



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

VHA Continues to Face  
Challenges with Billing  
Private Insurers for  
Community Care

AUDIT

REPORT #21-00846-104

MAY 24, 2022



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## Executive Summary

When veterans cannot receive the health care they need from a VA facility or meet certain wait time or distance criteria, they can instead receive care from providers in their local community. VA pays for such community care, however, if veterans have private insurance, VA has the right to recover treatment costs for conditions that are unrelated to veterans' military service from private health insurers.<sup>1</sup> The money VA recovers from private health insurers is used to support the Veterans Health Administration's (VHA) health care for all veterans. According to VA's fiscal year (FY) 2022 budget, VA estimates community care collections of approximately \$602 million in FY 2022 and \$657 million in FY 2023.<sup>2</sup> If VA does not effectively bill private insurers, however, it will miss opportunities to increase its funding for all veterans.

The VA Office of Inspector General (OIG) conducted this audit to determine how effectively VHA billed veterans' private health insurers when veterans received care from community providers for treatment of conditions unrelated to military service.<sup>3</sup> Prior OIG work has highlighted internal control weaknesses related to this billing process and has shown that VHA has missed opportunities to bill private insurers and recover money paid for care unrelated to military service.<sup>4</sup>

Because VHA's Office of Community Care (OCC) manages programs under which veterans receive medical care from non-VA providers, it is responsible for processing payments to community providers and billing private insurers. Within OCC, two business lines handle payment and billing: the Delivery Operations division manages the payment processes for

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<sup>1</sup> Under 38 U.S.C. § 1729, the United States has a right to recover from third parties the cost of medical care and treatment furnished by the United States. In addition, 38 C.F.R. § 17.101, the Collection or Recovery by VA for Medical Care or Services Provided or Furnished to a Veteran for a Non-Service Connected Disability, provides for recovery from private insurance by VA for medical care that was unrelated to veterans' military service. VA is not able to recover the cost of medical care for veterans without private health insurance.

<sup>2</sup> Estimates were obtained from VA's FY 2022 Budget Submission—Medical Care Collections Fund FY 2022 "Revised Request" and FY 2023 "Advance Appropriation" figures.

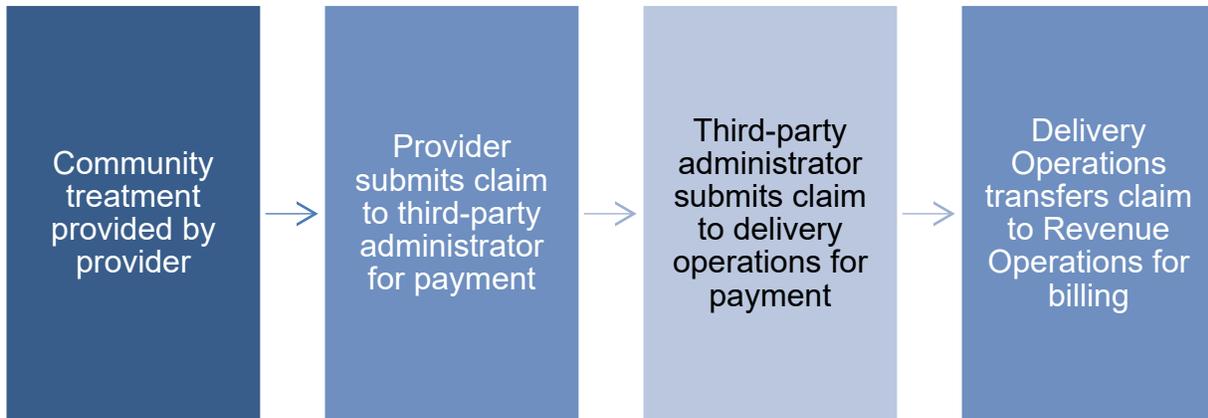
<sup>3</sup> This audit focuses on services provided to veterans under the Veterans Choice Program (Choice) and Patient Centered Community Care (PC3) programs or through veterans care agreements. The Choice program ended on June 6, 2019. The deputy under secretary for health for operations and management issued a memorandum on December 20, 2018, stating that the PC3 contract was the preferred routing for referrals until the Community Care Network contracts, under the new Veterans Community Care program, were fully implemented. Use of the PC3 contracts is expected to completely end as of March 31, 2022.

<sup>4</sup> See appendix A. VA OIG, *Audit of Medical Care Collection Fund Billings for Non-VA Care*, Report No. 10-02494-176, May 25, 2011; VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, Report No. 15-03036-47, December 21, 2017; VA OIG, *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, Report No. 17-02713-231, September 6, 2018.

community care programs, while the Revenue Operations division bills private health insurers for reimbursement.

After a veteran receives care from a provider in the community, the provider submits a claim for the community care treatment to the third-party administrators contracted by VHA to provide administrative and operational support for the Choice and PC3 programs.<sup>5</sup> That claim is then paid by the third-party administrator and submitted to OCC’s Delivery Operations for reimbursement. For veterans care agreements, providers submit claims directly to Delivery Operations for payment.

VHA must then bill the private insurer to recover money paid for care unrelated to military service, which is the responsibility of OCC’s Revenue Operations. Revenue Operations oversees the billing of private insurers at Consolidated Patient Account Centers (CPACs).<sup>6</sup> At each CPAC, insurance verification staff determine whether veterans have private health insurance for each community care claim. Next, during a process known as “revenue utilization review,” nurses perform a clinical review to assess the care provided and to determine if it was for conditions related to a veteran’s military service. If the care was unrelated to military service, billing staff then prepare and submit claims to private insurers for reimbursement. Summary figure 1 describes the payment and billing processes and the entities involved for Choice and PC3 programs, and summary figure 2 illustrates these actions for veterans care agreements.

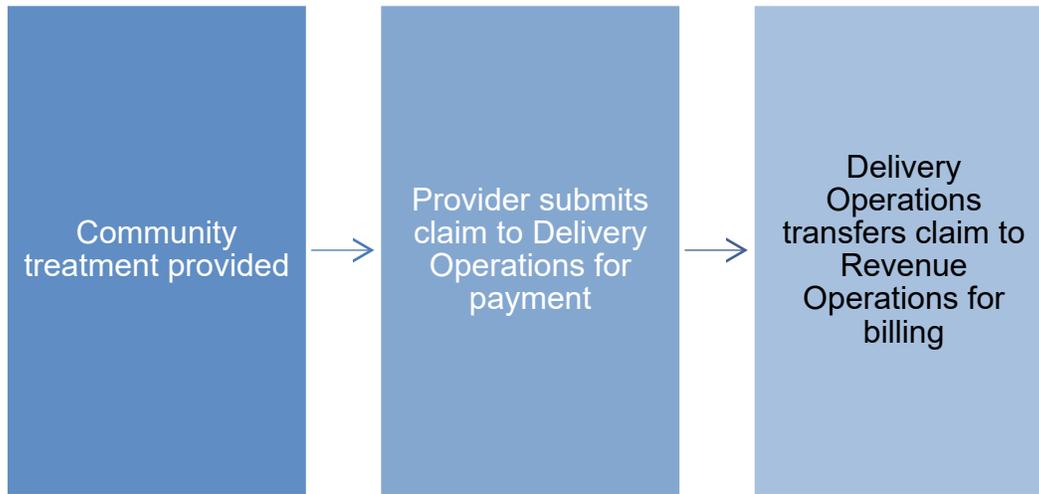


**Summary Figure 1.** OCC payment process for Choice and PC3 programs.

Source: VHA OCC payment process documentation.

<sup>5</sup> Veterans’ care in the community must be authorized in advance, and VA is generally responsible for authorizing care; however, third-party administrators could authorize care for veterans who were eligible based on distance from a VA facility.

<sup>6</sup> There are seven regional CPACs located around the country that provide revenue cycle management to the 18 Veterans Integrated Service Networks and their associated VA medical centers. See appendix A for a detailed map of the seven regional CPACs.



**Summary Figure 2.** OCC payment process for veterans care agreements.

Source: VHA OCC payment process documentation.

Because private health insurers have deadlines for filing claims, OCC must submit claims for reimbursement before these deadlines are reached if they expect to be reimbursed. These deadlines vary by company, but they range from 90 days to several years, and the time to file begins following the date of treatment. If VA does not bill private insurers for this care by the applicable deadline, then the claim may be denied, and VA is at risk of not being reimbursed for the community care it authorized.

## What the Audit Found

OCC did not establish an effective process to ensure Revenue Operations staff billed veterans' private health insurers for treatment of conditions unrelated to military service. The OIG found an estimated 1.3 million of 2.4 million billable community care claims (54 percent) paid between April 20, 2017, and October 31, 2020, were not submitted to private health insurers before filing deadlines expired.<sup>7</sup> As a result of the billing delays and missed deadlines, OCC did not collect an estimated \$217.5 million that should have been recovered from private health insurers, a figure that could grow to \$805.2 million by September 30, 2022, if these problems are not corrected.<sup>8</sup>

The OIG found that the following factors contributed to delays in billing and missed insurance filing deadlines: (1) OCC's billing and revenue collection process was not synchronized with insurers' filing deadlines, and claims information was not being completely transferred from Delivery to Revenue Operations; and (2) pending workload volume and staff shortages at the CPACs hindered effective billing. Although OCC was broadly aware of challenges to its process

<sup>7</sup> Billable community care claims consisted of claims for treatment of conditions that were unrelated to veterans' military service when the veteran had eligible private health insurance.

<sup>8</sup> See appendix D for further details on how the OIG calculated these estimates.

to bill and collect revenue from private insurers, its responses were not sufficient to correct these issues.

## **OCC's Process to Bill and Collect Revenue Is Ineffective in Meeting Insurance Filing Deadlines**

OCC's billing process was not synchronized with insurance filing deadlines. Also, the process relied on different systems that did not exchange complete information. Both factors caused missed billing opportunities when claims were not completed before deadlines expired.

### *Synchronization*

The OIG found that OCC's process to bill private insurers led to missed insurance filing deadlines because the overall process was not synchronized with insurers' filing deadlines. For the sampled claims that were not billed before the filing deadlines expired, insurers had deadlines for filing claims that range from four to 18 months (with one year being the most common deadline), but OCC's process for billing these insurers was not synchronized with these deadlines. Notably, the claims information Revenue Operations needs to bill the insurers does not transfer to the CPAC workflow tool until after the claim has been processed for payment.<sup>9</sup> Because VA allows third-party administrators (for Choice and PC3 claims) and providers (for veterans care agreements) up to six months (180 days) from the treatment date to submit provider claims to Delivery Operations for payment, Revenue Operations might not receive a claim it could bill until after some private insurers' deadlines had already passed.

Of the sample of 1,095 community care claims the audit team reviewed, third-party administrators and healthcare providers took an average of 134 days to submit the claim to OCC, and OCC took an additional 18 days to process the claim for payment, for a total of 152 days from community care treatment to OCC's Delivery Operations for payment. Since Revenue Operations thus had to wait an average of approximately five months before it could begin the billing process, its opportunity to collect payments from insurers was limited, especially in cases where the private insurer has a filing deadline of six months or less. Additionally, Revenue Operations did not monitor the expiration of insurance filing deadlines or have a way to prioritize claims that were nearing deadlines.

### *Completeness*

The team identified several instances in which claims information Delivery Operations relied on to pay third-party administrators and providers was not transferred completely from its payment systems to those systems Revenue Operations used to bill private health insurers. If this

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<sup>9</sup> The CPAC workflow tool is a software application the Revenue Operations staff use to manage the insurance billing process.

information is not available, Revenue Operations has difficulty completing the billing process before the insurance filing deadlines. If the workflow tool does not contain the necessary claim information, Revenue Operations staff review the veteran's medical records to attempt to find additional information that would support billing. If they cannot find the information they need, then they cannot bill insurers to recover money.

OCC is aware of the issues with the transfer of information between the payment and revenue system and has taken some steps to correct these issues. For example, to address the issue with the incomplete transfer of information to the CPAC workflow tool, OCC created a data integrity workgroup around November 2019. In addition, a Health Information Management Service official told the OIG that the information was transferring accurately from the payment systems to the Corporate Data Warehouse as of August 2020. However, the OIG did not validate this statement as part of its audit work because of the time frame for data collection for the audit. In addition, as VHA finalizes the movement of all community care to the new Veterans Community Care program, it will be important to make sure necessary information transfers accurately between payment and claims-processing systems.

## **Revenue Utilization Review Pending Workload and Staffing Challenges Hinder Insurance Billing and Collections**

Revenue utilization review workload and staffing challenges at the CPACs compromised VHA's ability to bill private insurers before their filing deadlines. Specifically, the West CPAC had the highest average workload of pending claims from September 2020 through February 2021—about 137,000 of 174,000 (79 percent). According to OCC-provided data from September 2020 through February 2021, the West CPAC also had the highest ratio of pending claims per utilization review nurse. However, the West CPAC ranked fifth among the seven CPACs in staffing levels with 45 nurses. The OIG concluded that developing a national productivity metric to measure how many claims a utilization review nurse can process could help OCC determine how many staff are needed to handle all pending claims.

Revenue Operations was aware, through its own internal audits and workload reports, that the volume of claims and lack of sufficient staff can create a backlog that hinders OCC's ability to bill and collect reimbursement from veterans' private insurance for the cost of care unrelated to military service. The OIG noted, however, that Revenue Operations has not taken corrective action adequate to resolve these workload concerns or staffing challenges.

## **What the OIG Recommended**

The OIG made three recommendations to VHA's under secretary of health intended to maximize opportunities to bill veterans' private health insurers for eligible claims. VHA should develop procedures that prioritize processing to meet insurers' filing deadlines. Next, VHA should strengthen its information system controls to ensure VHA has complete and accurate information

needed to process bills for reimbursement. Additionally, an assessment should be conducted to determine if staffing resources and workload are sufficiently aligned to process the anticipated volume of claims to be billed to veterans' private health insurers.

## VHA Comments and OIG Response

The deputy under secretary for health concurred with the three recommendations and provided corrective action plans. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.

VHA noted that the Revenue Operations payer relations department will work with national and regional payers to amend agreements that currently do not contain language acknowledging the six-year timely filing limit. The OIG's projections in this report are not based on any claims that had a six-year timely filing deadline. If Revenue Operations can negotiate agreements with national and regional insurers to extend timely filing deadlines, it could increase their chances of revenue recovery.

The table included with the comments shows the average monthly inflow of Community Care revenue utilization review claims for FY 2021 and FY 2022, per revenue utilization review nurse and for each CPAC. While the OIG recognizes that monthly claim inflow volumes are important workload measures, they are insufficient alone to explain the backlog of pending workload previous months.<sup>10</sup> Consequently, the OIG used the OCC's pending claims workload for the analysis in this report because it accounts for each CPAC's inflows, outflows, and pending community care workload for private health insurance billing. Appendix E provides the full text of the deputy under secretary's comments.



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<sup>10</sup> OCC's pending workload report identifies national community care workload for private health insurance billing. The pending claims report includes claim inflows and outflows and represents outstanding claims at the end of each month.

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## Abbreviations

Choice	The Veterans Choice Program
CPAC	Consolidated Patient Account Center
FY	fiscal year
GAO	Government Accountability Office
HIMS	Health Information Management Service
OCC	Office of Community Care
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
VHA	Veterans Health Administration
VistA	Veterans Health Information System Technology Architecture



## Introduction

VA pays for veterans to receive health care from providers in their local community when certain conditions are met, such as when VA cannot provide the care needed, the wait time is too long, or the drive to a VA facility is too far. However, if veterans have private health insurance, VA has a right to recover treatment costs for conditions unrelated to military service from veterans' insurers.<sup>11</sup> The money VA recovers is used to support Veterans Health Administration's (VHA) health care for all veterans. According to VA's fiscal year (FY) 2022 budget, VA estimates community care collections of approximately \$602 million in FY 2022 and \$657 million in FY 2023.<sup>12</sup> If VHA does not effectively bill these insurers, then it will miss opportunities to increase available funding for veterans' health care.

The VA Office of Inspector General (OIG) conducted this audit to determine how effectively VHA billed veterans' private health insurers when veterans received care from community providers for treatment of conditions unrelated to military service.<sup>13</sup> The effectiveness of VHA's system for billing private insurers and recovering revenue for community care has been an ongoing concern. Three previous OIG reports highlighted internal control weaknesses leading to missed opportunities to bill and recover funds.<sup>14</sup> Appendix A provides additional information about the findings in those reports.

## Community Care Programs

The VA MISSION Act of 2018 consolidated several existing community care programs into one permanent program.<sup>15</sup> VA launched the new program, known as the new Veterans Community Care program, on June 6, 2019. VHA may only purchase care for veterans through community care networks managed by contracted third-party administrators or veterans care agreements.

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<sup>11</sup> Under 38 U.S.C. § 1729, the United States has a right to recover from third parties the cost of medical care and treatment furnished by the United States. In addition, 38 C.F.R. § 17.101, the Collection or Recovery by VA for Medical Care or Services Provided or Furnished to a Veteran for a Non-Service Connected Disability, provides for recovery from private insurance by VA for medical care that was unrelated to veterans' military service. VA is not able to recover the cost of medical care for veterans without private health insurance.

<sup>12</sup> Estimates were obtained from VA's FY 2022 Budget Submission—Medical Care Collections Fund FY 2022 "Revised Request" and "FY 2023 Advance Appropriation" figures.

<sup>13</sup> This audit focuses on services provided to veterans under the Veterans Choice Program (Choice) and Patient Centered Community Care (PC3) programs or through veterans care agreements.

<sup>14</sup> VA OIG, *Audit of Medical Care Collection Fund Billings for Non-VA Care*, Report No. 10-02494-176, May 25, 2011; VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, Report No. 15-03036-47, December 21, 2017; VA OIG, *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, Report No. 17-02713-231, September 6, 2018.

<sup>15</sup> The VA MISSION Act of 2018, Pub. L. No. 115-182 (2018).

Third-party administrators are contracted entities that provide administrative and operational support for VHA community care programs.

Before June 6, 2019, VA used the Veterans Choice Program (Choice) and the Patient-Centered Community Care (PC3) program, along with veterans care agreements, to secure health care for veterans from community providers and serve veterans when care was unavailable at local VA medical facilities or if veterans met certain wait time and distance criteria.<sup>16</sup> Veterans could obtain community care through PC3 when referred by a VA medical facility or through Choice if they qualified through requirements such as wait times and distance from a VA medical facility.<sup>17</sup> Veterans care agreements were intended to be used in limited situations where care is not part of the contracted services through the Choice or PC3 programs. According to a VA official, the PC3 program is scheduled to end on March 31, 2022.

## Office of Community Care

VHA's Office of Community Care (OCC) manages programs under which veterans receive medical care from community providers.<sup>18</sup> OCC supports medical care delivery and the collection of revenue through two primary business lines: Delivery Operations and Revenue Operations, as shown in figure 1. Appendix A provides additional information on OCC.

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<sup>16</sup> The deputy under secretary for health for operations and management issued a memorandum on December 20, 2018, stating that the PC3 contract was the preferred routing for referrals until the Community Care Network contracts, under the new Veterans Community Care program, were fully implemented. According to a VA official, PC3 ended healthcare delivery for regions 1–4 (contiguous United States and Puerto Rico) and region 5 (Hawaii and Pacific Islands) on March 31 and September 30, 2021, respectively. The program did end for region 6 (Alaska) on March 31, 2022.

<sup>17</sup> Eligibility for Choice is based on specific criteria relating to wait times for appointments and distance from the nearest medical facility. Generally, eligibility is allowed if the wait time exceeds 30 days from the date on which a veteran requests an appointment for hospital care or medical services from VA or if the veteran resided more than 40 miles from a VA medical facility.

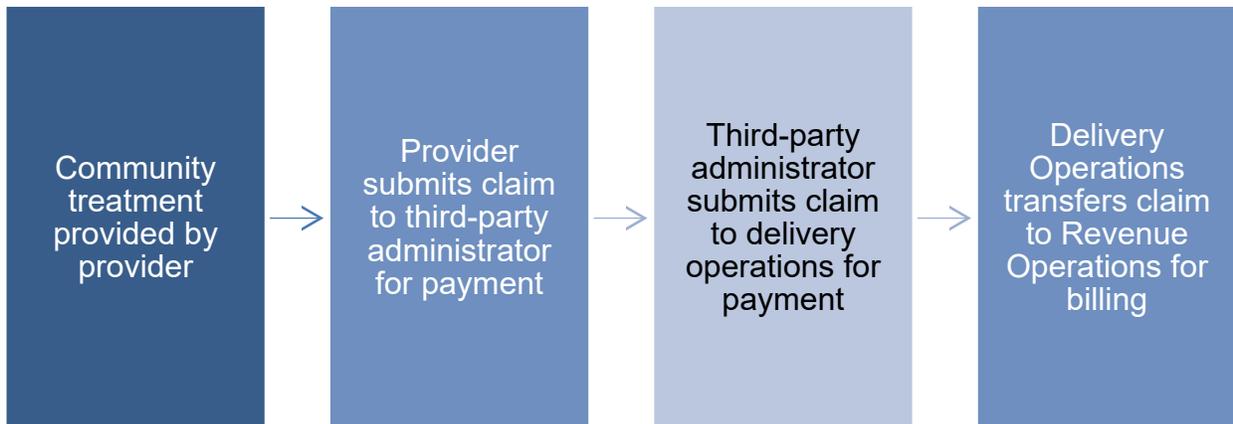
<sup>18</sup> Veterans' care in the community must be authorized in advance, and VA generally authorizes care; however, third-party administrators could authorize care for veterans who were eligible based on distance from a VA facility.



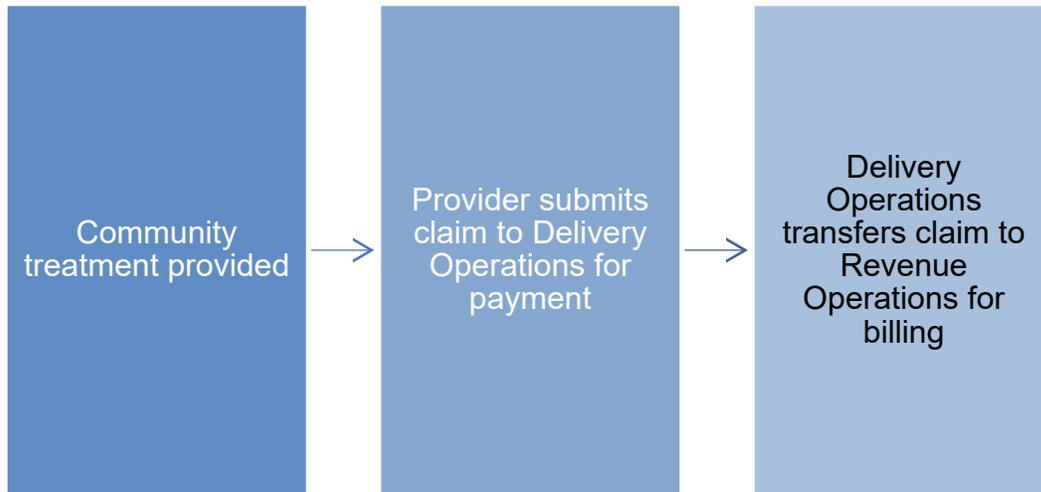
**Figure 1.** OCC organization structure.  
 Source: VHA OCC organizational chart, provided by OCC in January 2021.

## Delivery Operations

OCC’s Delivery Operations manages the processes related to paying community care providers for their services under both the Choice and PC3 programs and for veterans care agreements. For the Choice and PC3 programs, third-party administrators are responsible for paying community providers following the completion of the veteran’s community care treatment. Third-party administrators then submit the claims to Delivery Operations for reimbursement, as shown in figure 2. For the veterans care agreements, the community provider bills Delivery Operations directly and then is paid for the community care treatment provided, as shown in figure 3. After Delivery Operations pays either the third-party administrator or the community provider for the medical care provided, the claim is transferred to OCC’s Revenue Operations division to bill private health insurers.



**Figure 2.** OCC payment process for Choice and PC3 programs.  
 Source: VHA OCC payment process documentation.



**Figure 3.** OCC payment process for veterans care agreements.

Source: VHA OCC payment process documentation.

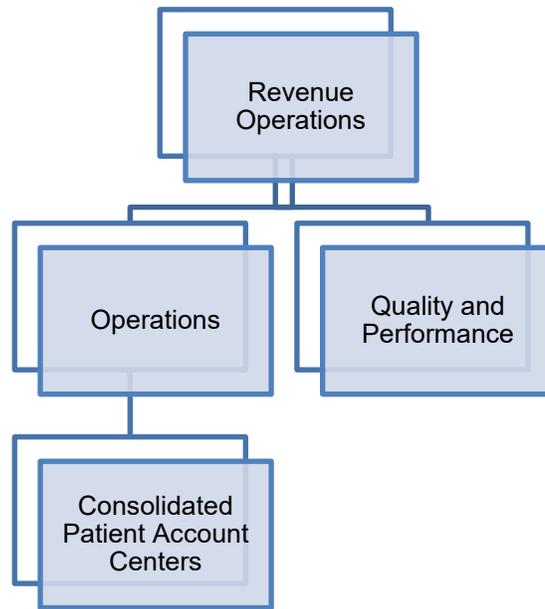
## Revenue Operations

Revenue Operations bills and collects revenue from private health insurers through a centralized process.<sup>19</sup> The Revenue Operations Quality and Performance division provides oversight for policy and the insurance billing process, and the Operations division oversees seven Consolidated Patient Account Centers (CPACs) that perform revenue services across each of VA’s seven regions, as shown in figure 4.<sup>20</sup> See appendix A for a detailed map of the seven regional CPACs.

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<sup>19</sup> Between October 1, 2021, and January 31, 2022, Revenue Operations will be integrated into the VHA Office of Finance. The VHA Office of Finance is gaining financial functions from OCC as part of the Integrated Veteran Care workgroup.

<sup>20</sup> There are seven regional CPACs located around the country that provide revenue cycle management to the 18 Veterans Integrated Service Networks and their associated VA medical centers. See appendix A for a detailed map of the seven regional CPACs.



**Figure 4.** Revenue Operations organization structure.  
Source: VHA OCC organizational chart provided by OCC in January 2021.

### Consolidated Patient Account Centers

Within each CPAC, there are three core functions that are necessary for billing private insurers, as shown in figure 5.



**Figure 5.** CPACs process for billing health insurers.  
Source: VHA OCC documentation.

At each CPAC, insurance verification staff determine whether veterans have private health insurance for all community care claims. Next, during a process known as revenue utilization review, nurses perform a clinical review to assess the care provided and to determine if it was for conditions related to a veteran’s military service. If the care was unrelated to military service, billing staff then prepare and submit bills to private insurers for reimbursement.

## Flow of Community Care Claims Information Used to Bill Private Insurers

The information that is needed to bill private health insurers for community care claims flows through several different data systems before it gets to Revenue Operations, as seen in figure 6.



**Figure 6.** Community care claim data flow for Revenue Operations process to bill private health insurance.  
Source: VHA OCC documentation and interviews.

As part of the payment process, claims data are passed through community care claim payment systems administered by Delivery Operations staff—the Plexis Claims Manager system (Choice and PC3 claims) and the Electronic Claims Adjudication Management System (veterans care agreements claims)—and then flow through the Program Integrity Tool to the Corporate Data Warehouse.<sup>21</sup>

From the Corporate Data Warehouse, this information is then transferred to Revenue Operations as part of the billing process. According to a VHA Health Information Management Service (HIMS) specialist, this information is used to create patient treatment files in the Veterans Health Information System Technology Architecture (VistA) for inpatient claims. Patient treatment files are records of community care inpatient encounters that provide Revenue Operations staff the information about the care provided that is used in the private insurance billing process.<sup>22</sup> Data

<sup>21</sup> According to Department of Program Integrity officials, the program integrity tool is used by VHA as a data source because it interfaces directly with community care payment systems and collects healthcare claim data that are used to detect fraud, waste, and abuse. Community care claims data are then transferred from the Program Integrity Tool to the Corporate Data Warehouse. The Corporate Data Warehouse is a national database that contains information from several VHA clinical and administrative systems. VHA uses the community care claims data from the Corporate Data Warehouse to populate OCCs’ Revenue Operations billing systems: the CPAC workflow tool and VistA patient treatment files.

<sup>22</sup> The patient files need to be complete before Revenue Operations can bill an inpatient claim. According to a HIMS specialist, HIMS staff create patient treatment files by manually entering information from the Corporate Data Warehouse into VistA for inpatient community care claims.

from the Corporate Data Warehouse are also used by Revenue Operations to populate the CPAC workflow tool for all claims.<sup>23</sup> The transfer of information from the payment systems to both VistA and the CPAC workflow tool need to occur before Revenue Operations staff can bill veterans' private health insurers. These tools—VistA and the CPAC workflow tool—are then used by Revenue Operations staff to bill the veteran's private insurance for treatment of conditions unrelated to military service. Revenue Operations staff rely on the above systems to provide the community care claims information needed to bill private health insurance.

## **Veterans' Private Health Insurance**

VA has a right to recover the costs of both inpatient and outpatient treatment for conditions unrelated to veterans' military service.<sup>24</sup> Private health insurers have insurance filing deadlines for submitting reimbursement claims. Insurance filing deadlines vary by insurer and can range from 90 days to several years, and the time to file begins following the date of treatment. VA must abide by these deadlines or risk not being reimbursed for authorized community care.

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<sup>23</sup> The CPAC workflow tool is a software application the Revenue Operations staff use to manage the insurance billing process.

<sup>24</sup> 38 U.S.C. § 1729 and 38 C.F.R. § 17.101.

## Results and Recommendations

### Finding: OCC Could Maximize Revenue by Improving Its Process to Bill Private Health Insurance

OCC did not establish an effective process to ensure its Revenue Operations staff billed veterans' private health insurers for treatment of conditions unrelated to military service. The OIG found an estimated 1.3 million of 2.4 million billable community care claims (54 percent) paid between April 20, 2017, and October 31, 2020, were not submitted to private health insurers before filing deadlines expired.<sup>25</sup> The following factors contributed to delays in billing and missed insurance filing deadlines: (1) OCC's billing and revenue collection process was not synchronized with the insurance filing deadlines and was often hindered by the incomplete transfer of claims information; and (2) pending workload volume and staffing shortages at the CPACs hindered effective billing. Although OCC was broadly aware of challenges to its process to bill and collect revenue from private insurers, its responses were not sufficient to correct these issues. As a result, OCC did not collect an estimated \$217.5 million that should have been recovered from private health insurance. The OIG also estimates that OCC will not recover about \$587.7 million through September 30, 2022, for a total of \$805.2 million, if current practices continue and the issues identified by the OIG are not fully addressed.<sup>26</sup>

OCC needs to ensure it can bill insurance before filing deadlines to maximize revenue recovery for community care. Until VHA effectively addresses the issues raised in this report, the OIG anticipates that VHA will remain at risk of not recovering revenue from community care not connected to military service.

This finding addresses the following challenges the OIG identified:

- OCC's Revenue Operations collection process is ineffective in meeting insurance filing deadlines, and
- revenue utilization review pending workload and staffing challenges at the CPACs hinder insurance billing and collection.

### What the OIG Did

The audit team selected a stratified statistical sample of community care claims from the audit universe of Choice, PC3, and veterans care agreements claims to determine if VHA recovered from private health insurers for billable claims. This sample included 1,095 inpatient and

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<sup>25</sup> Billable community care claims consisted of claims for treatment of conditions that were unrelated to veterans' military service when the veteran had eligible private health insurance.

<sup>26</sup> See appendix D for further details on how the OIG calculated its estimate of \$587.7 million from November 2020 to September 2022.

outpatient claims. The team then reviewed the sample to identify recoverable claims that had not been billed. More information about the statistical sampling methodology can be found in appendix C.

To identify billable community care claims, the team reviewed electronic health record registration data for each claim in the sample to determine whether veterans had private health insurance. The team next reviewed veterans' electronic health records to determine if the treatments provided were related to military service. The only claims considered billable were those for veterans with private health insurance that were for treatment of conditions unrelated to military service.

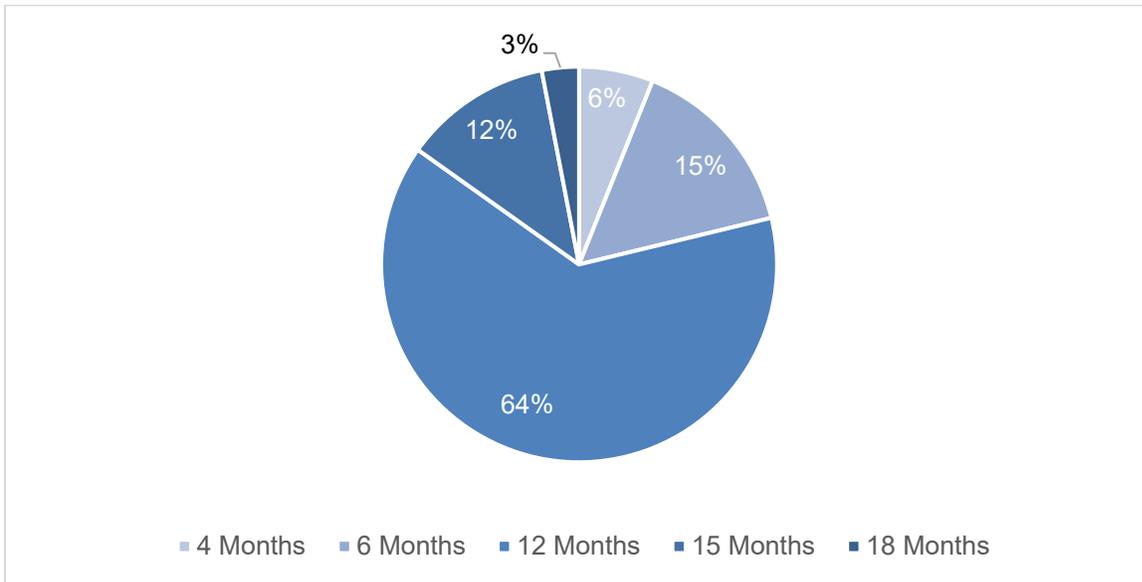
Next, the team reviewed OCC's Revenue Operations billing workload and staffing documentation and interviewed staff to understand the billing process. The team also coordinated with all seven CPACs to review sample findings. More information about the scope and methodology can be found in appendix B.

## **OCC's Revenue Operations Collection Process Is Ineffective in Meeting Insurance Filing Deadlines**

The OIG found the process of billing for community care unrelated to military service was not synchronized with insurance filing deadlines. The process also relied on different systems from those that were used to pay community care claims, and the systems did not fully exchange information. Both factors caused missed billing opportunities when the process to bill private insurers was not completed before deadlines expired. As a result, OCC did not collect an estimated \$217.5 million that should have been recovered from private health insurance between April 20, 2017, and October 31, 2020. As previously mentioned, if the processes to pay community care claims and bill private insurers do not change, the OIG estimates OCC will not collect about \$587.7 million through September 30, 2022, for a total of about \$805.2 million.

### **Billable Claims Were Not Submitted to Private Insurers before Filing Deadlines**

The OIG found that OCC's process to bill private insurers led to missed insurance filing deadlines because the overall process was not synchronized with insurers' filing deadlines. For the sampled claims that were not billed before the filing deadlines expired, private insurers had established deadlines that ranged from four to 18 months (with one year being the most common deadline). Figure 7 shows the average insurance filing deadlines for the recoverable claims not billed identified by the OIG sample.

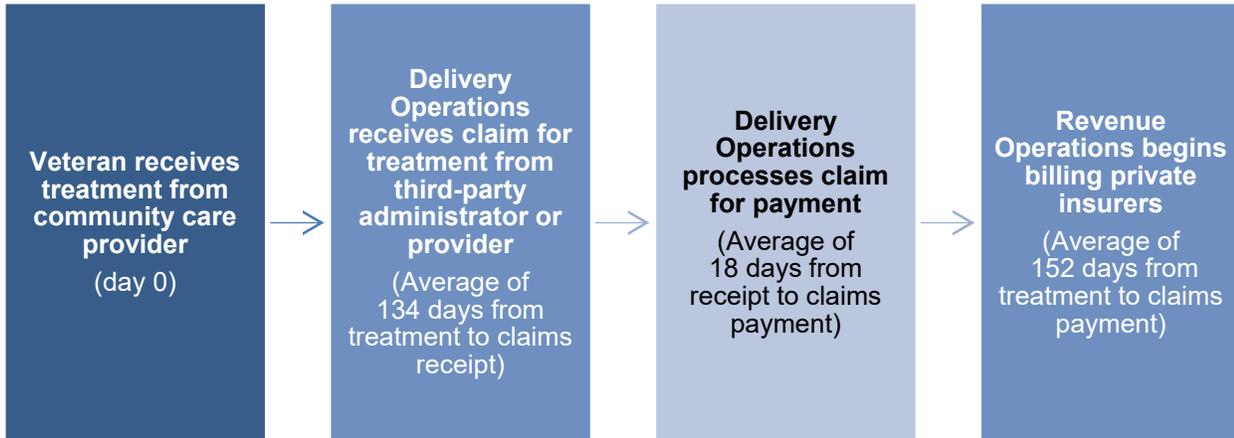


**Figure 7.** Average insurer filing deadlines for OIG sample of claims not billed by the insurance filing deadline. Source: OIG analysis of sample of community care claims.

However, Revenue Operations does not begin the billing process until Delivery Operations pays the community care claim and it is transferred to the CPAC workflow tool. Generally, VA allows third-party administrators (for Choice and PC3 claims) and providers (for veterans care agreements) six months (180 days) from the treatment date to submit claims to Delivery Operations for payment.

Based on the OIG’s sample review of 1,095 community care claims, it took an average of 134 days for Delivery Operations to receive the community care claim from the third-party administrator or the provider, and it took an additional 18 days for Delivery Operations to process the claim for payment. The claim is not transferred to the Revenue Operations CPAC workflow tool until after Delivery Operations pays the claim. At a total of 152 days, Revenue Operations was facing about a five-month delay before it could begin the process of billing private health insurance.<sup>27</sup> See figure 8 for details on this process.

<sup>27</sup> Appendix A provides more detail on the claims processing timeline for the Choice and PC3 programs and for veterans care agreements.



**Figure 8.** Community care claim processing timeline.

Source: VHA OCC documentation and OIG analysis.

This five-month time lag greatly reduces Revenue Operations’ opportunity to bill and collect payments from private insurers, especially in those cases where the private insurer has a filing deadline of six months or less. Example 1 describes a claim that was denied by private insurance because it was billed after the insurance filing deadline.

### **Example 1**

*A claim with a treatment date of April 29, 2019, was received in the workflow tool about two months after treatment. Revenue Operations then took an additional six months to process and bill the claim to the veteran’s insurer. The claim was billed on December 23, 2019, approximately two months after the six-month timely filing requirement. The veteran’s insurance denied the claim with the reason “the time limit for filing has expired.” As a result, VA paid \$229.18 for treatment of conditions unrelated to military service without recovering any funds from the veteran’s insurer.*

Prioritizing processing claims by the claim’s insurance filing deadline would help OCC maximize its opportunity to recover funds. However, Revenue Operations does not have a formal way to monitor the expiration of insurance filing deadlines or to prioritize their workload according to these deadlines. According to several Revenue Operations managers, they prioritize their work lists using the metric “days on worklist,” or sorting by “treatment date” or “insurance company name.”

Sorting claims by days on worklist identifies the oldest claims in the Revenue Operations workload. However, claims are not transferred to Revenue Operations after the treatment date but rather after payment to the community care provider. Because insurers have different filing deadlines the oldest claims are not necessarily the claims closest to the insurance filing deadline.

Sorting claims workload by treatment date also does not correspond to the insurance filing deadline. CPAC staff stated that, unless they manually open each claim to identify the insurance filing deadline, they will not know which claims are nearing their deadlines.

Two facility Revenue Operations managers stated CPAC staff may sort by the insurer's name if they know the filing time for a particular insurer is short. For example, staff may sort by a particular insurer with a known six-month filing deadline to try and process those first, rather than processing claims from an insurer with a 12-month filing deadline. However, staff cannot be sure that a particular insurer's claims are closer to the insurance filing expiration date without manually calculating the number of days since the date of treatment.

The OIG concluded that OCC should develop procedures to identify eligible claims by insurance filing deadlines so that Revenue Operations can increase opportunity to bill veterans' private health insurers.

### **Incomplete Transfer of Claims Information Limited Billing Opportunities**

Before the process of billing insurers can begin, the community care claims information needed to bill private health insurers must be transferred from the payment systems into the CPAC workflow tool. Additionally, for inpatient care, claims information must be transferred to the VistA patient treatment files before these bills can be submitted to private health insurance. These are the systems Revenue Operations staff have access to and use to process claims for billing private insurers. Once the information is moved to the workflow tool, Revenue Operations staff begin the revenue utilization review to determine if the claim should be billed to private health insurers for care unrelated to military service.

For the sample of claims the audit team reviewed, for claims paid between April 20, 2017, and October 31, 2020, the team identified instances where information used to pay community healthcare providers was not transferred completely from the payment systems to those used to bill private health insurance. This may have been partially due to inadequately developed data flow processes. According to an OCC program integrity manager, Revenue Operations staff did not thoroughly communicate their business requirements to stakeholders when developing the data flow process from the claims payment systems to the CPAC workflow tool. The manager told the team that when decision-makers initially agreed on the data elements to be pulled from the payment systems to the workflow tool, additional information necessary for billing private insurers should have been included.

If this information is not available in the CPAC workflow tool, Revenue Operations has difficulty completing the billing process before insurance filing deadlines. According to Revenue Operations' managers, when the workflow tool does not contain the necessary claim information staff will review the veteran's medical records to attempt to find the additional information that

could support billing. If they cannot find the necessary information, staff cannot bill insurance to recover money.

### *Review of CPAC Workflow Tool Activity History*

As Revenue Operations staff from different functional areas review and act on claims, the CPAC workflow tool records this activity history. During a review of the tool's activity history for the claims sample, the team identified instances in which the incomplete transfer of claim information prevented billing before insurance filing deadlines. The team's review of information identified claims that did not complete the billing process because of missing provider information and incomplete patient treatment files. Examples 2 and 3 highlight instances of each.

#### *Example 2*

*The CPAC workflow tool showed that an outpatient claim for a veteran's care was missing care provider information needed to bill private health insurance. Although the information was available in the payment system, it was not in the workflow tool. Revenue Operations staff did not bill the veteran's insurance before the one-year filing deadline. As a result, VA paid \$2,540.15 for treatment of conditions unrelated to military service without recovering any funds from the veteran's insurance.*

#### *Example 3*

*The CPAC workflow tool showed an inpatient claim awaiting completion of the patient treatment file, which CPAC staff noted was not complete. Revenue Operations did not bill the veteran's insurance before the one-year filing deadline expired. As a result, VA paid \$510,735.23 for treatment of conditions unrelated to military service without recovering any funds from the veteran's insurance.<sup>28</sup>*

The OIG determined information used to pay providers was not always transferred completely from the payment systems to those used to bill private health insurance. If this information is not available in the CPAC workflow tool, Revenue Operations has difficulty completing the billing process before insurance filing deadlines expire. OCC should conduct an assessment to determine how to strengthen its information system controls to ensure the transfer of complete and accurate claims information required to bill private health insurers between OCC payment systems and the CPACs' workflow tool and VistA patient treatment files.

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<sup>28</sup> This inpatient claim was for a 38-day hospital stay for complications from lung transplant surgery.

## *OCC Has Taken, and Continues to Take, Steps to Address Incomplete Transfer of Claims Information*

OCC is aware of the issues with the transfer of information between payment and revenue system and has taken some steps to correct these issues. Revenue managers from all seven CPACs told the audit team they have had to research incomplete claims in the workflow tool to obtain the information necessary to bill private health insurance. Since this problem was first identified, OCC has established workgroups to address the incomplete transfer of claim information. For example, in 2019, Revenue Operations staff began working with OCC and VHA on the incomplete transfer of information used to populate the CPAC workflow tool and create patient treatment files. HIMS staff reported in 2019 that the data being used to create the patient treatment files did not match the scanned data on the same claims OCC received in their payment systems.<sup>29</sup> To address the issue, OCC created a data integrity workgroup around November 2019. As part of this workgroup, HIMS halted the creation of patient treatment files to identify why data used to create the files did not match the data in the source payment systems and then took steps to address the underlying issues.

Starting in 2019, HIMS staff worked with source system technical representatives and Program Integrity staff to update and correct data transfers from the Plexis Claims Managers and Electronic Claims Adjudication Management payment systems to the Corporate Data Warehouse. A HIMS official told the team that data available in the Corporate Data Warehouse were transferring accurately from the source systems as of August 2020. According to officials, HIMS had been able to begin patient treatment file creation again for the Electronic Claims Adjudication Management System in February 2020 and for the Plexis Claims Manager in August 2020. However, as of August 2021, the patient treatment files continue to have a backlog that needs to be manually entered into VistA. HIMS reported a backlog of 95,430 claims awaiting patient treatment file creation as of August 13, 2021. Because of the time frame of the team's sample of claims (April 20, 2017, and October 31, 2020), the OIG has not verified that all issues with the transfer of information between different systems have been addressed. In addition, it will be important for the OIG to assess whether these problems continue for claims under the new Veterans Community Care program.

According to an OCC project manager, the data integrity workgroup continued to meet regularly to identify, discuss, and work through data issues affecting OCC's operations, as of

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<sup>29</sup> Revenue Operations highlighted in an internal document, dated August 2020, that “[Revenue Operations] has been unable to efficiently bill inpatient encounters since [Choice] (2014) due to issues with HIMS obtaining the necessary data to create Patient Treatment Files (PTFs) for [Revenue Operations] use.” OCC also noted that “Streamlined, standards-based [Community Care Network] billing approaches need[ed] to be developed to supplement [Revenue Operations] and HIMS activities...[to] avoid manual errors that occur due to variances in connected processes and procedures.”

October 2021. The workgroup includes stakeholders from OCC and various information technology and contract personnel.

## **Revenue Utilization Review Pending Workload and Staffing Challenges at the CPACs Hinder Insurance Billing and Collection**

The OIG found that large pending claims volume and inadequate staffing resources at the CPACs created challenges, affecting their ability to bill private insurers timely. The audit team reviewed VA budgets from FY 2017 and FY 2021 and determined that obligations for medical community care had increased by approximately 51 percent.<sup>30</sup> During the same time, overall CPAC staffing had only increased by about 6 percent. According to multiple CPAC managers, while CPAC responsibilities have continued to grow over the years, staffing levels have not increased at the same rate. The team reviewed pending workload and staffing data provided by OCC for the seven CPACs.<sup>31</sup>

OCC data identified a disparity of claims volume among the CPACs in the revenue utilization review workload. Revenue utilization review is a necessary step in the process of billing private insurance, as it is when nurses perform clinical reviews of care to determine whether the care was related to military service. Beyond conducting revenue utilization reviews, assigned nurses are also responsible for collaborating on other Revenue Operations process tasks with CPAC and VA medical facility staff. Some of their many work responsibilities include ensuring compliance with established private health insurance criteria for reimbursement; serving as patient advocates; and providing clinical information to private health insurers.

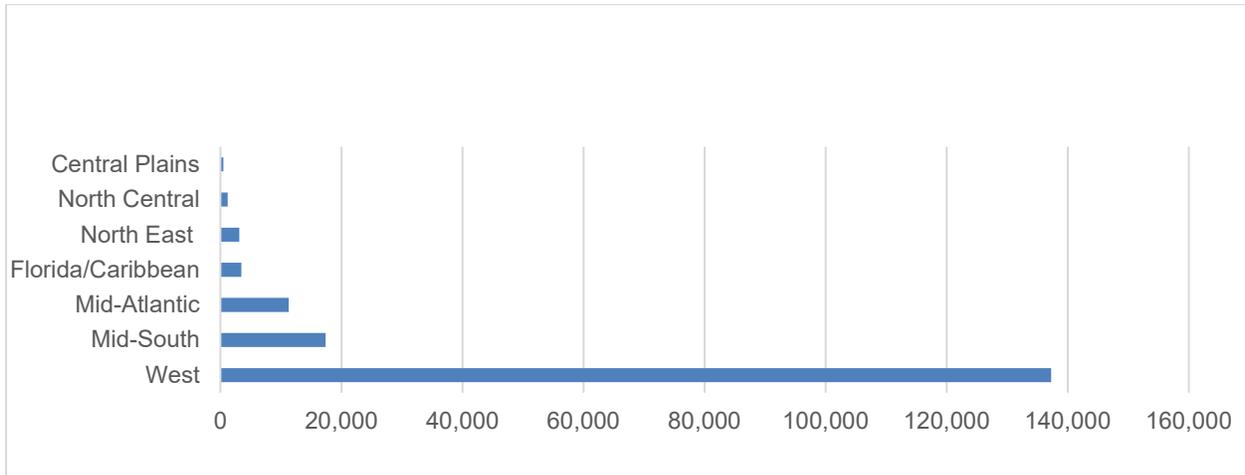
The team identified a range of averages for revenue utilization review pending workload among CPACs, but the West CPAC had by far the highest average workload of pending claims. West CPAC utilization review staff said they receive a large volume of community care claims because many of the veterans they serve live in rural areas.

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<sup>30</sup> Calculated as the difference between FY 2017 actual and FY 2021 current estimate for medical community care obligations from VA's annual budget submissions for FYs 2019 and 2022, respectively. For consistency, the FY 2021 estimate figures used in the calculation excluded obligations reported under the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act, both of which are related to the COVID-19 pandemic response.

<sup>31</sup> OCC's pending workload report identifies national community care workload for private health insurance billing. The pending claims report includes claim inflows and outflows and represents outstanding claims at the end of each month.

Figure 9 shows that the West CPAC revenue utilization review personnel had about 137,000 of 174,000 (79 percent) of total pending claims from September 2020 through February 2021.



**Figure 9.** CPAC revenue utilization review's monthly pending claims workload averages by CPAC, September 2020 to February 2021.

Source: OCC-provided pending workload and staffing data.

According to data provided by OCC for September 2020 through February 2021, the West CPAC had not only the highest pending claims workload overall but also the highest ratio of pending claims per utilization review nurse. Despite this ratio, they ranked fifth among the seven CPACs in staffing levels, with 45 nurses. Table 1 shows the number of nurses at each CPAC and the number of pending claims per nurse during that period.

**Table 1. Average Pending Claims per Revenue Utilization Review Nurse by CPAC (September 2020–February 2021)**

CPAC	Average number of revenue utilization review nurses	Average pending claims per revenue utilization review nurse
West	45	3,033
Mid-South	48	362
Mid-Atlantic	47	241
Florida/Caribbean	18	197
North East	57	54
North Central	39	31
Central Plains	46	11

Source: OCC-provided pending workload and staffing data.

The West CPAC's director and revenue utilization review assistant nurse manager both stated in March 2021 that staffing shortages significantly hindered their ability to process the community care workload.<sup>32</sup>

In April 2020, the West CPAC director reported he submitted a white paper to the Revenue Operations director of CPAC operations requesting 12 additional utilization review nurses, noting that the West CPAC had seen the largest increase in community care claims of any CPAC over the previous two fiscal years. His request stated the CPAC was risking millions of dollars in revenue due to missed insurance filing deadlines. According to the West CPAC director, he did not receive a formal response, but his staffing request was not approved, likely due to budget concerns.

According to the West CPAC nurse manager, in July 2021, following discussions with the OIG in March, other CPACs began assisting the West CPAC with the required clinical reviews to reduce the third-party community care claims backlog. According to OCC, staff from five CPACs provided more than 1,500 hours of overtime, costing about \$77,000 over four weeks, to reduce the West CPAC's backlog of claims awaiting utilization review.<sup>33</sup> According to a West CPAC manager, Revenue Operations staff also identified and removed pending claims that were past the insurance filing deadline. The manager said removing those claims from the workflow tool enabled revenue utilization review staff to focus their efforts on potentially billable claims. According to OCC's community care report, pending claims volume decreased from approximately 108,000 claims at the beginning of July 2021 to about 260 claims at the end of August 2021.

### *Staffing and Workload Challenges Affected Revenue Recovery at All Seven CPACs*

The OIG found that staffing and workload issues at all seven CPACs affected VA's ability to recover funds from private insurers. Revenue utilization review managers at each CPAC said inadequate staffing impeded their ability to process community care workload. Five of seven managers stated staffing levels were insufficient to manage the existing workload. A Mid-South CPAC manager described leadership team nurses as having to assist staff nurses with their workload to keep current. A Central Plains CPAC manager said staff cannot keep up with their workload.

All seven revenue utilization review managers said vacancies and nurses on vacation or sick leave often hindered their ability to process claims on time. The North Central CPAC manager

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<sup>32</sup> Revenue Utilization Review staff have 39 separate work responsibilities or tasks they must perform including their responsibility for reviewing community care claims.

<sup>33</sup> According to OCC, staff worked overtime to decrease West CPAC's backlog of utilization review pending claims during two pay periods: July 18 to July 31, 2021, and August 15 to August 28, 2021.

said staffing issues and vacations often resulted in backlogs because there were insufficient employees to keep up with the volume of claims. The Florida Caribbean CPAC manager said in August 2021 that Family and Medical Leave Act and sick leave issues made it very challenging to stay current.

Additionally, all seven revenue utilization review managers described filling nurse vacancies as a slow process, three managers stating it can take as long as six months to hire and integrate new employees, further affecting their ability to manage the workload. To meet workload demand with staffing shortages, revenue utilization review managers from four CPACs reported they were sharing or floating staff from sites within the CPAC to assist with sites that could not keep up with the workload.

The OIG found that the workload at each CPAC was erratic, making it harder to manage. For example, the Mid-South CPAC manager said variable workloads made it difficult to determine adequate staffing. The West CPAC manager shared an example of having 4,000 community care claims added to the workload from one day to the next. The manager calculated that with the current staff level, each nurse would have to evaluate 100 claims each day along with their other responsibilities. All seven CPAC managers said overtime was authorized so staff could keep up with the variable workload. Specifically, the Central Plains CPAC manager said he assigned 50 hours of overtime per pay period to work on reviews to determine if treatment was for conditions related to military service. At the time of this audit, there were no productivity metrics detailing how many claims revenue utilization review nurses should be expected to process over a given time. Productivity metrics would help Revenue Operations determine how many utilization review nurses they need to process community care workload.

High and variable pending workload combined with Revenue Utilization review staffing deficiencies contributed to backlogs of claims requiring clinical reviews, particularly for West CPAC. The OIG concluded an assessment should be conducted to determine if staffing resources and workload are sufficiently aligned to process the anticipated volume of claims to be billed to veterans' private health insurers.

***OCC Has Not Taken Adequate Corrective Actions to Address Workload and Staffing Issues, Resulting in Missed Billing Opportunities***

Revenue Operations was aware through its own internal audits and workload reports that the volume of claims and lack of sufficient staff can create a backlog that hinders OCC's ability to bill and collect reimbursement from veterans' private insurance for the cost of care unrelated to military service. The OIG noted, however, that Revenue Operations has not taken corrective action adequate to resolve these workload concerns or staffing challenges.

Revenue Operations conducts internal quarterly audits of CPAC operations. All seven CPACs are audited annually. Statements in these audit reports mirrored the OIG’s findings specific to workload and staffing challenges. As part of the FY 2020 fourth-quarter annual OCC revenue utilization review audit, Revenue Operations tested the number of pending community care claims waiting to be processed by revenue utilization review staff. According to OCC’s internal audit reports from October 2020, five CPACs had delinquent revenue utilization reviews.<sup>34</sup> For three of these CPACs, this was a repeat finding—Central Plains, Mid-Atlantic, and West CPACs also were delinquent in the FY 2019 first-quarter audit report. These findings align with the OIG’s analysis identifying a high level of pending claims workload for the West CPAC. See table 2 for the five CPACs identified with deficiencies for delinquent claims in FY 2020.

**Table 2. Percentage of Total Dollars Considered Delinquent for CPACs with an Internal Control Deficiency in FY 2020’s Quarter 4 Internal Audits**

CPAC	Percentage delinquent
Mid-South	89%
West	87%
North Central	69%
Mid-Atlantic	51%
Central Plains	48%

*Source: OCC-provided Revenue Operations internal audit reports from FY 2020 Quarter 4 from October 2020.*

*Note: West, Mid-Atlantic, and Central Plains CPACs also were delinquent in the FY 2019 first-quarter audit report.*

When Revenue Operations determines a CPAC is deficient in an internal control, the CPAC is required to create and implement a corrective action plan and be retested when the deficiency is considered addressed. But CPAC corrective action plans from FY 2020 did not always include an acknowledgment of the factors affecting the timely processing of claims or sufficient corrective action that would address the causes. Further, for CPACs that note staffing as a cause for a failed audit test, the corrective actions did not address the staffing deficiency. Therefore, the OIG concluded that corrective actions were not sufficient to address the cause of deficiencies identified by the internal audits.

The Government Accountability Office’s (GAO) *Standards for Internal Controls in the Federal Government* requires managers to evaluate issues and remediate identified internal control

<sup>34</sup> Revenue Operations measures the delinquency of the CPAC’s pending workload of community care claims by comparing the total dollars of the delinquent community care claims against the total dollars of the community care claims that are current (delinquent claims/current claims). According to Revenue Operations staff, delinquent claims are those that have been on a worklist for longer than 14 days. Current claims are those that have been on a worklist for 14 days or less. The internal audit threshold for passing this test is less than five percent delinquent claims.

deficiencies on a timely basis.<sup>35</sup> Although Revenue Operations consistently monitored CPAC performance, an OIG review of available reports and internal audits showed oversight has not been sufficient to address identified deficiencies. Revenue Operations has various reports available for ongoing monitoring of community care claims processing related to billing private health insurance and for assisting leaders in identifying delays that could hinder billing before the insurance filing deadlines expire.

## Conclusion

VHA could increase the funding available for veteran health care services by making sure it bills veterans' private health insurers for treatment provided in the community for conditions unrelated to military service. However, OCC's Revenue Operations struggled with a claims process that was not synchronized with insurance company filing deadlines and did not ensure the necessary information was transferred to those responsible for billing insurers. Revenue Operations also faced workload and staffing challenges that created backlogs, resulting in missed opportunities to bill insurers. Although Revenue Operations has taken some steps to address these issues, problems remain. These issues have already led to an estimated \$217.5 million in lost revenue that could have been used for veteran health care, a figure that could grow to \$805.2 million by September 30, 2022, if these problems are not corrected.

## Recommendations 1–3

The OIG made the following recommendations to the under secretary for health:

1. Maximize opportunities to bill veterans' private health insurers for recoverable claims by developing procedures that align and prioritize the processing of such claims to insurers' filing deadlines.
2. Strengthen information system controls to make certain that complete and accurate claims information is transferred between applicable current and future Community Care payment systems and the Consolidated Patient Account Centers' workflow tool and VistA patient treatment files.
3. Conduct an assessment to determine if staffing resources and workload are sufficiently aligned to process the anticipated volume of claims to be billed to veterans' private health insurers and make adjustments as needed.

## VHA Management Comments

The deputy under secretary for health concurred with the three recommendations and provided corrective action plans. For recommendation 1, the deputy under secretary stated that Revenue

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<sup>35</sup> GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

Operations will update its guidebooks to prevent current and future claims from inappropriately being removed for timely filing deadlines. Revenue Operations will also develop a patch for VistA to add new timely filing parameters including termination dates, to insurance files. In addition, Revenue Operations will work with national and regional payers to amend agreements that do not currently include language acknowledging a six-year timely filing limit and then develop a plan to bill insurers for eligible past encounters. Finally, Revenue Operations will make sure it has guidance for staff on how to prioritize claims based on service date. For recommendation 2, the deputy under secretary stated that Revenue Operations and VHA Business Architecture will develop a plan to strengthen information systems so that complete and accurate claims information is available from the Community Care payment systems and processes. For recommendation 3 the deputy under secretary stated that Revenue Operations will conduct a review of its Workforce Optimization and Resource Planning Model and use the results to evaluate adjustments to authorized staffing levels across CPACs based on work volume and productivity standards.

In addition to concurring with the recommendations, the deputy under secretary provided a table showing the average monthly inflow of Community Care Revenue Utilization Review claims for FYs 2021 and 2022, per revenue utilization review nurse and for each CPAC. The deputy secretary stated that this data was included to enhance clarity and accuracy in the report. Appendix E provides the full text of the deputy under secretary's comments.

## **OIG Response**

The deputy under secretary for health's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.

The deputy under secretary for health noted that the Revenue Operations payer relations department will work with national and regional payers to amend agreements that currently do not contain language acknowledging a six-year timely filing limit. The OIG understands this to be a reference to a federal regulation providing that legal proceedings to enforce the right of the United States to be reimbursed by insurers must be filed within six years of the date of provision of medical services.<sup>36</sup> According to a VHA official, of VHA's five national payer agreements, only three agreements with private insurers included language stating that the payer will honor the six-year federal regulation. The OIG's projections in this report are not based on any claims that had a six-year timely filing deadline. If Revenue Operations can negotiate agreements with national and regional insurers to extend timely filing deadlines, it could increase their chance of revenue recovery.

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<sup>36</sup> 38 C.F.R. § 17.106(c).

Related to the additional claims data that VHA provided with its comments, while the OIG recognizes that monthly claim inflow volumes are important workload measures, alone they are insufficient for explaining the backlog of outstanding pending workload still from previous months.<sup>37</sup> Consequently, the OIG used the OCC's pending claims workload for the analysis in this report because it accounts for what each CPAC has left to process at the end of each month based on inflows, outflows, and pending community care workload for private health insurance billing.

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<sup>37</sup> OCC's pending workload report identifies national community care workload for private health insurance billing. The pending claims report includes claim inflows and outflows and represents outstanding claims at the end of each month.

## Appendix A: Background

### Prior Related OIG Work

VHA has experienced persistent challenges in billing private insurers for community care. Three previous OIG reports highlighted internal control weaknesses leading to missed opportunities to bill and recover funds for community care claims:

- *VA OIG, Audit of Medical Care Collection Fund Billings for Non-VA Care*, Report No. 10-02494-176, May 25, 2011.
- *VA OIG, Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, Report No. 15-03036-47, December 21, 2017.
- *VA OIG, Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, Report No. 17-02713-231, September 6, 2018.

The first report found that VHA did not have reasonable assurance it was maximizing the billing of private health insurance for care provided in the community for conditions unrelated to veterans' military service. Because VHA lacked an effective process and a system of controls, it missed billing opportunities that could have increased revenue by \$110.4 million annually. This report reviewed community care claims for the period of October 1, 2009, through March 31, 2010. The report recommended VHA ensure it had a business process to identify and process billable claims, train employees, establish a monitoring program to periodically test process outcomes, and establish separate collection goals for revenue recovery.

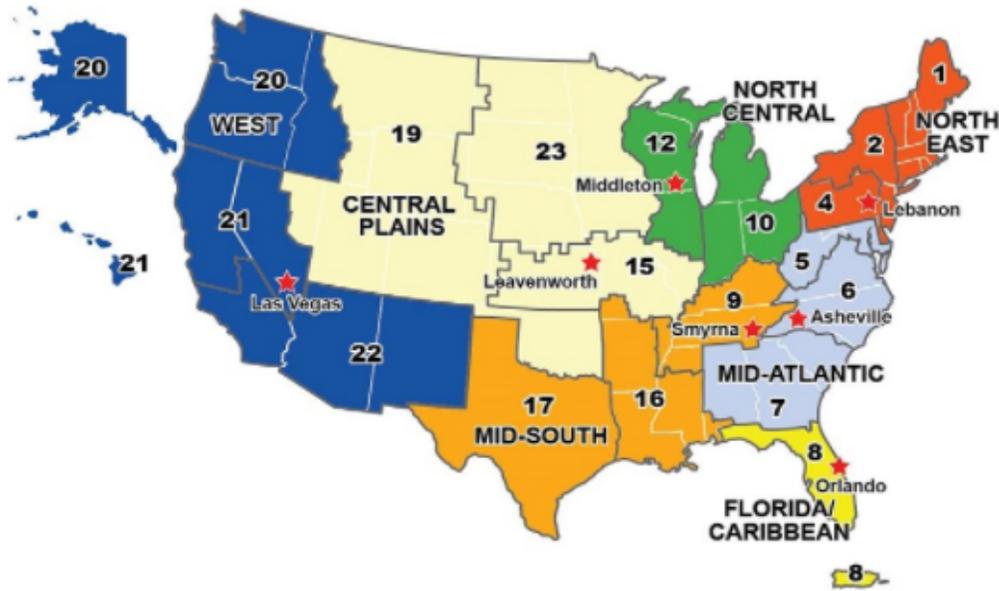
The second report found that VHA did not have an effective internal control system for the Choice payment process specifically. The OIG again found that insufficient controls contributed to VHA not recovering approximately \$6.5 million in revenue from private insurers for claims from November 1, 2014, through September 30, 2016. The report recommended that VHA payment processing staff have access to accurate insurance coverage data and establish appropriate processes for collecting payments from those health insurers. Additionally, the report recommended that VHA develop and issue written payment policies to guide staff processing community care claims received from third-party administrators and establish expectations and obligations for those who submit invoices for payment.

The last report found the same internal control issues as the 2017 OIG report. As a result of these weak controls, VHA did not recover an estimated \$16.8 million from private insurers for claims

from March 4, 2016, through March 31, 2017.<sup>38</sup> The OIG mirrored the previous report recommendations to address the written policy, access to quality information, minimizing overpayments, and monitoring the payment process.

### Consolidated Patient Account Centers

There are seven regional CPACs located nationwide (see figure A.1).



CPACs	VISNs
West	20, 21, 22
Central Plains	15, 19, 23
Mid-South	9, 16, 17
Mid-Atlantic	5, 6, 7
North Central	10, 12
Florida/Caribbean	8
North East	1, 2, 4

**Figure A.1.** Location of VA VISNs by CPAC region.  
 Source: OCC, Revenue Operations division.

<sup>38</sup> When this recommendation was made for recovery from private health insurance, Choice program legislation required community providers to bill private insurers before billing VA as the secondary payer. Legislative amendments on April 19, 2017, made VA the primary payer for veterans’ healthcare services and responsible for seeking reimbursement directly from private health insurers. The current audit focused on community care treatment through the Choice program that occurred after April 19, 2017.

## Community Care Medical Record Documentation

VHA does not always have access to medical record documentation from community care providers. A 2015 OIG report estimated 68 percent of medical documentation was either incomplete or not provided on time. In addition, a 2019 OIG report determined VHA staff did not scan paper documents and enter electronic information into patients' electronic health records promptly, which created significant medical record backlogs. Further, a third OIG report in June 2021 found community care staff at six VA medical facilities did not always accurately index medical records from non-VA providers into veterans' electronic health records.<sup>39</sup>

According to Revenue Operations staff, community care medical records are often needed to bill private insurers. For example, when claim coding is not detailed enough, staff review medical records to determine if the claim is for a condition related to a veteran's military service, in which case it would not be billable to private health insurance. According to revenue utilization review managers from all seven CPACs, the inconsistent availability of medical documentation from the community care providers makes it difficult to complete their required reviews on time.

In addition, a Revenue Operations manager said insurers often request additional information from medical records for their processing. Revenue Operations staff should have access to medical records to fulfill these requests. Failure to provide the requested information to insurers presents a risk that the claim will be denied, and no funds will be recovered. OCC highlighted this issue in December 2020 by stating in an internal document that claims are often denied because of significant delays in processing due to no connection between the claim and clinical record.

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<sup>39</sup> VA OIG, *Review of Patient-Centered Community Care (PC3) Health Record Coordination*, Report No. 15-00574-501, September 30, 2015; VA OIG, *Health Information Management Medical Documentation Backlog*, Report No. 18-01214-157, August 21, 2019; VA OIG, *Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records*, Report No. 19-08658-153, June 17, 2021.

## Community Care Processing Timeline

**Table A.1. Average Days from Treatment to Delivery Operations Payment**

Community care program	Claims-processing system	Community care treatment to Delivery Operations receipt of claim (average days)	Delivery Operations receipt of claim to payment (average days)	Community care treatment to Delivery Operations payment (average days)
Choice	Plexis Claims Manager	169	9	177
PC3	Plexis Claims Manager	90	10	100
Veterans care agreements	Electronic Claims Adjudication Management System	54	58	112
	<b>Total</b>	<b>134</b>	<b>18</b>	<b>152</b>

*Source: OIG analysis of data obtained from the Plexis Claims Manager and Electronic Claims Adjudication Management System payment processing systems from April 20, 2017, through October 31, 2020.*

*Note: OIG rounded numbers in table.*

## Appendix B: Scope and Methodology

### Scope

The audit team performed its work from January 2021 to January 2022 to determine how effectively VHA billed veterans' private health insurers when veterans received care from community providers for treatment of conditions unrelated to military service. The audit covered claims processed through VA's Plexis Claims Manager and paid between April 20, 2017, and October 31, 2020, as well as claims processed through VA's Electronic Claims Adjudication Management System and paid between March 13, 2019, and October 31, 2020. The audit included a universe of approximately 34.5 million healthcare claims with roughly \$17.1 billion in claims payments paid by VHA from April 20, 2017, through October 31, 2020. The team then reviewed a sample of healthcare claims to identify claims that would be billable to a veteran's private health insurance.

### Methodology

To achieve the objective, the audit team reviewed applicable laws, regulations, policies, procedures, Choice and PC3 program contracts, and related program guidance. The team also interviewed program officials from OCC, including from its Revenue Operations division and from the seven individual CPACs, to obtain information about payment processes and the recovery of funds from veterans' private insurers.

The team selected a sample of claims paid by the VA Financial Services Center's Plexis Claims Manager system for Choice and PC3 claims and from the Electronic Claims Adjudication Management System for veterans care agreements claims. The team worked with an OIG statistician to select a stratified random statistical sample that consisted of 1,095 outpatient and inpatient claims within the payment universe. This sample included 899 claims processed through the Plexis Claims Manager system and 196 claims processed through the Electronic Claims Adjudication Management System. Appendix C provides details of the statistical sampling methodology.

For these claims, the team obtained and reviewed the payment data and related evidence from the patients' medical records to (1) identify the claims that were billable to veterans' private insurers and (2) determine whether OCC Revenue Operations identified and billed these claims to private health insurance before the insurance filing deadline had expired.

Next, the OIG used VA's Medical Care Collection Fund's third-party collections-to-billing percentage of 35 percent to estimate how much would be recovered from private health insurance. The third-party collections-to-billing percentage is what VA collects for each dollar

billed to private health insurance for medical services provided to veterans; it thus provides a reasonable benchmark for the amount VA could expect to recover from private health insurers.<sup>40</sup>

## Internal Controls

The audit team assessed the internal controls of VHA's Office of Community Care Revenue Operations significant to the audit objective. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.<sup>41</sup> In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following three components and four principles as significant to the objective.<sup>42</sup>

- Component 3: Control Activities
  - Principle 12: Management should implement control activities through policies.
- Component 4: Information and Communication
  - Principle 13: Management should use quality information to achieve the entity's objectives.
- Component 5: Monitoring
  - Principle 16: Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.
  - Principle 17: Management should remediate identified internal control deficiencies on a timely basis.

Based on the team's internal controls assessment, deficiencies were not identified for Component 3, Principle 12 and Component 5, Principle 16. However, the team identified deficiencies for Component 4, Principle 13, as information used to achieve the objective of billing veterans' private health insurance for care provided through the community for treatment of conditions unrelated to military service was not always complete. The team also identified a deficiency for Component 5, Principle 17. These deficiencies are discussed in the report findings and addressed in the recommendations.

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<sup>40</sup> VA's third-party collections to billing metric was used to estimate what could be recovered for claims that were not billed. The actual amount of a recovery cannot be determined because the claims were not submitted to the veteran's private health insurers so that the insurance company could determine their responsibility to pay with respect to the member's benefits.

<sup>41</sup> GAO, *Standards for Internal Control in the Federal Government*.

<sup>42</sup> Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

## **Fraud Assessment**

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contract, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence by conducting an assessment to identify fraud risk indicators and the likelihood of their occurrence. The OIG did not identify any instances of fraud or potential fraud during this audit.

## **Data Reliability**

The OIG statistician and audit team used computer-processed data from VA's Plexis Claims Manager and Electronic Claims Adjudication Management System, provided by the OIG Data Services Division. To test for reliability, the team determined whether any data were missing from key fields or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, the data were formatted appropriately, values were within expected ranges, and values in related fields were logically consistent. Testing of the data disclosed that they were sufficiently reliable for the audit objectives.

## **Government Standards**

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

## **Appendix C: Statistical Sampling Methodology**

### **Approach**

The VA OIG conducted this audit to determine how effectively VHA billed veterans' private health insurers when veterans received care from community providers for treatment of conditions unrelated to military service. The audit covered claims that were processed through VA's Plexis Claims Manager and were paid between April 20, 2017, and October 31, 2020, as well as claims processed through VA's Electronic Claims Adjudication Management System and paid between March 13, 2019, and October 31, 2020.

### **Population**

The audit team identified approximately 34,501,470 healthcare claims with approximately \$17,133,231,978 in claims paid by VHA from April 20, 2017, through October 31, 2020.

### **Sampling Design**

The team divided the population into three strata to include claims from between April 20, 2017, and October 31, 2020. The following table describes the total Choice, PC3, and veterans care agreements claim counts and dollar values, and sampled items for each type of claim. The OIG statistician selected 1,095 items to achieve a sample of billable claims. The OIG estimated 6.89 percent of the claims in the universe would be billable.

**Table C.1. Claims Sample by Type of Claim**

Stratum	Description	Date range	Sample size (number of claims)	Sample size (\$ value of claims)	Total number of claims paid	Total amount of claims payments (\$)
1	Choice	Apr. 2017– Sep. 2019	699	38,895,040	12,488,282	5,466,597,922
2	PC3	Feb. 2019– Oct. 2020	200	36,530,363	19,393,431	10,489,389,449
3	Veterans care agreements	Mar. 2019– Oct. 2020	196	\$7,743,127	2,619,757	1,177,244,607
	<b>Total</b>	Apr. 2017– Oct. 2020	1,095	83,168,529	<b>34,501,470</b>	<b>17,133,231,978</b>

Source: VA OIG statistician’s stratified population. Data were obtained from the Plexis Claims Manager and Electronic Claims Adjudication Management System payment processing systems from April 20, 2017, through October 31, 2020.

## Weights

The OIG calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the audit team calculated the error rate estimates by first summing the weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records.

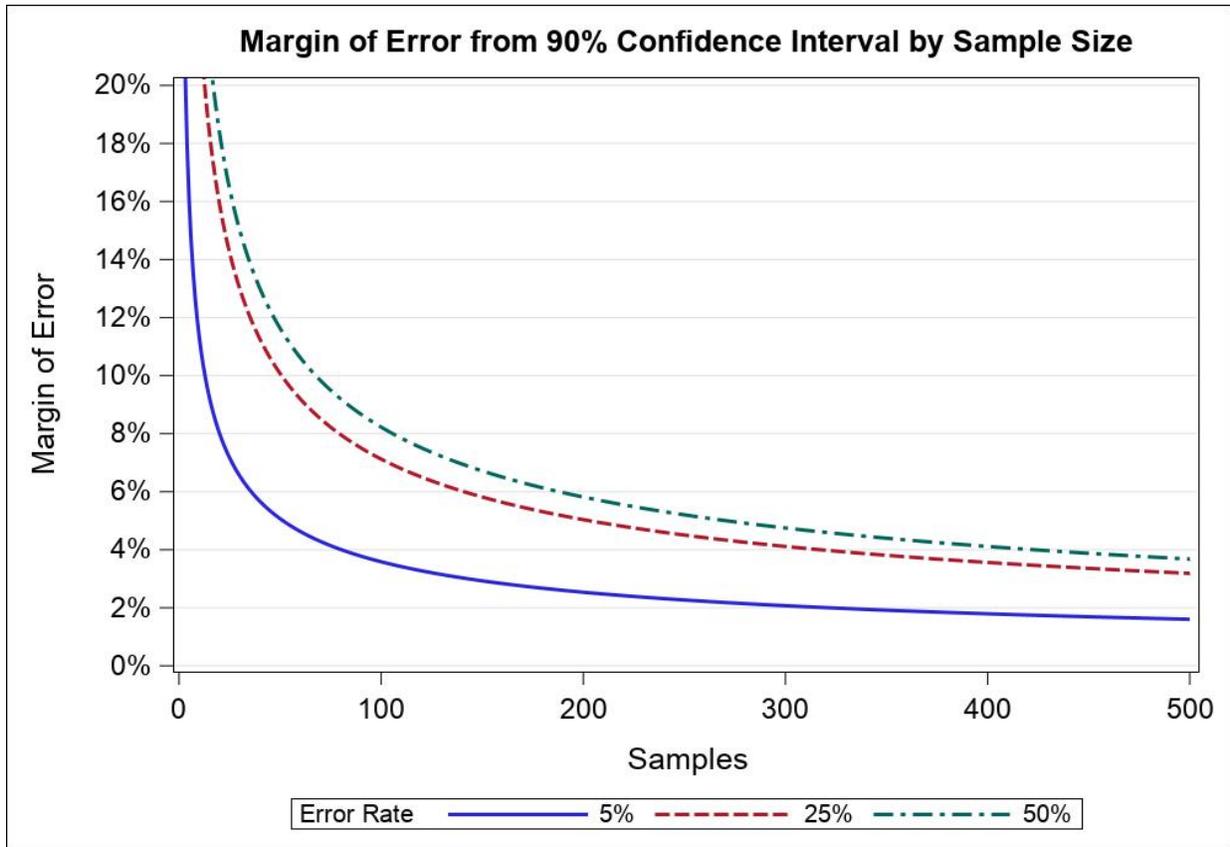
## Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.



**Figure C.1.** Effect of sample size on margin of error.

Source: VA OIG statistician's analysis

## Projections

Table C.2-C.4 present the OIG projections including the estimates derived from the sample population including estimate of value or claims, margin of error, lower 90 percent value, and upper 90 percent value, sample size and count.

**Table C.2. Estimated Dollar Amount of Community Care Claims Recoverable from Private Health Insurance**

Estimate name	Estimate number	90 percent confidence interval			Sample size	Count
		Margin of error	Lower limit	Upper limit		
Not billed	\$622,888,363 (52.3%)	\$236,410,508 (15.8%)	\$386,477,855 (36.6%)	\$859,298,871 (68.1%)	1,095	33
Billed	\$567,165,259 (47.7%)	\$261,510,418 (15.8%)	\$305,654,841 (31.9%)	\$828,675,678 (63.4%)	1,095	20
<b>Total billable</b>	<b>\$1,190,053,623</b>	<b>\$349,946,377</b>	<b>\$843,922,657</b>	<b>\$1,540,000,000</b>	<b>1,095</b>	<b>53</b>

Source: VA OIG statistician's stratified population. Data were obtained from the Plexis Claims Manager and Electronic Claims Adjudication Management System payment processing systems from April 20, 2017, through October 31, 2020.

Note: Tables C.2 through C.4 contain rounded projected estimates that do not total precisely due to rounding.

**Table C.3. Estimated Number of Community Care Claims Recoverable from Private Health Insurance**

Estimate name	Estimate number	90 percent confidence interval			Sample size	Count
		Margin of error	Lower limit	Upper limit		
Not billed	1,287,641 (54.1%)	462,426 (15.1%)	1,481,793 (39.1%)	1,750,067 (69.2%)	1,095	33
Billed	1,090,522 (45.9%)	491,162 (15.1%)	599,360 (30.8)	1,581,684 (60.9%)	1,095	20
<b>Total billable</b>	<b>2,378,163</b>	<b>662,569</b>	<b>1,715,594</b>	<b>3,040,733</b>	<b>1,095</b>	<b>53</b>

Source: VA OIG statistician's stratified population. Data were obtained from the Plexis Claims Manager and Electronic Claims Adjudication Management System payment processing systems from April 20, 2017, through October 31, 2020.

**Table C.4. Estimated Percentage of Community Care Claims Recoverable from Private Health Insurance**

Estimate name	Estimate	90 percent confidence interval			Sample size	Count
		Margin of error	Lower limit	Upper limit		
Not billed	3.73%	1.34%	2.39%	5.07%	1,095	33
Billed	3.16%	1.42%	1.74%	4.58%	1,095	20
<b>Total billable</b>	<b>6.89%</b>	1.92%	4.97%	8.81%	<b>1,095</b>	<b>53</b>

*Source: VA OIG statistician's stratified population. Data were obtained from the Plexis Claims Manager and Electronic Claims Adjudication Management System payment processing systems from April 20, 2017, through October 31, 2020.*

## Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Revenue from private health insurance that VA did not collect* (April 20, 2017, through October 31, 2020)	\$217.5 million	
1	Estimate of revenue from private health insurance that VA will not collect (November 2020 through September 2022)†	\$587.7 million	
	<b>Total</b>	<b>\$805.2 million‡</b>	

*Sources: The OIG team’s better use of funds are based on projections of private health insurance billing errors found in a sample from the universe of community care claims paid between April 20, 2017, and October 31, 2020. The FY 2021 “Current Estimate” and the FY 2022 “Revised Request” Medical Community Care and Veterans Choice obligations were used, as they reflected the most recent information in the budget at the time of the review. The FY 2021 “Current Estimate” was discounted by 1/12th to avoid double counting October 2020 (part of FY 2021), which was included in the scope of the audit and as part of the \$217.5 million.*

*\* The OIG estimated that OCC failed to bill veterans’ private health insurers \$622.9 million between April 20, 2017, to October 31, 2020, which is approximately 3.73 percent of the \$17.1 billion in claims paid during that period. The OIG estimated that \$217.5 million of that \$622.9 million could have been recovered, based on the VA’s Medical Care Collection Fund’s average of 35 percent collected for each dollar billed to private insurers during this period. The third-party collections-to-billing percentage is what VA collects for each dollar billed to private health insurance for medical services provided to veterans; it thus provides a reasonable benchmark for the amount VA could expect to recover from private health insurers. The actual amount of a recovery cannot be determined because the claims were not submitted to the veterans’ private health insurers so that the insurance companies could determine their responsibility to pay with respect to the member’s benefits.*

*† The OIG extrapolated these figures from the end of the period under audit, October 31, 2020, through the end of FY 2022. If VHA does not address the issue identified in this report, the OIG estimates that VA will fail to bill an additional \$1.7 billion of the \$45.1 billion FY 2021 and FY 2022 obligations based on the 3.73 percent ratio of unbilled claims to private insurance revenue found in fieldwork. As a result, the OIG further estimates that \$587.7 million of that \$1.7 billion would be recoverable if billed, based on the VA’s Medical Care Collection Fund’s average of 35 percent collected for each dollar billed to private insurers for medical services provided to veterans.*

*‡Amounts are rounded and so total may not sum precisely.*

## Appendix E: Management Comments

### Department of Veterans Affairs Memorandum

Date: March 29, 2022

From: Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, Veterans Health Administration: VHA Continues to Face Challenges with Billing Private Insurers for Community Care (Project Number 2021-00846-AE-0029) (VIEWS # 06976764)

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

Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on billing private insurers for community care. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.

To enhance clarity and accuracy in the report, VHA provides the updated table below to show average pending claims per Revenue Utilization Review (RUR) Nurse by Consolidated Patient Account Center (CPAC) (September 2020 – February 2021). The updates reflect data that represent Community Care Third Party Service Connection/Special Authority RUR inflow received by the CPACs for fiscal years 2020 and 2021. Using inflow over a 2-year period is a more representative measure of workload volume, as opposed to a 6-month period of pending claims. Any individual month could include a significantly higher inflow of claims. The use of a relatively short 6-month time period means that anomalies like this would have a higher likelihood of skewing the data.

CPAC	Two-year average (FY20-FY21) monthly inflow	Average number of revenue utilization review nurses	Average monthly inflow per revenue utilization review nurse
MSCPAC	72,430	48	1,509
CPCPAC	68,388	46	1,487
WCPAC	58,994	45	1,311
MACPAC	59,426	47	1,264
FCCPAC	21,811	18	1,212
NCCPAC	32,755	39	840
NECPAC	33,157	57	582

*The OIG removed point of contact information prior to publication.*

(Original signed by)

Steven L. Lieberman, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)**

**Action Plan**

**Veterans Health Administration: VHA Continues to Face Challenges with Billing Private Insurers for Community Care**

**(OIG Project 2021-00846-AE-0029)**

**Date of Draft Report: February 4, 2022**

**Recommendation 1. The OIG recommended that the Under Secretary for Health maximize opportunities to bill Veterans' private health insurers for recoverable claims by developing procedures that align and prioritize the processing of such claims to insurers' filing deadlines.**

**VHA Comments:** Concur. The Office of Revenue Operations will update current processes in its guidebooks to prevent current and future claims from inappropriately being removed for timely filing limits. A patch to the Veterans Health Information Systems and Technology Architecture (VistA) will be developed to add new timely filing parameters on insurance files. This enhancement will allow the Department of Veterans Affairs (VA) to update timely filing limits of insurance plans, with an effective termination date, without negatively impacting the auto-biller. When new timely filing parameters are modified, the auto-biller will identify all encounters within the new timeframe for each Veteran covered by payer. The Revenue Operations Payer Relations Department will work with national and regional payers to amend agreements that currently do not contain language acknowledging the 6-year timely filing limit. Revenue Operations will develop a plan to bill all appropriate and eligible encounters going back 6 years for care unrelated to military service. Revenue Operations will review current standard operating procedures and internal controls to confirm appropriate guidance is included for staff to prioritize claims based on order of service date. These corrective actions are underway.

Status: In Progress

Target Completion Date: March 2023

**Recommendation 2. The OIG recommended that the Under Secretary for Health strengthen information system controls to make certain that complete and accurate claims information is transferred between applicable current and future Community Care payment systems and the Consolidated Patient Account Centers' workflow tool and VistA patient treatment files.**

**VHA Comments:** Concur. The Office of Revenue Operations and VHA Business Architecture will review and develop a plan to strengthen information systems to confirm Revenue Operations receives complete and accurate claims information. In order to define Revenue Operations requirements for Community Care claims data, Revenue Operations will create a process to identify gaps and challenges with data from Community Care payment systems and processes. The process will use VA data integrity and governance frameworks to strengthen information system controls. These corrective actions are underway.

Status: In Progress

Target Completion Date: March 2023

**Recommendation 3. The OIG recommended that the Under Secretary for Health conduct an assessment to determine if staffing resources and workload are sufficiently aligned to process the anticipated volume of claims to be billed to veterans' private health insurers, and make adjustments as needed.**

**VHA Comments:** Concur. The Office of Revenue Operations will conduct a review of its Workforce Optimization and Resource Planning Model (WORPM). The updated WORPM data will be used to evaluate adjustments to authorized staffing levels across Consolidated Patient Account Center

Departments based on work volumes received and applicable productivity standards. These corrective actions are underway.

Status: In Progress

Target Completion Date: March 2023

*For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.*

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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