

**STATEMENT OF OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
TO SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
VA FEE BASIS: EXAMINING SOLUTIONS TO A FLAWED SYSTEM
SEPTEMBER 14, 2012**

Madam Chairwoman, Ranking Member Michaud, and Members of the Subcommittee, thank you for the opportunity to provide testimony concerning the Office of Inspector General's (OIG) work related to VA's purchase of health care services for veterans from non-VA providers. As health care costs continue to increase, ensuring that VA has strong controls over purchased care activities is a critical aspect of providing the health care veterans need.

Over the past 3 years, the OIG has issued seven reports¹ on VA's fee care program. Our audits and reviews of fee care have identified significant weaknesses and inefficiencies. Specifically, we found that VA had not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly contracted and billed.

BACKGROUND

Title 38 of the United States Code permits VA to purchase health care services on a fee-for-service or contract basis when services are unavailable at VA facilities, when VA medical centers (VAMCs) cannot provide services economically due to geographical inaccessibility, or in emergencies when delays may be hazardous to a veteran's life or health. At the time of our initial work in fiscal year (FY) 2008, the Veterans Health Administration's (VHA) medical care budget totaled approximately \$39 billion. In FY 2011, the medical care budget increased to about \$48 billion. We estimate that of this amount, VHA spent about \$4.6 billion to purchase health care services from non-VA entities such as other government agencies, affiliated universities, community hospitals, nursing homes, and individual providers. VHA uses various mechanisms to purchase health care services, including sharing agreements with affiliated universities and the Department of Defense, Federal Supply Schedule (FSS) contracts, the Non-VA Fee Care Program, Project HERO, and the Foreign Medical Program. According to VHA managers, the authority to purchase services from non-VA sources helps to improve

¹ Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program (August 3, 2009); Audit of Non-VA Inpatient Fee Care Program (August 18, 2010); Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program (June 8, 2010); Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System (November 8, 2011); Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado (April 12, 2012); and Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations (August 20, 2012).

veterans' access to needed health care services, in particular specialty care that may not be available at VAMCs.

OIG REPORTS

Audit of Non-VA Outpatient Fee Care Program

At the time of our audit in FY 2008, 137 VAMCs processed an estimated 3.2 million outpatient fee claims at a cost of about \$1.6 billion. These claims were for a wide range of diagnostic and therapeutic services including visits to primary care physicians, x-rays and diagnostic imaging procedures, chemotherapy and radiation therapy, dialysis, physical therapy, and outpatient surgical procedures. Based on our review of a statistical sample of 800 claims, we concluded that VHA had not established adequate management controls and oversight procedures to ensure that claims for outpatient fee services were accurately paid, justifications for services were adequately documented, and services were properly pre-authorized. We concluded that the improper payments, justifications, and authorizations occurred because VHA had not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. For example:

- VAMCs improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other less frequent payment errors, such as paying for the wrong quantity of services. As a result, we estimated that in FY 2008, VAMCs overpaid \$225 million and underpaid \$52 million to fee providers, or about \$1.13 billion in overpayments and \$260 million in underpayments over 5 years.
- For 80 percent of outpatient fee claims we reviewed VAMCs did not adequately document justifications for use of outpatient fee care or properly pre-authorize services as required by VHA policy, thereby increasing the risk of additional improper payments.

We identified three specific areas that required strengthening:

- Comprehensive Fee Policies and Procedures – VHA did not have a centralized source of comprehensive, clearly written policies and procedures for the Fee Program. Instead, fee supervisors and staff had to rely on an assortment of resources including the Code of Federal Regulations, outdated VA policy manuals, and other procedural guides, training materials, or informal guidance.
- Identification of Core Competencies and Required Training for Fee Staff – Because the Fee Program is very complex and requires significant judgment by fee staff to ensure correct payments, processing fee claims requires specialized knowledge and skills, such as understanding medical records, insurance billing concepts, and medical procedure coding. However, VHA did not require fee staff or their supervisors to attend initial or refresher training.

- Clear Oversight Responsibilities and Procedures – Strong oversight of the Fee Care Program should include procedures and performance metrics for assessing compliance with program requirements, conducting risk assessments, assessing program controls, and monitoring accuracy and quality of claims processing. However, no one from VHA’s Chief Business Office, National Fee Program Office, Veterans Integrated Service Networks, or Compliance and Business Integrity Office was routinely performing oversight activities of the Fee Program.

We made eight recommendations to strengthen controls over the Outpatient Fee Care Program. The Under Secretary for Health agreed with the findings and recommendations and has since implemented all the recommendations.

Audit of Non-VA Inpatient Fee Care Program

In our report, *Audit of Non-VA Inpatient Fee Care Program*, we estimated that VAMCs had a combined authorization error and improper payment rate of 30 percent during the 6-month period of January 1, 2009–June 30, 2009². VAMC staff made authorization errors because VHA’s policies did not provide adequate guidance on how to determine eligibility for inpatient fee care or were not understood by fee staff. Payment errors occurred because fee staff did not have accurate and timely information to determine correct payments, and the VAMC did not have sufficient controls to detect clerical errors. We estimated that VHA made net overpayments of \$120 million on inpatient care for veterans in FY 2009 or \$600 million in improper payments over 5 years. For example:

- VAMCs improperly paid 9 percent of all inpatient fee claims by authorizing non-emergency inpatient fee care for veterans who were not eligible for this care. These errors occurred because VHA’s policy did not adequately address how to determine eligibility for non-emergency inpatient fee care.
- VAMCs improperly paid 4 percent of all inpatient fee claims by authorizing emergency care for veterans who were ineligible for this care. These errors occurred because fee staff did not understand the individual eligibility criteria for emergency inpatient fee care, such as the authorized treatment must be related to a service-connected disability.
- VAMCs paid improper amounts for 17 percent of pre-authorized inpatient fee claims. VAMCs made three types of payment errors; they did not:
 - Know where to find inpatient transfer information needed to determine when to apply per diem payment methodology.
 - Utilize Preferred Pricing Program rates because the Program process was not timely.
 - Pay other proper rates because fee staff were provided with inaccurate rate information or made clerical errors.

² The population of claims consisted of 32,380 non-VA inpatient claims valued at approximately \$386.2 million for the 6-month period. Our review was of 791 inpatient fee claims valued at \$10.6 million which identified 235 payments errors valued at \$1.6 million. We found 181 overpayments valued at \$1.7 million and 54 underpayments valued at about \$25,000.

We made recommendations to establish guidance on how to determine eligibility, to develop and implement mandatory training on eligibility criteria for inpatient fee care, to establish guidance on where to find inpatient transfer information needed to determine when to apply the per diem payment methodology, and to implement a quality control mechanism to address the types of payment errors identified by this audit. The Under Secretary for Health agreed with the findings and recommendations and has since implemented the recommendations.

Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program

As a result of the identification of the lack of outpatient and inpatient fee care program controls and the problems reported in other Federal medical programs, we also reviewed the fee care's fraud program and controls. In June 2010, we completed a review that determined VHA had not established controls designed to prevent and detect fraud primarily. This occurred because it had not identified fraud as a significant risk to the Fee Care Program, even though VHA's Fee Care Program is not significantly different from other health care programs that have identified numerous cases of fraud. We estimated that the program could be paying between \$114 million and \$380 million annually for fraudulent claims. We recommended that the Under Secretary for Health establish a fraud management program that includes such fraud controls as data analysis and high-risk payment reviews, system software edits, employee fraud training, and fraud awareness and reporting. The Under Secretary for Health agreed with our finding and recommendation and completed all corrective actions.

Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System

In November 2011, we issued *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* approximately 2 ½ years since we issued our first report on the Fee Care Program. However, we found that this medical facility mismanaged fee care funds and experienced a budget shortfall of \$11.4 million or 20 percent of their FY 2010 fee care program funds. We concluded that the authorization procedures were so weak that the Phoenix Health Care System (HCS) processed about \$56 million of fee care claims without adequate review.

The reason for the shortfall was the lack of effective pre-authorization procedures, a problem we reported in August 2009. The Phoenix HCS did not have effective pre-authorization procedures for fee care because the physician who was responsible for reviewing and pre-authorizing virtually all of the of fee care claims routinely approved requests for fee care with no substantive questions or requests for additional information. Further, the medical facility did not have adequate procedures to obligate sufficient funds to ensure it could pay its commitments for these services.

The mismanagement of fee authorization procedures at the Phoenix HCS highlights the risks to the Non-VA Fee Care Program, such as authorizing:

- Diagnostic tests or procedures that are not medically necessary.
- Services that are available at a VA medical facility.

- Unnecessary and often excessive numbers of medical treatments.

Our recommendations included the establishment of monitoring procedures to ensure that the official designated to pre-authorize fee care thoroughly review fee care requests and that fee staff obligate sufficient funds for approved fee care. The Interim Director of the Phoenix HCS agreed with our findings and recommendations and is working to implement our recommendations.

Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado

The OIG Administrative Investigations Division recently completed an administrative investigation regarding the Deputy Chief Business Officer for Purchased Care. We substantiated that the Deputy Chief Business Officer for Purchased Care engaged in improper contracting activities by instructing subordinates to issue sole-source task orders to one specific contractor and engaged in a conflict of interest when failing to maintain an arm's-length relationship with two VA contractors.

This is significant because VHA's Patient-Centered Community Care (PCCC) initiative proposes to purchase non-VA care by contracting with various provider networks. The engagement of improper contracting practices at the senior executive level and previous OIG findings on ineffective and improper contracting in the Department, only highlights our concerns that VA must ensure proper controls are implemented and monitored before, during, and after contracts are awarded. In addition, responsible contract officers and contracting officers' technical representatives (COTRs) must be properly trained and supervised to effectively oversee PCCC vendors.

Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations

The OIG Office of Contract Review initiated and conducted a compliance review of subcontracting limitations contained in five contracts with Enterprise Technology Solutions, LLC (ETS) for re-pricing fee claims. The review was initiated after VHA requested an audit of a claim submitted by ETS regarding an unauthorized commitment that VHA procurement officials appropriately refused to ratify. ETS is a service-disabled veteran-owned small business (SDVOSB) concern and all five contracts for re-pricing fee claims were awarded as SDVOSB set-asides.

We determined that ETS subcontracted all of the re-pricing tasks to its subcontractor Health Net Federal Services (Health Net), a large business. We concluded that ETS did not process any of the claims nor did they have the expertise or capability of re-pricing claims and never intended to perform the work. Health Administration Center contracting personnel were fully aware that ETS was subcontracting all of the work to Health Net in violation of the provision in the contract limiting subcontracting because ETS had VA forward all claims directly to Health Net for processing.

Based on work conducted by the Office of Contract Review and by the Office of Healthcare Inspections, we also determined that the revised regulations implemented in

February 2011 allow for VA to use the amount submitted by a re-pricer if the amount is lower than the Medicare rate established by the Centers for Medicare and Medicaid Services. We found that the amounts submitted by the re-pricer were not lower than the established Medicare rates; therefore, we questioned whether VA was overpaying for the services given the hierarchy for payment established in the regulations. We also questioned whether it was fiscally sound to pay for both a Medicare pricer and a re-pricer to review each claim for VA to determine which is lower. This is especially true given the significant fees paid to the re-pricer regardless of whether there was a cost savings.

We made seven recommendations to the Under Secretary for Health: terminate the five ETS contracts for claims re-pricing; determine if there is a need for any contract(s) to re-price non-VA care fee claims; ensure that the requirements for future contracts do not preclude competition; establish procedures to ensure that all non-VA fee claims are submitted to VA's Medicare pricer; determine whether claims re-pricing for non-VA care have resulted in rates that are lower than Medicare rates; implement mandatory training requirements for program offices to ensure requirements are not written to preclude competition; and ensure justifications for sole-source awards receive appropriate approvals. The Under Secretary for Health concurred with our findings and recommendations. The contracts with ETS were terminated for cause in August. We will follow up on the remaining planned actions until implemented.

CONCLUSION

While purchasing health care services from non-VA providers may afford VHA flexibility in terms of expanded access to care and services that are not readily available at VAMCs, it also poses a significant risk to VA when adequate controls are not in place. Although the Under Secretary for Health agreed to our recommendations and provided implementation plans to correct identified issues, VHA still faces major challenges managing the fee care program. Improper contracting practices as reported in other OIG reports only highlight our concerns that VA must ensure proper controls are implemented and monitored before, during, and after contracts are awarded, and responsible contract officers and COTRs must be properly trained and supervised to effectively oversee future PCCC vendors.