party insurance coverage, and fee billing information for a statistical sample of fee claims paid by eight VA medical facilities during the period from October 1, 2009, through March 31, 2010.

To determine the reliability of data concerning veterans' service-connected condition, we compared the service-connected condition information in our review of 40 sample claims to the veterans' records maintained by the Veterans Benefits Administration. We found no significant discrepancies and concluded the service-connected data was sufficiently reliable for the audit objective.

To determine the reliability of veterans' insurance information used in our review, we assessed procedures used by revenue staff to verify veterans' insurance policy coverage. We also compared veterans' insurance data for 40 sample claims with insurance documentation collected by the medical facilities. We found no significant discrepancies and concluded the insurance information was sufficiently reliable for the audit objective. As stated in the audit scope, we did not review how accurately veterans self-identified their third-party insurance.

To determine the reliability of billing data, we relied on previous data testing of medical billing codes conducted as part of our *Audit of Non-VA Inpatient Fee Care Program* (Report No 09-03408-227, August 18, 2010). During the inpatient fee care audit, we tested the reliability of billing data of fee payments made from January 1 through June 30, 2009. We tested billing

data, such as billed amounts and medical billing codes, in VistA Fee with 791 original billing invoices. We found no significant discrepancies and concluded the billing data was sufficiently reliable for use on this audit. We took an additional step by interviewing CBO officials knowledgeable about this data and any limitations. We found that the processes and procedures for generating this data have not changed from our previous audit.

Government Audit 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

Approach

To evaluate the extent to which VHA effectively bills third-party health insurers for fee care costs, we selected a representative sample of outpatient and inpatient fee claims for review. VistA fee files did not identify whether the episode of care was related to the veteran's service-connection or if the veteran had insurance. Therefore, we reviewed 7,700 claims to identify 600 billable claims. We analyzed each of the 600 billable claims to determine whether VHA properly billed the claims.

We considered the claim to be in error if the episode of care was not related to the veteran's service-connected disability, the veteran had third-party insurance, and VA did not bill the third-party insurer. We reviewed each resulting error with revenue staff at each VA medical facility. The staff agreed with each error used to calculate our error rate and cost savings.

Population

The population consisted of more than 581,500 fee claims valued at approximately $1.3 billion. These claims were paid from October 1, 2009 through March 31, 2010.

Sampling Design

We conducted a two-stage, stratified, random sample of all claims identified in our population. The first stage consisted of randomly selected VA medical facilities, and the second stage consisted of a billable paid fee claim within each VA medical facility selected.

We selected a sample of eight medical facilities using probability proportional to the paid value of claims in each facility. We stratified medical facilities into two groups: those consolidated medical facilities in VISNs 6 and 7, and the nonconsolidated medical facilities in all other VISNs. We selected two medical facilities from the consolidated stratum and six from the nonconsolidated stratum with probability proportional to the paid value of claims in each facility.

In the second stage of the sample, we selected a simple random sample of claims at each of the eight medical facilities selected in the first stage sample. We estimated that about 10 percent of claims would be billable. Our target sample size was 75 billable claims per medical facility. In order to achieve that sample size, we initially selected a sample of 1,000 claims to review.

Projections and Margins of Error

After sampling and data collection were completed, the distribution of the errors ranged from $0 to $100,000. We applied a post-stratification scheme within the original two strata by further segregating the population by expenditure amounts. The allocation of stratum ranges were arbitrarily set based on the paid invoice amount. We further refined the post-stratification

technique to ensure that sample totals equaled known population values. Table 3 shows the distribution of the universe and sample size among the sample strata and post-strata.

Post Stratification of Paid Amounts

Table 3

Number of Stations Selected	Post-Stratum Name	Universe Size	Universe Sum Value ($ million)	Sample Size
Consolidated 6 out of 113	<$1,000	325,659	164.8	3,531
	$1,000–$9,999	154,491	455.5	1,720
	$10,000–$24,999	16,053	239.8	183
	$25,000–$49,999	4,335	147.1	52
	$50,000–$99,999	893	58.1	12
	> $100,000	214	31.5	2
Non-Consolidated 2 out of 16	<$1,000	50,147	25.4	1,233
	$1,000–$9,999	26,788	80.3	870
	$10,000–$24,999	2,320	34.0	90
	$25,000–$49,999	598	25.2	7

Source: VA OIG

The margin of error and confidence interval are indicators of the precision of the projections. If we selected a large number of samples and we made estimates from each one, 90 percent of those estimates would fall within the confidence interval. For each estimate, we used the midpoint of the 90 percent confidence interval. The first estimate is billable fee claims as a percent of all paid fee claims in the audit universe. Our review of 7,700 paid fee claims found 626 that were billable. Table 4, shows the estimated percent of all billable claims in the audited universe at 9.3 percent with a margin of error of 0.6 percent.

Table 4

Estimate of Billable Fee Claims

Claim Status	Percent	Margin of Error	90% Confidence Interval		Sample Size
			Lower Limit	Upper Limit	
Not Billable	90.7	0.6	90.1	91.3	7,074
Billable	9.3	0.6	8.8	9.9	626
Total	**100**				**7,700**

Source: OIG

Of the 626 fee claims identified as billable, we did further work on the first 600 (75 per VA medical facility) in the random order of sample selection to determine whether they were correctly billed. We identified 325 of 600 billable fee claims with errors. Of the 325 claims, revenue offices did not bill 296 claims and they partially billed 29 claims. Table 5 below shows the estimation of the error rates. We calculated the overall error rate of approximately 46 percent by adding the sum of the estimates of not billed (40.8 percent) and partially billed (5.0 percent).

Table 5

Summary of Error Rates

Claim Status	Percent	Margin of Error	90% Confidence Interval		Number of Errors
			Lower Limit	Upper Limit	
Not Billed	40.8	3.4	37.3	44.2	296
Partly Billed	5.0	1.7	3.4	6.5	29
Total	**45.8**				**325**

Source: VA OIG

The estimates in Table 6 are an extrapolation of the reasonable charges applied to each medical procedure code identified on the paid fee invoice of the 600 billable claims we reviewed. The 6-month projection column shows that VHA should have billed $331 million during the period and only billed $172 million. The unbilled amount of $159 million is the amount VHA should have billed but failed to do so. The FY 2010 projection column is our calculation of the potential monetary benefit. To make the estimate, we doubled the 6-month unbilled amount projection, and then applied the FY 2010 average collection rate of 34.7 percent resulting in a potential monetary benefit of $110.4 million.

Table 6

Summary of FY 2010 Projections (in millions)

Claim Status	6-Month Projection	Margin of Error	90% Confidence Interval		FY 2010 Projection
			Lower Limit	Upper Limit	
Billable Amount	$331	$92	$239	$423	$229
Billed Amount	$172	$82	$89	$254	$119
Unbilled Amount	$159	$39	$120	$198	$110

Source: VA OIG

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–5	Improve business process and establish procedures and controls to increase third-party revenue over 5 years.	$552 million	$0
	Total	**$552 million**	**$0**

Appendix E Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: April 28, 2011

From: Under Sectretary for Health (10)

Subj: OIG Draft Report, Audit of VHA Medical Care Collection Fund Billings for Non-VA Care (VAIQ 7036066)

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

1. I have reviewed the draft and concur with the report's five recommendations.
2. I also concur with the report's estimate that the Veterans Health Administration could increase its revenue by approximately $110.4 million annually, or by as much as $552 million over the next 5 years, by implementing an effective process for identifying billable fee claims and augmenting that process with a system of controls. Attached is the Veterans Health Administration's corrective action plan for the report's recommendations.
3. 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.

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Audit of VHA Medical Care Collection Fund Billings for Non-VA Care (VAIQ 7036066)

Date of Draft Report: April 6, 2011

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommend that the Under Secretary for Health reengineer and implement a standardized business process to ensure billable fee claims are identified.

VHA Comments

Concur

The Veterans Health Administration (VHA) Chief Business Office (CBO) recognized the need to enhance business processes for identifying billable fee claims by establishing a pilot project at two facilities (Mountain Home, TN, and Huntington, WV) in February 2011. The pilot project includes implementing the following:

- standard operating procedures for capturing fee workload for billing purposes
- standardized reports from the Fee Basis Claims System to use in the billing process
- standardized communications protocols between fee and revenue staff and performance metrics to monitor progress

The pilot is intended to build upon revenue cycle performance evaluation by applying evidence based practices to fee billing in order to identify best-practice performers and opportunities for reengineering business processes to ensure consistent application of business processes.

In Process July 31, 2011

Upon completion of the pilot project in July 2011, reengineered business processes will be deployed nationally based on a schedule developed during the pilot. As part of the national deployment, there will be staff training provided to both fee and revenue staff outlining each step of the reengineered business processes. It is anticipated that national implementation will take 6 to 9 months.

In Process August 30, 2011 through March 31, 2012

Recommendation 2. We recommend that the Under Secretary for Health publish management policies and procedures to ensure the business process for identifying billable fee claims is followed.

VHA Comments

Concur

Following the completion of the pilot project described in response to Recommendation 1 and development of Standard Operating Procedures, CBO will update the Consolidated Patient Account Center (CPAC) functional area guidebooks and National Fee Program Office procedure guidebooks.

In Process August 30, 2011

CBO will conduct risk assessments and develop internal controls that mitigate the potential risk of having a non-standardized process.

In Process October 31, 2011

CBO will test and add internal monitors to annual revenue cycle monitoring plan.

In Process March 31, 2012

Recommendation 3. We recommend that the Under Secretary for Health provide training to Fee and Revenue staff to ensure they understand how to use the business process for identifying billable Fee claims.

VHA Comments

Concur

CBO will add training modules for CPAC staff following the completion of the pilot to reengineer business processes. As facilities transition to CPACs, these processes and procedures will be included in functional area training programs.

In Process November 30, 2011

The National Fee Program Office will update the current procedure guide for claims processing to provide instructions to the field regarding identification of potentially billable claims. All fee claims that have been authorized and approved for payment will be referred to revenue for identification of billing opportunity.

In Process September 30, 2011

VHA's Office of Compliance and Business Integrity (CBI) will collaborate with affected programs offices to develop and deliver joint education for CBI Officers/CPAC Liaisons on the fee basis process as it relates to billing and collection efforts. CBI's targeted completion dates for staff education includes the following milestones: educational plan created by September 2011; preliminary efforts to deliver education tested and refined by December 2011; and fully delivered by March 2012.

In Process March 31, 2012

Recommendation 4. We recommend that the Under Secretary for Health establish separate collection goals for Fee care third party revenue.

VHA Comments

Concur

CBO will establish a fee-care portion of the third party revenue collection goals by facility using historical fee collections as a baseline to establish a ratio of fee collections compared to total third party collections. CBO will use the VHA Office of Policy & Planning Enrollee Health Care Projection Model to forecast workload at the facility level, and then apply the facility-level ratio of fee collections to total third party collections in order to establish a fee target or collection goal. Since Medical Care Collection Fund (MCCF) dollars from fee expenditures vary on an annual basis at the facility level, CBO will prototype fee collection goals in the Fiscal Year (FY) 2012 expected results process and will fully implement fee collection goals as a component of third party collections beginning in FY 2013.

In Process September 30, 2012

Recommendation 5. We recommend that the Under Secretary for Health establish a facility revenue monitoring program that periodically tests the reliability of the business process for identifying billable Fee claims.

VHA Comments

Concur

The CPAC Program Management Office will develop a facility monitoring program to test reliability of re-engineered business processes. As part of this effort relevant baseline metrics which will be monitored will include: Aged Days-to-Bill (DTB); Third Party Fee Billing vs. Fee Dispersed Amount; and Collections vs. Fee Dispersed Amount. Metrics associated with the pilot project described in the reply to Recommendation 1 will be assessed between March and July 2011.

In Process July 31, 2011

Also, the metrics will then be deployed nationally and recorded in the CBO's Performance and Web Enabled Reporting Plus Web site (POWER+) on a monthly basis beginning in November 2011 using October FY 2012 data. Additionally, the CPAC Program Management Office will conduct ongoing risk assessment/internal control improvements for the CPAC Billing Functions for FEE beginning in November 2011.

In Process November 30, 2011

The VHA CBI office will create and implement a standardized tool and/or process for CBI Officers/CPAC Liaisons to test the reliability of the business process for identifying billable fee claims. CBI's targeted completion dates for monitoring includes the following milestones: tool and/or process to be created by September 2011; tool and/or process tested and refined by December 2011; and fully implemented by March 2012.

In Process March 31, 2012

Department of Veterans Affairs

Memorandum

Date: May 10, 2011

From: Under Sectretary for Health (10)

Subj: OIG Draft Report, Audit of VHA Medical Care Collection Fund Billings for Non-VA Care (VAIQ 7036066)

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

1. The Veterans Health Administration (VHA) has revised its response to Recommendation 4 of the Office of Inspector General (OIG) Draft Report, Audit of VHA Medical Care Collection Fund Billings for Non-VA Care. Attached is the revised action plan.

2. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan (Revised May 4, 2011)

OIG Draft Report, Audit of VHA Medical Care Collection Fund Billings for Non-VA Care (VAIQ 7036066)

Date of Draft Report: April 6, 2011

Recommendations/ Actions	Status	Completion Date

Recommendation 4. **We recommend that the Under Secretary for Health establish separate collection goals for Fee care third party revenue.**

VHA Comments

Concur

The Veterans Health Administration (VHA) Chief Business Office (CBO) will establish a fee-care portion of the third party revenue collection goals by facility using historical fee collections as a baseline to establish a ratio of fee collections compared to total third party collections. CBO will use the VHA Office of Policy & Planning Enrollee Health Care Projection Model to forecast workload at the facility level, and then apply the facility-level ratio of fee collections to total third party collections in order to establish a fee target or collection goal. Since Medical Care Collection Fund (MCCF) dollars from fee expenditures vary on an annual basis at the facility level, CBO will prototype fee collection goals in the Fiscal Year (FY) 2012 expected results process and will refine this framework to incorporate the FY 2012 experience for establishing future fee collection goals as a component of third party collections. This framework to establish fee collection goals will be completed by March 2012.

In Process March 31, 2012

Appendix F OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Gary Abe, Director Chris Enders Lee Giesbrecht Todd Groothuis Sophia Mar Matt Rutter Ron Stucky Orlando Velásquez Sherry Ware Theresa Zoun

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